SARASOTA COUNTY PEOPLE WITH SPECIAL NEEDS (PSN) APPLICATION

Sarasota County
scgov.net | 941.861.5000 | TV19

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Sarasota, Florida 34236
Fax (941) 861-5501

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 with medical conditions or need transportation to a shelter.

GENERAL INFORMATION

Name:_____ ___ _____ Spouse: _____
Last MI First

_____ _____ FL _____ _____
Address City, St. Zip Unit

Phone # (____)_____ Email Address:_____

Birth Date: ____/____/____ Age: ____ Gender: Male ____ Female ____ **Weight** ____ Height ___'___"

Primary Language Spoken: _____English _____Spanish _____Other: _____

Phone number to be reached if not a full-time resident of Sarasota? (____)_____

Sub-Division/Facility – Location Description: _____

Type of Home_____ Type of Construction _____Year Built _____
(i.e.: Single Family, Apt/Condo) (i.e.: Block, Wood, Brick, **Mobile home,** Unknown etc.)

PETS
___Pet provided for
___Number of Cats
___Number of Dogs
Working Dog? _____Yes _____No

TRANSPORTATION FOR PSN APPLICANT
Do you need Transportation? ____Yes ____No
___Ambulance (bedridden)
___Lift Gate Vehicle (wheelchair)
___Standard Vehicle (canes, walkers, walks without help)

TRANSPORTATION FOR OTHER EVACUEES
___Ambulance (bedridden)
___Lift Gate Vehicle (wheelchair)
___Standard Vehicle (canes, walkers, walks without help)

Offical Use Only

FZ	Evac/Flood Div #	CodeRED	Grid	Destination	File #

	Received date:	Entered Date

CONTACTS AND EVACUEES *PSN Applicant Name* **(from front):**_____

_____ (____)_____ _____ (____)_____
Primary Doctor: Phone Home Health Agency Info Phone:

_____ (____)_____ _____ (____)_____
Emergency Contact Phone Caregiver Phone

___ Evacuate Spouse?
___ Evacuate Caregiver?

____Number of additional Evacuees (Excluding PSN Spouse, Caregiver)

MEDICAL INFORMATION

___Aphasia
___Arthritis
___Asthma
___Breathing Treatment
___Bronchitis
___Cancer
___Cerebral Palsy
___Comatose
___Contagious Disease – Type: _____
___Dementia ____Early ____Moderate ____Late
___Diabetes
___Dialysis: (In Home Dialysis?) ____Yes ____No
___Difficulty Speaking
___Edema
___Emphysema/COPD
___Hearing Impaired
___Heart Condition ____Stable ____Unstable
___High Blood Pressure
___Hip/Knee Replacement: When? _____
___Hospice ("end-of-life" diagnosis, not palliative care)
___Medical Equipment. Circle any that apply: (Feeding tube, Ventilator, IV, Indwelling Catheter)
___Memory Loss
___Mentally Impaired
___Multiple Sclerosis
___Muscular Dystrophy
___Nebulizer
___Open Sores
___Ostomy – Type _____
___**Oxygen** Use ____**LPM** (Number on dial)
___Parkinson's Disease: ___Early ___Mod ___Late
___Psychosis ____Controlled ____Uncontrolled
___Seizures ____Controlled ____Uncontrolled
___Sight Impaired
___Skin Disease
___Skin Infections
___Special Diet (Bring doctor-prescribed food)
___Speech Impaired
___Stroke/CVA (Limitations)

List known allergies: _____
List medication: _____
Other Comments: _____

POWER DEPENDENT

___Electric Dependent, Why? _____
___Oxygen Concentrator
___Sleep Apnea (CPAP Machine)
___Ventilator/Respirator (Machine is used to breath for you, unlike the Oxygen Concentrator and CPAP)
___Other, Please Specify: _____

MOBILITY

___I have someone assist me with all my daily activities
___I walk without help
___I use a cane
___I use a walker. Walk long distances? ___Yes ___No
___I use a wheelchair
___I am bedridden

*** CONTACT US WITH <u>CHANGES</u> TO YOUR INFORMATION, <u>NO</u> NEED TO RE-REGISTER YEARLY.**

Revised 5/26/2010

Medical History (Please check all that apply)

❶

__ Skin infections
__ Dementia (early)
__ Arthritis
__ Asthma
__ Bronchitis
__ Heart condition (stable / CHF)
__ High blood pressure
__ Skin disease
__ Diabetes
__ Edema
__ Ostomy (type:_____)
__ Seizures (controlled)
__ Kidney disease (stable)
__ Emphysema / COPD

❷

__ Muscular Dystrophy (MD)
__ Stroke/CVA (limitations)
__ Open sores
__ Nebulizer
__ Multiple Sclerosis (MS)
__ Hip/knee replacement (less than 6 months)
__ Cerebral Palsy (CP)
__ Aphasia
__ Oxygen use, ___ **L/min (Liters per minute, number on dial)**

❸

__ Comatose
__ Parkinson's disease, (early)
__ Special diet (**Bring any doctor-prescribed food items with you when you evacuate.**)
__ Medical Equipment (IV, tube feeder, indwelling catheter)
__ Dementia (moderate to late)
__ Parkinson's disease, (advanced)

❹

__ Psychosis (uncontrolled)
__ Unstable heart condition
__ Seizures (uncontrolled)
__ Dialysis
__ Hospice
__ Contagious disease (name:) _____

Other medical conditions / Comments _____

Power Dependant

__ Ventilator/respirator __ Sleep apnea (CPAP Machine) __ Oxygen concentrator
__ Other: _____

Mobility

__ I walk without help __ I use a cane __ I use a walker
__ I use a wheelchair __ I am wheelchair bound __ I am bedridden

__ 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.

Sarasota County