SPECIAL NEEDS FORM

The City of Bushnell is an equal opportunity service provider and performs all phases of service related activity without regard to race, color, religion, gender, sexual orientation, gender identity, or national origin, age, disability status, Genetic Information & Testing, Family & Medical Leave, protected veteran status, or any other characteristic protected by law.

PLEASE PRINT CLEARLY **DATE: _____________**

Name: (Last)_________________________ (First)_______________________ (Mid. Initial)_________

Address: ____ **Phone:** ______________________

City: _________________________________ **State:** __________________ **Zip:** ______________
Permanent ( ) Temporary ( ) From: ___________ To: __________

Date of Birth: ___________________ **Sex:** ________

Emergency Contact:
Last: ___________________ First: ___________________ Phone: ______________ Relation: __________

Out-of-State Contact:
Last: ___________________ First: ___________________ Phone: ______________ Relation: __________

Living Situation: ( ) Lives Alone ( ) With Relative ( ) Other: _________________________

♣♣

Doctor's Name: ____

Doctor's Address: ____ **Phone:** ________________________

City: _____________________________________ **State:** _______________________ **Zip:** ______________

Check All Characteristics That Apply:

( ) Oxygen Dependent
( ) Partially Oxygen Dependent
( ) Respirator Dependent
( ) Hearing Impaired
( ) Sight Impaired
( ) Speech Impaired
( ) Wheelchair Bound
( ) Bedridden
( ) Emergency Alert Equipment

Doctor's note has been provided with all information. _____

By signing below I hereby state that the above information is true to the best of my knowledge. I am aware that providing the above information and any attached documents does not exempt me from paying my monthly bill, but may give me a 24-hour courtesy before having my utilities disconnected for non-payment depending upon the nature of my needs.

Applicant's Signature:____ **Date:** __________________

Sumter County
Special Needs Registration

Received:

Office Use Only

Date Called:_____ Contacted By: _____ Time:_____ AM / PM

Speak with registrant: ☐ Yes ☐ No If No, Who/Relationship: _____

Conversation Support Notes: _____

_____

Date Message Left:_____ Contacted By: _____ Time:_____ AM / PM

☐ Busy ☐ Left Message ☐ No Answer ☐ Number Disconnected ☐ Number Reassigned ☐ Wrong Number

☐ Registrant Will Call Back ☐ Needs to Be Called Back On _____ at: _____ AM / PM

Date Entered into SPIN: _____ Date Updated: _____

Date Removed from SPIN: _____ Removal Reason: _____

Please Fill in All Blanks in All Fields

*****Please note that an incomplete form may result in denial from the Special Needs program*****

*To register on our secure website, please visit **https://secure.spinreg.org***

Registrant's General Information: **Date:** _____

Name: _____
First Middle **Last**

I Prefer to Be Called: _____

Date of Birth: _____ ☐ Male ☐ Female **Height:** _____ft. ____ in
(XX-XX-XXXX)

Over 300 lbs. ☐ Yes ☐ No Primary Language: _____
(If other than English)

Physical Address:

Address: _____ **City:** _____ **Zip:** _____

County of Residence: ☐ Sumter ☐ Lake ☐ Marion ☐ Other: _____

Registrant's Contact Information: *All Telephone Numbers Must Be in This Format (XXX) XXX-XXXX*

Home Phone: (_____) _____ TTY/TDD: ☐ Yes ☐ No

Work Phone: (_____) _____ Mobile Phone: (_____) _____

Email Address: _____

Local Emergency Contact: *All Telephone Numbers Must Be In This Format (XXX)XXX-XXXX*

Name: _____

Next of Kin: ☐ Yes ☐ No **Relationship:** ☐ Spouse ☐ Other _____

Home Phone: (_____) _____ Alternate Phone: (_____) _____

Out of Town or Alternate Emergency Contact:

Name: _____

Next of Kin: ☐ Yes ☐ No Relationship: ☐ Spouse ☐ Other _____

Home Phone: (_____) _____ Alternate Phone: (_____) _____

Transportation Information:

Public Transportation is Required: ☐ Yes ☐ No

Type of Transportation: ☐ Bus ☐ Wheelchair Accessible Vehicle ☐ Ambulance

Transportation Requirement Reasoning: _____

Housing Information:

Living Situation: ☐ Alone ☐ Spouse/Significant Other ☐ Caregiver ☐ Child ☐ Friend ☐ Parent

☐ Other _____

Residence Type: ☐ Apartment (Floor: ____) ☐ Condominium (Floor:____) ☐ House

☐ Manufactured Home ☐ Other _____

Seasonal Resident: ☐ Yes ☐ No If yes, what months? ***Check all that apply***

☐ Jan. ☐ Feb. ☐ Mar. ☐ Apr. ☐ May ☐ June
☐ July ☐ Aug. ☐ Sept. ☐ Oct. ☐ Nov. ☐ Dec.

