

People with Special Needs (PSN) Application

Return Application to:

PSN Registry
 Emergency Management
 1660 Ringling Blvd., 6th floor
 Sarasota, Florida 34236
 (941) 861-5000

Official Use (Revision 8/09/06)

FZ	Div# & Evac/Flood	GRID	Destination	File #
Received		Entered		Processed

Please print clearly

For convenience and comfort, citizens are encouraged to make their own evacuation and shelter plans if possible. As an alternative, the PSN program addresses the needs of people who have medical conditions or need transportation to shelters.

Name: _____ Birth date: ____/____/____ Age: _____

Address: _____ Apt.: _____
Street City State Zip code

Name of residential complex / sub-division / facility: _____

Telephone: (____) _____ E-mail address: _____

Spouse's name: _____ Your weight: _____ lbs.

Emergency contact (who does **not** reside with you):

Name: _____ Phone: (____) _____

My spouse will evacuate with me: Yes No My caretaker: Yes No
 Other person: _____ Total people to evacuate (including you): _____

Primary doctor's name: _____ Phone: (____) _____

Home health agency: _____ Phone: (____) _____

Type of home: Single family Condo Apartment Villa

Construction: Mobile home Wood-frame Masonry Red brick Not sure

Do you have a work/guide dog? Yes No Total number of: _____ Dogs _____ Cats
(Work/guide dogs are the only animals allowed in Special Needs shelters.) (Make arrangements for your pet with a vet or kennel prior to evacuation.)

Transportation

"I need evacuation transportation." Yes No

If marked "Yes" above, what kind of transportation do you need?

Standard vehicle Stretcher vehicle Wheelchair vehicle

Medical History (Please check all that apply)

1

- | | | |
|---|---|--|
| <input type="checkbox"/> Skin infections | <input type="checkbox"/> Heart condition (stable / CHF) | |
| <input type="checkbox"/> Dementia (early) | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ostomy (type: _____) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Skin disease | <input type="checkbox"/> Seizures (controlled) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease (stable) |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Edema | <input type="checkbox"/> Emphysema / COPD |

- | | |
|---|--|
| <input type="checkbox"/> Muscular Dystrophy (MD) | <input type="checkbox"/> Hip/knee replacement (less than 6 months) |
| <input type="checkbox"/> Stroke/CVA (limitations) | <input type="checkbox"/> Cerebral Palsy (CP) |
| <input type="checkbox"/> Open sores | <input type="checkbox"/> Aphasia |
| <input type="checkbox"/> Nebulizer | <input type="checkbox"/> Oxygen use, ___ L/min (Liters per minute, number on dial) |
| <input type="checkbox"/> Multiple Sclerosis (MS) | |

3

- | | |
|---|--|
| <input type="checkbox"/> Comatose | <input type="checkbox"/> Dementia (moderate to late) |
| <input type="checkbox"/> Parkinson's disease, (early) | <input type="checkbox"/> Parkinson's disease, (advanced) |
| <input type="checkbox"/> Special diet (Bring any doctor-prescribed food items with you when you evacuate.) | |
| <input type="checkbox"/> Medical Equipment (IV, tube feeder, indwelling catheter) | |

- | | |
|---|---|
| <input type="checkbox"/> Psychosis (uncontrolled) | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> Unstable heart condition | <input type="checkbox"/> Hospice |
| <input type="checkbox"/> Seizures (uncontrolled) | <input type="checkbox"/> Contagious disease (name:) |

4

Other medical conditions / Comments _____

Power Dependant

- | | | |
|--|---|--|
| <input type="checkbox"/> Ventilator/respirator | <input type="checkbox"/> Sleep apnea (CPAP Machine) | <input type="checkbox"/> Oxygen concentrator |
| <input type="checkbox"/> Other: _____ | | |

Mobility

- | | | |
|--|--|---|
| <input type="checkbox"/> I walk without help | <input type="checkbox"/> I use a cane | <input type="checkbox"/> I use a walker |
| <input type="checkbox"/> I use a wheelchair | <input type="checkbox"/> I am wheelchair bound | <input type="checkbox"/> I am bedridden |
| <input type="checkbox"/> I have someone assist me with all my daily activities | | |

Read and Sign

To the best of my knowledge, I certify that this information contained herein is true and correct. I understand that based on the data I have provided, the Department of Emergency Management in consultation with the Department of Health will determine which evacuation assistance, if any, this program may be able to provide.

The law permits Sarasota County Government, Emergency Services to use and disclose my protected health information, for treatment, payment and health care operations. Understanding the PSN evacuation program is provided at no charge, I also accept responsibility for all expenses associated with any extenuating medical issues that arise.

Name: (print) _____ Signature: _____

If person completing this form is **NOT** the applicant, please answer the following:

Name/Phone: _____ Relationship/agency: _____

You will be contacted with more information.

☞ *Thank you for allowing us to help you be prepared.* ☞