Healing Hands at Home™ Orthopaedic Home Health & Rehabilitation, Inc.

PALM BEACH COUNTY SPECIAL NEEDS APPLICATION

Please complete and sign the application with your physician.

Name ______________________________

Address ______________________________

City ____________________ Apt # __________ Zip Code __________

Phone ____________________ Cell/Other ____________________

Age __________ Date of Birth ____________________ Sex __________ Weight __________

If you live in a mobile home park, condominium, or apartment, indicate the name, address, and telephone number of the complex ______________________________

____

Do you have a Caregiver? ❑ Yes ❑ No

If yes, does your caregiver have special needs? Please explain: ______________________________

____

____

Does your caregiver need special accommodations? ❑ Yes ❑ No

If yes, please explain: ______________________________

____

____

Please list the name and phone number of a ❑ Relative ❑ Neighbor ❑ Emergency Contact: __________

Name ____________________ Description ____________________

Phone ____________________ Cell/Other ____________________

DO YOU NEED ASSISTANCE IN THE FOLLOWING: *(Check those that apply)*

❑ Using the restroom ❑ Taking your medication ❑ Feeding yourself

❑ Walking greater than 50 feet ❑ Getting in or out of bed

* * **If you checked any of the above, you may need a caretaker with you in the shelter.**

DISABILITY: *(Check those that apply)*

❑ Visually Impaired ❑ Hearing Impaired ❑ Mobility ❑ Bedridden

* * **If you checked any of the above, you may need a caretaker with you in the shelter.**

Continued...

Orthopaedic Home Health & Rehabilitation, Inc.

PALM BEACH COUNTY SPECIAL NEEDS APPLICATION *Continued...*

SPECIAL EQUIPMENT: *(Check those that apply)*

❑ Walker ❑ Cane ❑ Electric Scooter ❑ Feeding Tube ❑ IV Equipment

❑ Dialysis How many times a week? ________ Which Dialysis Center do you use? ______________________________

Have you discussed your emergency treatment plan with your Dialysis Center? ❑ Yes ❑ No

* * **If you checked any of the above, you may need a caretaker with you in the shelter.**

ELECTRIC DEPENDENT: *(Check those that apply)*

❑ Oxygen ❑ Nebulizer ❑ C-Pap ❑ Bi-Pap Oxygen Supplier and Phone: ______________________________

TRANSPORTATION: *(Check the one that applies)*

❑ You will provide your own transportation (or)

❑ You will need transportation: ❑ Palm Tran Bus Service (or) ❑ Stretcher type transportation

Stretcher type of transportation is only provided if you are unable to transfer into a wheelchair. Please be advised that currently both Special Needs Shelters are located in the West Palm Beach area.

If you are unable to drive or have difficulty driving, please check the "Need Transportation Option". By choosing that you need transportation, you will be receiving assistance from the bus drivers with supplies that you are required to bring with you to the shelter. You will also receive a call from the bus service giving you an approximate time of your pick-up.

If you choose to drive yourself, then you will have the freedom to immediately leave the shelter when the all clear is given. You will not receive a call and will have to watch or listen to media announcements advising the opening of Special Needs Shelters

This is a very important decision, so please take the time to consider it.

Continued...

Orthopaedic Home Health & Rehabilitation, Inc.

PALM BEACH COUNTY SPECIAL NEEDS APPLICATION *Continued...*

STATEMENT OF UNDERSTANDING

The information contained herein is true and correct to the best of my knowledge. I have read the Special Needs Program Applicant Information sheet accompanying this request and I understand the limitations on the services and level of care available.

I understand that if accepted and space is available, assistance will be provided only for the duration of the emergency, and that alternative arrangements should be made in advance in case I am unable to return to my home. If you are unable to make arrangements, then you will be placed in a facility that can accommodate you medical issues (Assisted living facilities or Nursing Homes) until other options become available.

I understand that I may or may not be assigned to the Special Care Unit/Special Needs Shelter based on the criteria stated in the information provided. **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 understand that this registration is voluntary and hereby request registration in the Palm Beach County Special Needs Program. I understand registration is updated twice a year. If I do not respond to requests to contact the county, I will be removed from the registration list. I will notify the county of any changes in my address or condition.

Person Registering for Special Needs or Special Care Unit Program ______________________________

Print Applicant Name ______________________________ Date ______________

Applicant Signature ______________________________

Name of Person Filling Out The Application (If different than applicant) ______________________________

Signature of Person Filling Out The Application (If different than applicant) ______________________________

Send completed application and statement to:

Palm Beach County Division of Emergency Management
Special Needs Program
20 South Military Trail
West Palm Beach, FL 33415

Continued...

Orthopaedic Home Health & Rehabilitation, Inc.

PALM BEACH COUNTY SPECIAL NEEDS APPLICATION *Continued...*

TO BE COMPLETED BY PHYSICIAN:

The following medical criteria is used to evaluate placement eligibility for your patient to be accepted in the Special Care Unit or the Special Needs Shelter. Please complete this form if you think that your patient would benefit from a medical shelter.

1. Persons who cannot be without electricity because they depend upon their own electrically energized life support equipment within the home. i.e.: oxygen, nebulizers, c-pap, bi-pap, etc.
2. Persons that are too immobile and/or have a chronic stable illness but are not suitable for regular shelter placement or do not require hospitalization.
3. People with minor health/medical conditions that require professional observation, assessment and maintenance.
4. People with the need for medications and/or vital sign monitoring and are unable to do so without professional assistance.
5. Persons who are bedridden and require custodial care.

Caregivers must accompany their patients if they are unable to care for themselves.

Diagnosis: *(Please print clearly)* ____________________

Allergies: ____________________

Does your patient depend upon life support equipment within his or her residence? ☐ Yes ☐ No

Is your patient on Dialysis? ☐ Yes ☐ No

If yes, how often? ____________________

Is the patient insulin dependent? ☐ Yes ☐ No

If yes, please discuss other options for cooling and storage of the insulin with your patient.

Does your patient need assistance with Activities of Daily Living? ☐ Yes ☐ No

If yes, please explain: ____________________

____

In your opinion, would your patient require assistance in a shelter environment? ☐ Yes ☐ No
(For example, would your patient need assistance walking greater than 50 feet for bathroom access, getting in and out of a cot which is two feet tall, dosing personal medications, etc?)

If Yes, please explain: ____________________

____

____

Continued...

Orthopaedic Home Health & Rehabilitation, Inc.

PALM BEACH COUNTY SPECIAL NEEDS APPLICATION *Continued...*

TO BE COMPLETED BY PHYSICIAN: *(Continued)*

Does the patient have any Mental Deficiencies (i.e. Alzheimer's, Dementia)? ❑ Yes ❑ No

Is your patient under Hospice Care? ❑ Yes ❑ No

If yes, which Hospice organization? ______________________________

List the patient's medications and the dosages: ______________________________

____

____

____

Physician's Info: *(Please print clearly)*

Physician's Name ______________________________

Street Address ______________________________

City ____________________ State __________ Zip Code __________

Phone ____________________ Fax ____________________

Physician's Signature: ____________________ Date: __________

Applicant's Signature: ____________________ Date: __________

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