



ORANGE COUNTY HEALTH SERVICES DEPARTMENT
PEOPLE WITH SPECIAL NEEDS PROGRAM
REGISTRATION FORM



PLEASE STOP & READ

This form is for **NEW REGISTRATIONS ONLY**. If you are providing an update to an existing registration, please contact Orange County 311 at (407) 836-3111.

To complete this registration form online  <https://netapps.ocfl.net/psn>

PERSONAL INFORMATION FOR INDIVIDUAL WITH SPECIAL NEEDS

First Name _____ Middle Name _____ Last Name _____

Physical Address _____ Apt/Lot No. _____ City _____ State _____ Zip Code _____

Residence Type ☐ Single Family Home ☐ Mobile Home ☐ Multi-Family Home ☐ Apartment ☐ Other _____

Name of Subdivision/Condo/Mobile Home Park/Apartment Complex/Building _____

Primary Phone _____ ☐ Primary Phone is TTY/TTD Secondary Phone _____ ☐ I do not have a phone

Email address _____ ☐ Male ☐ Female Height _____ Ft _____ In

Date of Birth _____ Gender ☐ Transgender ☐ Non-Binary Weight _____ lbs

☐ Prefer not to answer

MAILING ADDRESS IF DIFFERENT THAN PHYSICAL ADDRESS

☐ Same as physical address

Mailing Address _____ Apt/Lot No. _____ City _____ State _____ Zip Code _____

EMERGENCY CONTACT(S) INFORMATION

Primary Contact

First Name _____ Last Name _____ Relationship _____

Primary Phone _____ Secondary Phone _____

☐ Checking this box allows medical information to be shared with this contact.

Secondary Contact

First Name _____ Last Name _____ Relationship _____

Primary Phone _____ Secondary Phone _____

☐ Checking this box allows medical information to be shared with this contact.

***CAREGIVER* (ANY PERSON, OFTEN A FAMILY MEMBER, WHO HELPS WITH THE ACTIVITIES OF DAILY LIVING)**

Caregiver Name _____ Caregiver's Phone _____

Do you require a 24-hour caregiver? ☐ Yes ☐ No

Will your caregiver travel and/or stay with you? ☐ Yes ☐ No

MEDICAL PROVIDERS

Physician's Name _____ Physician's Phone _____

Pharmacy Name _____ Pharmacy Phone _____

Home Health Care Agency Name _____ Home Health Care Agency Phone _____

Medical Equipment Provider Name _____ Med Equipment Provider Phone _____

Oxygen Provider Name _____ Oxygen Provider Phone _____

TRANSPORTATION NEEDS

Transportation Required? ☐ Yes ☐ No ☐ Unsure

PLEASE CHECK ALL VEHICLE TYPES THAT CAN BE USED FOR TRANSPORTATION:

☐ Car can be used

☐ Wheelchair accessible van

☐ Ambulance

☐ Needs to be transported on a stretcher

Continuous oxygen is required during transport ☐ Yes ☐ No

Number of family members (living in your home) who will accompany you to a shelter?

MOBILITY NEEDS

Do you have mobility needs? ☐ Yes ☐ No

☐ Confined to Bed

☐ Paralyzed

☐ Wheelchair

☐ Attendant to Assist in Ambulating

☐ Partial Paralysis

☐ Complete Paralysis

Select all devices that are used to aid mobility

☐ Walker / Cane / Rollator

☐ Standard Wheelchair

☐ Motorized Wheelchair

☐ Motorized Scooter

EQUIPMENT NEEDS

Are you dependent on Electrical Equipment? ☐ Yes ☐ No

Are you Oxygen Dependent? ☐ Yes ☐ No

Oxygen Type

☐ Gaseous

☐ Liquid

Oxygen Mode

☐ Mask

☐ Nasal Cannula

☐ Trach Collar

Liter Flow

_____ LPM

Frequency

☐ 24 Hours

☐ Only Overnight

☐ As Needed

Select All Equipment Used:

☐ Apnea Monitor

☐ CPAP / BIPAP

☐ Cardiac Monitor

☐ Dialysis Catheter

☐ Feeding Pump

☐ Feeding Tube

☐ Nebulizer

☐ Oxygen Concentrator

☐ Suction Pump

☐ Ventilator

☐ Wound Vac

☐ Tracheostomy Tube

☐ Hoyer Lift

☐ Pulse Oximeter

☐ Catheter

☐ Medications that Require Refrigeration

☐ Other Equipment _____

ADDITIONAL INFORMATION *Please enter any additional information that may be useful to emergency personnel.*