Housing Plan, Post Disaster: ☐ None ☐ Stay with Friends ☐ Stay with Relatives ☐ Other _____

Service Animal Information: *Please Refer to Department of Justice/ADA and FEMA Fact Sheets for clarification*

Service Animal: ☐ None ☐ Dog ☐ Pony ☐ Other _____

Companion Animal/Pet: ☐ None ☐ Dog ☐ Cat ☐ Bird ☐ Other _____

Health Provider Information:

Physician Name: _____ Phone: (_____) _____

Pharmacy Name: _____ Phone: (_____) _____

Home Health Agency: _____ Phone: (_____) _____

Dialysis Center: _____ Phone: (_____) _____

Hospice Agency: _____ Phone: (_____) _____

Caregiver Information:

Name: _____ Home Phone: (_____) _____

Work Phone: (_____) _____ Mobile Phone: (_____) _____

Caregiver Allergies/Medical Conditions: _____

Relationship: ☐ Family ☐ Friend ☐ Home Healthcare ☐ Retirement Home ☐ Assisted Living Facility ☐ Other _____

Staying at Evacuation Facility: ☐ Yes ☐ No # of other Friends/Family Staying at Evac Loc: _____

Medical Condition Information:

☐ Assistance to take Medication
☐ Alzheimer
☐ Amputation: (☐ Arm ☐ Leg ☐ Other_____
_____)
☐ Anxiety/Depression
☐ Asthma
☐ Bedsores
☐ Vision Impaired/Blind
☐ Catheter Dependent
☐ Cancer
☐ Cerebral Palsy
☐ Colostomy Dependent
☐ Comatose
☐ Confined to Bed
☐ Contagious Illness
☐ Cystic Fibrosis
☐ Deaf/Hearing Impaired
(☐ American Sign Language ☐ Can Read Lips)
☐ Dementia
☐ Diabetic/Insulin Dependent
☐ Electric Dependent:(☐ Heart Monitor ☐ Nebulizer
☐ Oxygen Concentrator ☐ Ventilator ☐ CPAP
☐ Other _____)
☐ Emphysema
☐ Epilepsy
☐ Feeding Tube/Gastronomy Tube
☐ Heart Disease
☐ High Blood Pressure
☐ Immune System Disorder:(☐ Hepatitis ☐ HIV ☐ Lupus
☐ Tuberculosis ☐ Other _____)
☐ Incontinent
☐ Intravenous Line Dependent
☐ Kidney Disease/Dialysis: (☐ Hemodialysis ☐ Peritoneal)
☐ Mobility Impaired: (☐ Cane ☐ Crutches
☐ Electric Scooter ☐ Electric Wheelchair ☐ Walker
☐ Wheelchair ☐ Other _____)
☐ Morbid Obesity (> 300 lbs.)
☐ Multiple Sclerosis
☐ Oxygen Dependent: Please list oxygen provider below
Flow Rate:_____ Hrs. Per Day:_____
☐ Pacemaker Dependent
☐ Paraplegic
☐ Parkinson's disease
☐ Quadriplegic
☐ Seizures
☐ Terminal Illness/Imminent Death
☐ Tracheotomy
☐ Wound Care Assistance

☐ Other Health Issues: _____

☐ Medical Equipment Provider: _____

I understand that submission of this form does not guarantee my acceptance into the Sumter County Special Needs Program. I give Sumter County Emergency Management authorization to share this information with other local support agencies, such as the Department of Health or EMS, that are involved in the evacuation and sheltering process. I also understand that I will be contacted regarding my application before I am officially registered.

Signature: _____ Date: _____

Print Name: _____ Relationship to Registrant: _____

***Please Note: If registrant is unable to sign on their own behalf, an authorized representative should sign in their place, as well as providing the representative's name and relationship to registrant.