



# Palm Beach County Special Needs Shelter Application

APPLICATION DATE: \_\_\_\_\_

## SHELTER INFORMATION

Thank you for your interest in the Palm Beach County Special Needs Shelter. Please understand that the shelter is a place of refuge of last resort from dangerous weather or other emergencies. While basic services such as feeding, electricity, and medical supervision will be provided; clients and caregivers must be independent for the first three days. The shelter is not a medical facility and cannot provide the appropriate care to ventilator patients.

**Please remember:** The shelter only provides adjustable back hospital cots for clients. **Caregivers do not receive cots**

## SPECIAL NEEDS ELIGIBILITY ASSESSMENT

- Is the client diagnosed with Progressive Alzheimer's or Dementia and accompanied by a caregiver?  YES or  NO  
 Does the client require assistance with transferring or needs a Hoyer lift?  YES or  NO  
 Is the client dependent on electric medical devices to stay well?  YES or  NO  
 Is the client using an oxygen concentrator?  YES or  NO  
 Does the client receive assistance with Activities of Daily Living from a full time caregiver?  YES or  NO

## TRANSPORTATION

**Do you need transportation to a special needs shelter?**  YES or  NO (Arrive on my own)

## ASSISTANCE WITH DAILY LIVING NEEDED (Check all ADLs that Apply)

**1. Assistance with Daily Living: (check all that apply)**

- Toileting  Taking Medications  Feeding/Eating  Walking more than 50 ft.  Getting out of bed  Dressing

**2. Can you sleep on an adjustable back cot?**  YES or  NO (No other options are provided)

## SPECIAL NEEDS (check all that apply)

Electrical Needs	Mobility Assessment	Specialized Equipment
<input type="checkbox"/> Bi-Pap or C-Pap <input type="checkbox"/> Cardiac Monitor <input type="checkbox"/> Feeding Pump <input type="checkbox"/> Nebulizer <input type="checkbox"/> Suction Pump <input type="checkbox"/> Oxygen Concentrator  <input type="checkbox"/> Oxygen: ____ of hours daily at ____ liters per minute	<input type="checkbox"/> I can walk <b>-or-</b> <b>I use:</b> <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Scooter  <input type="checkbox"/> Lift used to get out of bed <input type="checkbox"/> I am bedridden continuously	<input type="checkbox"/> Feeding Tube <input type="checkbox"/> IV Equipment <input type="checkbox"/> Service Animal (Canine or Miniature Pony) <input type="checkbox"/> Dialysis: (#)____ days per week  <input type="checkbox"/> Other _____ <hr/> <input type="checkbox"/> <b>I need a nurse or caregiver to administer medications.</b>
Cognitive Assessment	Vision and Hearing Assessment	Special Care/Considerations
<input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia <input type="checkbox"/> Anxiety <input type="checkbox"/> Autism <input type="checkbox"/> Depression <input type="checkbox"/> Mental health problem <input type="checkbox"/> Obsessive Compulsive Disorder <input type="checkbox"/> Psychiatric or personality disorder	<input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Deaf <input type="checkbox"/> Partially Blind <input type="checkbox"/> Blind	<input type="checkbox"/> Ostomy <input type="checkbox"/> Catheter <input type="checkbox"/> Morbid obesity <input type="checkbox"/> Open wounds/Decubitus <input type="checkbox"/> Incontinence <input type="checkbox"/> Wear Adult Diapers

**CLIENT IDENTIFICATION**

LAST: \_\_\_\_\_ FIRST: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ HEIGHT: \_\_\_\_ FEET \_\_\_\_ INCHES WEIGHT: \_\_\_\_\_

GENDER:  MALE or  FEMALE LANGUAGE SPOKEN: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

**CLIENT RESIDENCE INFORMATION**

ADDRESS: \_\_\_\_\_ APT/LOT #: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

MAILING ADDRESS:  SAME AS ABOVE \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

