



Pasco County Emergency Management

Special Needs Registration Form

Applicant Information

Full Name: _____ Date of birth: _____
Last First M.I.

Address: _____
Street Address Subdivision/Apartment/Unit #

City State ZIP Code

Phone number: _____ Email: _____

Gender- Male Female Do you live alone? YES NO Do you have a service animal? YES NO

Caregiver: _____ Caregiver Phone Number : _____

Does your caregiver live with you? YES NO Do you have any non-service pets? YES NO

Do you live in a mobile home? YES NO Do you live here full time or seasonally? _____

Emergency contact/ Phone number/ Address: _____

Healthcare Provider Information

Home Health Agency: _____ Phone Number: _____

Primary Physician: _____ Phone Number: _____

Medical Conditions

- Bedridden Wheelchair Walker Ventilator Continuous Equipment Over 300 lbs Combative/violent
- Nebulizer Concentrator CPAP Oxygen Dependent- Hours per day: _____ Liter Flow: _____
- Alzheimer's Dementia Mobility Issues Contagious Disease- Which one? _____
- Communication Difficulty Wound Care Incontinent Dialysis- How frequent _____
- Diabetic Insulin Dependent Feeding Tube Ileostomy/Colostomy Heart Disease Blood Pressure
- Stroke Visual Impairment Hearing Impairment Neurological Condition- Explain: _____
- Cancer- Is it being treated, if so explain how: _____

Transportation

- I will provide my own transportation I need transportation I require a wheelchair lift bus/van and transportation

Acknowledgment - Please Read Carefully

The information contained herein is true and correct to the best of my knowledge. I have read the letter and the Special Needs Shelter Fact Sheet accompanying this request, and I understand the limitations on the services and level of care available. I understand that this registration is voluntary and hereby request registration in the Pasco County Special Needs Program. I also understand that this registration does not guarantee my access to a Special Needs Shelter. I grant permission to medical providers and transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs. I hereby grant permission for the release of this information to emergency response agencies and pre-authorize these agencies to enter my residence for the purpose of emergency search and rescue.

SIGNATURE: _____ **DATE:** _____

REPRESENTATIVE (If you are unable to sign): _____

RELATIONSHIP TO THE APPLICANT: _____

Please Return Form To:
Pasco County Department of Emergency Management
8744 Government Drive, Bldg. A, New Port Richey, FL 34654
For more information call: 727-847-8137
(For Official Use Only)

Reviewed by: _____ **Date:** _____