MEDICAL HISTORY

- ☐ Alzheimer's Disease
 - ☐ Mild
 - ☐ Severe
- ☐ ALS
 - ☐ Early Stage
 - ☐ Middle Stage
 - ☐ Late Stage
- ☐ Aphasia
- ☐ Assistance with Daily Living
- ☐ Asthma
- ☐ Arthritis
- ☐ Autism
- ☐ Behavioral Health
- ☐ Blind / Low Vision / Vision Impaired
- ☐ Cancer
 - ☐ Chemotherapy
 - ☐ Radiation
 - ☐ Surgical
 - ☐ Palliative
 - ☐ Remission
 - ☐ End-stage
 - ☐ N/A
- ☐ Cardiac Type
 - ☐ Stable
 - ☐ Unstable
- ☐ Cerebral Palsy
- ☐ Chronic Obstructive Pulmonary Disease (COPD)

- ☐ Comatose
- ☐ Contagious Disease
- ☐ Cystic Fibrosis
- ☐ Deaf / Hard of Hearing
- ☐ Dementia
 - ☐ Mild
 - ☐ Moderate
 - ☐ Severe
 - ☐ N/A
- ☐ Diabetes
 - ☐ Insulin Dependent
 - ☐ Non-Insulin Dependent
- ☐ Dialysis Type
 - ☐ Hemodialysis at Facility
 - ☐ Hemodialysis at Home
 - ☐ Peritoneal
 - ☐ N/A
- ☐ Dialysis Frequency
 - ☐ Daily
 - ☐ 2 times week
 - ☐ 3 times week
- ☐ Eating and Swallowing Disorder
- ☐ Edema
- ☐ Emphysema
- ☐ Fractured Bones
- ☐ Frail Elderly
- ☐ High Blood Pressure

- ☐ Hip/Knee Replacement
 - ☐ Ambulatory
 - ☐ Non-Ambulatory
 - ☐ Confined to Bed
- ☐ Incontinence
- ☐ IV Care
- ☐ Mentally / Memory Impaired
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Neuromuscular Disorder
- ☐ Ostomy
- ☐ Paralysis
- ☐ Parkinson's Disease
- ☐ Premature Birth
- ☐ Seizures
- ☐ Sleep Apnea / CPAP User
- ☐ Speech Impediment
- ☐ Stroke
- ☐ Terminal
 - ☐ Endstage
 - ☐ N/A
- ☐ Wounds / Sores / Rashes
- ☐ Other

SERVICE ANIMALS / PETS

Do you own an animal? ☐ Yes ☐ No What type of animal? ☐ Dog ☐ Cat ☐ Miniature Horse ☐ Other _____

Is this animal a service animal (e.g. a seeing-eye dog)? ☐ Yes ☐ No Is this animal an emotional support animal? ☐ Yes ☐ No

Animal's Name _____ Breed/Description _____ Weight _____

Is there a carrier cage available? ☐ Yes ☐ No Is there a leash available? ☐ Yes ☐ No Is there a muzzle available? ☐ Yes ☐ No

Do you own more than one animal? ☐ Yes ☐ No If yes, how many animals will accompany you to a shelter? _____

Additional Information about Service Animals / Pets

Please list every additional animal separately along with answers to the questions asked above.

ACKNOWLEDGEMENT

The following statements provide information on how Orange County handles Personal Health Information (PHI). They will not impact the receipt of services during time of hurricanes or disasters.

It is crucial to our response efforts that the information you provide be as accurate and up to date as is possible. You will be contacted periodically to verify and ensure the information provided is correct, and to make any necessary changes. Individual forms will need to be updated on an annual basis to remain active on the registry.

Your information will only be released to emergency response agencies for assistance during emergency and disaster situations; and emergency responders may enter your home and provide for your needs in an emergency situation.

Expenses associated for transport or admission to a hospital while in a shelter setting will be the client’s responsibility.

This form was completed by:

☐ Special Needs Client:

Client Signature _____

Date _____

☐ Family Member:

Name _____

Phone No. _____

☐ Case / Social Worker:

Name _____

Phone No. _____

☐ Healthcare Proxy:

Name _____

Phone No. _____

☐ Other:

Name _____

Phone No. _____

Return Completed Forms to:
Orange Co Special Needs Program
4654 35th Street
Orlando, FL 32811
FAX: (407) 836-2838