For Office Use Only

Special Needs Shelter:: _____

Red Cross Shelter: _____

Hillsborough County Health Department Shelter Evaluation Form
(PLEASE PRINT * MUST BE COMPLETED)

Last Name*: _____ First Name: _____ SSN*:_____

*****Placement in a Special Needs Shelter cannot be guaranteed if submitted after June 1st each year.*****

I understand the limitation on the services and level of care available at a Special Needs Shelter. I grant permission to medical providers, transportation agencies, and others as necessary, to provide care and disclose any information necessary to respond to my needs. I understand that registration does not guarantee assignment to the requested special needs shelter type, all assignments will be made on the basis of medical need and available space at the time of evacuation. **I understand that I can identify one individual to be my caregiver while I am at the shelter.** This registration is voluntary and I hereby request registration in the Special Needs Program.

_____ _____

Signature of Patient / Guardian Date Signed

Sex: ☑ Male ☐ Female Weight*: _____ Date of Birth*: _____

Street Address: _____ Phone:_____

Lot/Apt #: _____ City: _____ Zip Code: _____

Do you live in a mobile home? ☐ **Yes** ☐ **No** **Park Name (If applicable)** _____

Mailing Address:_____

Local Emergency Contact Name: _____Phone #: _____

Are you a seasonal/temporary resident? ☐ Yes ☐ No In County: _____ - _____

From Date To Date

Is there a relative/neighbor/manager who can check your residence after the storm? ☐ Yes ☐ No

If yes: Name: _____ Phone #:_____

Your caregiver at the shelter: _____Phone #: _____

Your Primary Physician's Name: _____ Phone #: _____

Medical Problems: _____

Mobility: ☐ Ambulatory

☐ Wheelchair Do you have your own wheelchair? ☐ Yes ☐ No

Is your wheelchair motorized? ☐ Yes ☐ No

If you have a wheelchair, please bring it to the shelter.

☐ Bedridden Can you be moved in a wheelchair? ☐ Yes ☐ No

Do you need transportation to the shelter? ☐ **Yes** ☐ **No**

Do you have a seeing-eye dog or other service animal? ☐ **Yes** ☐ **No**

Electric Dependent: ☐ Yes ☐ No ☐ Nebulizer ☐ Concentrator ☐ Other _____

Oxygen Required: ☐ Yes ☐ No If Yes, Oxygen Provider: _____

Dialysis ☐ Yes ☐ No If Yes, Dialysis Provider:_____

Ongoing Wound Care ☐ Yes ☐ No Describe: _____

Home Health Agency:

Name:_____ Address: _____Phone #: _____

Other Agencies who provide you care:

Name:_____ Address: _____Phone #: _____

Name:_____ Address: _____Phone #: _____

Name:_____ Address: _____Phone #: _____

Return form to: Hillsborough County Health Department PO Box 5135 Tampa, Fl 33675-5135
Or FAX to (813) 276-8689. For more information call (813) 307-8015 Ext. 6006.