



Florida Special Needs Registry Registration Information - DeSoto County

Instructions: Complete this form and fax or mail it to DeSoto County to register an individual for the Florida Special Needs Registry. This form is not required if you have already registered on line. Required fields are indicated with an asterisk (*).

Mail: DeSoto County Special Needs Registry
2200 NE Roan St.
Arcadia, FL 34266

Fax: (863) 993-4839

PERSONAL INFORMATION ABOUT THE REGISTRANT	
*First Name	
Middle Name	
*Last Name	
Suffix	
*Birth Date	
*Gender (select only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Non-Binary <input type="checkbox"/> Prefer Not To Provide
*Height	Feet: Inches:
*Weight (pounds)	
Living Situation (select only one)	<input type="checkbox"/> Live alone <input type="checkbox"/> Live with relative or caregiver <input type="checkbox"/> Other living situation
*Primary Language	
Secondary Language	
Veteran	<input type="checkbox"/> Yes <input type="checkbox"/> No
Last 4 digits of SSN	
Email Address	
Are you completing this form on behalf of the registrant? If so, please indicate your relationship to the registrant (select only one)	<input type="checkbox"/> Family Member <input type="checkbox"/> Caregiver <input type="checkbox"/> Neighbor <input type="checkbox"/> Friend <input type="checkbox"/> Home Health Care Provider <input type="checkbox"/> County Emergency Management Staff <input type="checkbox"/> County Health Department Staff <input type="checkbox"/> DOH State Staff

ADDRESS FOR THE REGISTRANT (physical address is required)	
*Physical Address (cannot be a PO Box)	
*Physical City	
*Physical State	FL
*Physical Zip Code	
Name of Complex, Subdivision or Mobile Home Park	
Is the home at this address a mobile home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the home at this address a highrise or multi-story home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does this home have stairs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a gate that requires a code to enter?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you live at this address year round?	<input type="checkbox"/> Yes <input type="checkbox"/> No If No, from month: _____ To month: _____
Mailing Address (if different from above)	



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ADDRESS FOR THE REGISTRANT (physical address is required)

Mailing City	
Mailing State	
Mailing Zip Code	

PHONE NUMBERS FOR THE REGISTRANT (a primary and at least one other phone number is required)

*Phone Number	Extension	*Phone Type (select only one)	Primary	TTY/TDD Capable
() -		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
() -		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
() -		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

PRIMARY EMERGENCY CONTACT FOR THE REGISTRANT (required)

*Primary Emergency Contact Name	
Contact Address	
Contact City	
Contact State	
Contact Zip Code	
*Contact Primary Phone Number	() - Extension:
Is this phone TTY/TDD capable?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact Secondary Phone Number	() - Extension:
Is this phone TTY/TDD capable?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact Email Address	

OTHER CONTACTS FOR THE REGISTRANT (entry is optional)

*Other Contact Name	
*Contact Type (select only one)	<input type="checkbox"/> Secondary Emergency Contact <input type="checkbox"/> Caregiver <input type="checkbox"/> Family Member <input type="checkbox"/> Neighbor <input type="checkbox"/> Friend <input type="checkbox"/> Physician <input type="checkbox"/> Pharmacy <input type="checkbox"/> Home Health Care Provider <input type="checkbox"/> Home Medical Equipment Provider <input type="checkbox"/> Hospice Provider <input type="checkbox"/> Oxygen Provider <input type="checkbox"/> Dialysis Clinic <input type="checkbox"/> Other Medical Provider <input type="checkbox"/> Out Of Area Contact
Contact Address	
Contact City	
Contact State	
Contact Zip Code	
*Contact Primary Phone Number	() - Extension:
Is this phone TTY/TDD capable?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact Secondary Phone Number	() - Extension:
Is this phone TTY/TDD capable?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact Email Address	



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OTHER CONTACTS FOR THE REGISTRANT (entry is optional)

*Other Contact Name	
*Contact Type (select only one)	<input type="checkbox"/> Secondary Emergency Contact <input type="checkbox"/> Caregiver <input type="checkbox"/> Family Member <input type="checkbox"/> Neighbor <input type="checkbox"/> Friend <input type="checkbox"/> Physician <input type="checkbox"/> Pharmacy <input type="checkbox"/> Home Health Care Provider <input type="checkbox"/> Home Medical Equipment Provider <input type="checkbox"/> Hospice Provider <input type="checkbox"/> Oxygen Provider <input type="checkbox"/> Dialysis Clinic <input type="checkbox"/> Other Medical Provider <input type="checkbox"/> Out Of Area Contact
Contact Address	
Contact City	
Contact State	
Contact Zip Code	
*Contact Primary Phone Number	() - Extension:
Is this phone TTY/TDD capable?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact Secondary Phone Number	() - Extension:
Is this phone TTY/TDD capable?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact Email Address	

Additional County Information

Name of person who will stay with you at the shelter?	
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REGISTRANT'S PETS

*Pet Name	*Type of Animal	*Breed / Description	Vaccinations Up to Date	Will Bring to Shelter	Requires Medication	Other information about this pet
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

REGISTRANT'S SERVICE ANIMALS

*Animal Type (select only one)	*Required Due to Disability	*Work or Task Animal has been trained to perform
<input type="checkbox"/> Dog <input type="checkbox"/> Miniature Horse	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Dog <input type="checkbox"/> Miniature Horse	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Dog <input type="checkbox"/> Miniature Horse	<input type="checkbox"/> Yes <input type="checkbox"/> No	

