Emergency Evacuation
Special Needs Shelter Information

What is a Special Needs Shelter?

A special needs shelter is a temporary emergency facility capable of providing care to residents whose medical condition is such that it exceeds the capabilities of the Red Cross Shelter but is not severe enough to require hospitalization. Hillsborough County Health Department doctors and nurses support these shelters.

Who is eligible for a Special Needs Shelter?

Individuals that meet the following medical criteria:

1. They are unable to administer their own frequently required or daily injectable medicines.
2. They require daily or more frequent dressing changes because of moderate or copious drainage from ulcers, fistulas, or other similar problems.
3. They need assistance with ostomy management, dialysis, and indwelling catheters of any kind.
4. Activities of daily living are so restricted by immobility that others provide assistance to meet there basic needs and those people are unavailable at this time.
5. They require daily assessment of unstable medical condition by professional nursing personnel, or other similar conditions.
6. They have a respiratory condition, which requires special equipment such as monitors or oxygen.
7. They have a terminal illness but are ambulatory and in need of professional assistance in administering heavy doses of pain medicine (HOSPICE).
8. They have received a letter by the Hillsborough County Health Department, assigning them to a Special Needs Shelter. **People assigned to the Special Needs Shelter will need to take any medication, equipment or articles of comfort they routinely use.**

How do I go about registering for a Special Needs Shelter?

It is important that any person who meets the above ctitria register **prior to June 1st** in advance of hurricane season. This will help in determining which shelter is appropriate and what, if any, assistance is required for evacuation.

If you feel you may qualify and are not pre-registered, please complete a Special Needs Evaluation form. **The forms should be returned to: Hillsborough County Health Department PO Box 5135 Tampa, Fl 33675-5135, or faxed to (813) 276-8689. For more information please call (813) 307-8015 Ext. 6006.**

The following people SHOULD NOT go to a special needs shelter (unless otherwise stated, they should go to a hospital):

1. Pregnant woman within six weeks of estimated day of delivery, or who are in labor.
2. Individuals suffering from acute infection or infestation.
3. Those having an immediate medical or emergency condition.

Special Needs Shelter Information (Hillsborough County Website)

http://www.hillsboroughcounty.org/emergency/programsservices/specialneeds.cfm

Please see reverse side for evaluation form.

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 #: _____

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