Do you live above the ground level?  YES If yes, what floor? \_\_\_\_\_

DEVELOPMENT NAME: \_\_\_\_\_ GATE CODE: \_\_\_\_\_

**DWELLING TYPE:** SINGLE FAMILY  DUP/MULTIPLEX MOBILE HOME  APT/CONDO**CAREGIVER INFORMATION****Patients requiring a caregiver must be accompanied by their caregiver at all times.****Do you have a caregiver that will accompany you to the shelter?  YES or  NO**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

Does your caregiver have special needs?  YES or  NO If yes, explain: \_\_\_\_\_**EMERGENCY CONTACTS**

(LOCAL) NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

(NON-LOCAL) NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

**MEDICAL SUPPORT INFORMATION**

PRIMARY DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

HOME HEALTH AGENCY: \_\_\_\_\_ PHONE: \_\_\_\_\_

HOME MEDICAL EQUIPMENT PROVIDER: \_\_\_\_\_ PHONE: \_\_\_\_\_

DIALYSIS CENTER: \_\_\_\_\_ PHONE: \_\_\_\_\_

OXYGEN SUPPLIER: \_\_\_\_\_ PHONE: \_\_\_\_\_

**DIAGNOSIS**

Alzheimer's and Dementia	<input type="checkbox"/> Progressive Alzheimer's disease (ALZD) <input type="checkbox"/> Psychosis (This requires full time trained caregiver) <input type="checkbox"/> Dementia (This requires full time trained caregiver)
Chronic but Stable Illness	<input type="checkbox"/> Aphasia (Difficulty communicating) <input type="checkbox"/> Cardiac Abnormalities (Controlled with medication and requiring supervision) <input type="checkbox"/> Continuous Ambulatory Peritoneal Dialysis (Stable, self care) <input type="checkbox"/> Cystic Fibrosis (Assistance with daily living) <input type="checkbox"/> Diabetes/Hyperglycemia (Requiring assistance with insulin and monitoring) <input type="checkbox"/> Dialysis (Peritoneal and Hemodialysis) (Dialysis not provided in shelter) <input type="checkbox"/> Fractured Bones (Pin care/dressing changes) <input type="checkbox"/> Neurological Deficit (Monitoring and assistance with daily living) <input type="checkbox"/> Obesity <input type="checkbox"/> Parkinson's disease (Assistance with daily living) <input type="checkbox"/> Seizures (Medication assistance)
Chronic but Stable Illness With Mobility Impairment	<input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Cerebral Vascular Accident (Recent CVA) (Wheelchair bound) <input type="checkbox"/> Foley Catheter (Requiring Monitoring) <input type="checkbox"/> Wheelchair Bound due to Chronic Illness (Such as: ALS, CVA, Multiple Sclerosis, Muscular Dystrophy, etc)
Electricity Dependant	<input type="checkbox"/> Electric Energized Medical Equipment (CPAP, Nebulizers, etc.) <input type="checkbox"/> Eating and Swallowing Disorders (Requiring electric equipment) <input type="checkbox"/> Sleep Apnea
Oxygen Dependant	<input type="checkbox"/> Oxygen Dependant <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) (Requiring oxygen) <input type="checkbox"/> Emphysema (Requiring oxygen)

**List any other medical problems:** \_\_\_\_\_

**Allergies:**  YES or  NO If yes, list: \_\_\_\_\_

**ATTACH MEDICATIONS LIST (list medication name and dose)**

Form Completed By: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

By submitting this form, I give my authorization for the Palm Beach County Special Needs program to release this information to other emergency response personnel, human service agencies, officials or those they deem necessary to facilitate the evaluation of this application and required activities to ensure assistance for me. Records relating to registration of disabled citizens are exempt as listed in the provisions of F.S. 119.07 (1), Public Records Law. The information contained herein will be kept confidential. I also understand that assistance will only be provided for the duration of the emergency and that alternative arrangements should be made in advance if I cannot return to my home. Should I require hospital or assisted living care, I understand that I must make these arrangements myself.

\_\_\_\_\_  
Signature of Patient / Guardian

\_\_\_\_\_  
Date