

OSCEOLA COUNTY SPECIAL NEEDS SHELTER APPLICATION

2009

DATE _____

PLEASE COMPLETE BOTH PAGES

LAST NAME		FIRST NAME			M.I.
STREET ADDRESS				APT OR LOT #	
CITY			ZIP		
HOME PHONE #		DATE OF BIRTH		MALE <input type="checkbox"/>	
() -		/ /		FEMALE <input type="checkbox"/>	
COMMUNITY OR SUBDIVISION NAME				IS THIS A MOBILE HOME?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
NAME OF FAMILY OR FRIEND TO CONTACT IN AN EMERGENCY					
NAME _____ PHONE: _____					
RELATIONSHIP TO YOU? _____					
WHO DO YOU LIVE WITH?		Live Alone <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Parents <input type="checkbox"/> Others <input type="checkbox"/>			
DO YOU HAVE A CAREGIVER?		YES <input type="checkbox"/> NO <input type="checkbox"/>		CAREGIVER GENDER MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
WHAT IS YOUR CAREGIVER'S NAME?					
WHAT IS YOUR CAREGIVER'S PHONE NUMBER?		() -			
ARE YOU A PARENT OR LEGAL GUARDIAN FOR PERSONS WHO RESIDE WITH YOU?				YES <input type="checkbox"/> NO <input type="checkbox"/>	
IF YES, LIST THEIR NAME(S) AND AGE(S)					
WHAT IS YOUR DOCTOR(S) NAME?					
WHAT IS YOUR DOCTOR(S) PHONE NUMBER?		() -			
YOUR AGE		YOUR HEIGHT		YOUR WEIGHT	lbs
DO YOU USE A WALKER?		YES <input type="checkbox"/> NO <input type="checkbox"/>		DO YOU USE A WHEELCHAIR?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
DO YOU SPEAK ENGLISH?		YES <input type="checkbox"/> NO <input type="checkbox"/>		IF NO, WHAT LANGUAGE?	
DO YOU HAVE TRANSPORTATION TO THE SPECIAL NEEDS SHELTER?				YES <input type="checkbox"/> NO <input type="checkbox"/>	
IF TRANSPORTATION IS NEEDED, CAN YOU HANDLE STEPS ON A BUS?				YES <input type="checkbox"/> NO <input type="checkbox"/>	
IF NOT, WILL YOU NEED A WHEELCHAIR LIFT?				YES <input type="checkbox"/> NO <input type="checkbox"/>	

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DO YOU RECEIVE IN-HOME CARE FROM A LOCAL AGENCY?		YES <input type="checkbox"/> NO <input type="checkbox"/>
IF YES, LOCAL AGENCY NAME		
LOCAL AGENCY PHONE NUMBER	() -	
PLEASE TELL US ABOUT YOUR MEDICAL CONDITION(S):		
DO YOU NEED A MACHINE TO HELP YOU BREATHE?	YES <input type="checkbox"/> NO <input type="checkbox"/>	
ARE YOU RECEIVING DIALYSIS?	YES <input type="checkbox"/> NO <input type="checkbox"/>	IF YES, HOW OFTEN?
DO YOU HAVE ALLERGIES?	YES <input type="checkbox"/> NO <input type="checkbox"/>	
IF YES, EXPLAIN:		
MEDICAL SUPPLIER'S NAME		
MEDICAL SUPPLIER'S PHONE NUMBER	() -	
CURRENT MEDICATIONS		
1	4	7
2	5	8
3	6	9

PLEASE REMEMBER YOU MUST BRING ALL NECESSARY MEDICATION AND SUPPLIES WITH YOU TO THE SPECIAL NEEDS SHELTER. ALSO BRING A COPY OF ALL PRESCRIPTIONS.

NAME OF YOUR PHARMACY		
PHARMACY'S PHONE NUMBER	() -	

I AGREE THAT MY NAME BE ADDED TO THE SPECIAL NEEDS SHELTER LIST. I GIVE OSCEOLA COUNTY EMERGENCY MANAGEMENT AUTHORITY TO SHARE THIS INFORMATION WITH OTHER AGENCIES IN THE EVENT OF AN EMERGENCY EVACUATION. I UNDERSTAND THAT BY SIGNING THIS FORM, I GRANT EMERGENCY RESPONDERS PERMISSION TO ENTER MY HOME AT THE TIME OF AN EMERGENCY. I UNDERSTAND THE LIMITATION ON THE SERVICES AND LEVEL OF CARE AVAILABLE.

SIGNED _____ DATE _____

Note: THIS FORM MUST BE SIGNED BY THE SPECIAL NEEDS CLIENT OR AUTHORIZED AGENT!

If Authorized Agent; Name _____ Phone _____

Relationship to Client _____