REGISTRANT'S EQUIPMENT

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REGISTRANT'S EQUIPMENT

Please indicate the medically necessary equipment that is electric dependent for this registrant: (select all that apply)	<input type="checkbox"/> Apnea Monitor <input type="checkbox"/> Cardiac Monitor <input type="checkbox"/> CPAP / BiPAP <input type="checkbox"/> Dialysis Catheter <input type="checkbox"/> Feeding Pump <input type="checkbox"/> Medication that requires refrigeration <input type="checkbox"/> Nebulizer <input type="checkbox"/> Oxygen Concentrator <input type="checkbox"/> Suction Pump <input type="checkbox"/> Ventilator <input type="checkbox"/> Wound Vac
Other: <input style="width: 90%;" type="text"/>	
Please indicate any medically necessary equipment that is NOT electric dependent for this registrant: (select all that apply)	<input type="checkbox"/> Indwelling Urinary Catheter <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Peripheral Intravenous Line <input type="checkbox"/> PICC Line <input type="checkbox"/> Port-a-Cath <input type="checkbox"/> Pulse Oximeter <input type="checkbox"/> Tracheostomy

TRANSPORTATION & MOBILITY

Registrant has the following transportation needs: (select all that apply)	<input type="checkbox"/> Can be transported in a car <input type="checkbox"/> Can be transported in a bus <input type="checkbox"/> Must be transported in a wheelchair accessible vehicle <input type="checkbox"/> Must be transported in a stretcher van <input type="checkbox"/> Uses a wheelchair but can transfer to a van seat <input type="checkbox"/> Weight requires special transportation <input type="checkbox"/> Needs continuous oxygen during transport <input type="checkbox"/> Just needs transportation to a shelter
Registrant has the following mobility issues: (select all that apply)	<input type="checkbox"/> Needs help to walk <input type="checkbox"/> Needs help to get into/out of a cot <input type="checkbox"/> Uses a lift to get out of a cot <input type="checkbox"/> Is confined to a bed <input type="checkbox"/> Is paralyzed (complete or partial) <input type="checkbox"/> Uses a Walker <input type="checkbox"/> Uses a Cane <input type="checkbox"/> Uses a Wheelchair <input type="checkbox"/> Uses a Motorized Wheelchair / Scooter
Other: <input style="width: 90%;" type="text"/>	

MEDICAL & OTHER

Behavioral: (select all that apply)	<input type="checkbox"/> Autism <input type="checkbox"/> Bipolar <input type="checkbox"/> Combative / Violent <input type="checkbox"/> Conduct Disorder <input type="checkbox"/> Obsessive / Compulsive <input type="checkbox"/> Personality Disorder <input type="checkbox"/> Psychosis <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Self-injurious or danger to others <input type="checkbox"/> Substance Abuse
Other: <input style="width: 90%;" type="text"/>	
Memory: (select all that apply)	<input type="checkbox"/> Alzheimer and related dementias <input type="checkbox"/> Dementia <input type="checkbox"/> Memory Impaired
Dialysis: (select all that apply)	<input type="checkbox"/> Hemodialysis (Facility/Home) <input type="checkbox"/> Peritoneal Dialysis
Dialysis Frequency: (select only one)	<input type="checkbox"/> 1 time a week <input type="checkbox"/> 2 times a week <input type="checkbox"/> 3 times a week <input type="checkbox"/> 4 times a week <input type="checkbox"/> 5 times a week <input type="checkbox"/> 6 times a week <input type="checkbox"/> 7 times a week (daily)
Oxygen Type: (select only one)	<input type="checkbox"/> Gaseous <input type="checkbox"/> Liquid
Oxygen Liter Flow / Amount: (select only one)	<input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/> 3.0 <input type="checkbox"/> 3.5 <input type="checkbox"/> 4.0 <input type="checkbox"/> 4.5 <input type="checkbox"/> 5.0 <input type="checkbox"/> 5.5 <input type="checkbox"/> 6.0 <input type="checkbox"/> 6.5 <input type="checkbox"/> 7.0
Oxygen Mode of Administration: (select only one)	<input type="checkbox"/> Mask <input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Trach Collar
Medication Allergies & Reactions (list all)	<input style="width: 90%;" type="text"/>



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MEDICAL & OTHER

Do you need assistance with administering your medications?

- Yes No

Other: (select all that apply)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Vision Impaired | <input type="checkbox"/> Partially Blind | <input type="checkbox"/> Legally Blind | <input type="checkbox"/> Hearing Impaired |
| <input type="checkbox"/> Deaf | <input type="checkbox"/> ALS | <input type="checkbox"/> Arthritis / Osteoporosis | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bedsore (Decubitus Ulcer) | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> COPD | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Incontinent | <input type="checkbox"/> IV Pump | <input type="checkbox"/> Flight Risk |
| <input type="checkbox"/> Non verbal | <input type="checkbox"/> Difficulty understanding verbal instructions | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> MS | <input type="checkbox"/> Ostomy (Colostomy, Ileostomy, Urostomy) |
| <input type="checkbox"/> Pacemaker / AICD | <input type="checkbox"/> Parkinsons | <input type="checkbox"/> Peritoneal Dialysis Pump | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Stroke | | | |

Contagious Disease:

Food Allergies & Reactions:

Other:

Name of Primary Insurance Company:

Insurance ID #:

Medicare #:

Medicaid #:

REGISTRANT'S MEDICATION (Use additional paper if more space needed)

*Name of Medication	Dosage	Route	Requires Refrigeration
		<input type="checkbox"/> Auto Injector <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Mouth <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Sublingual <input type="checkbox"/> Transdermal	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Auto Injector <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Mouth <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Sublingual <input type="checkbox"/> Transdermal	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Auto Injector <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Mouth <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Sublingual <input type="checkbox"/> Transdermal	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Auto Injector <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Mouth <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Sublingual <input type="checkbox"/> Transdermal	<input type="checkbox"/> Yes <input type="checkbox"/> No

