ORANGE COUNTY HEALTH & FAMILY SERVICES DEPARTMENT
PEOPLE WITH SPECIAL NEEDS QUESTIONNAIRE

PLEASE PRINT ⬭ New ⬭ Update

Registrant's General Information

First Name _____ **Middle Name**_____ **Last Name** _____

Date of Birth _____ **Gender** ⬭Male ⬭ Female

Race _____ **Is English Spoken?** ⬭ Yes ⬭No **If no, what is language?** _____

Registrant's Residential Address Information

Home Address _____ **Apt/Lot No.** _____

City _____ **Zip +4**_____ **Mobile Home Park/Apartment Complex Name** _____

Registrant's Mailing Address ⬭ **Same as Residential Address Information**

Mailing Address _____ **City** _____ **Zip Code +4** _____

Registrant's Phone Information

Home Phone ( ) _____ **Work Phone** ( ) _____ **Cell Phone** ( ) _____ **Other** ( )_____

Agency / Registrant's Caregiver / Registrant's Emergency Contact Information

What is the name of your Home Health Care Agency? _____ **Agency Phone Number** _____

What is the name of your Medical Equipment Supplier? _____ **Supplier Phone Number** _____

Name of Caregiver who will accompany you to shelter? _____ **Caregiver Phone** _____

Emergency Contact Name _____ **Contact Phone** _____

Transportation

Will you need transportation assistance in an emergency? ⬭ Yes ⬭ No

If yes, please check ONE of the following:

⬭ I can sit in a regular car seat. ⬭ I must stay in a wheelchair.

⬭ I can walk but can't climb stairs. ⬭ I am confined to a bed.

Select All That Apply

⬭ Guide Dog/Service Animal ⬭ Walker

⬭ Use TDD/TTY ⬭ Own Pet

⬭ Motorized Scooter/Wheelchair **Type of Pet** _____

⬭ White Cane

PEOPLE WITH SPECIAL NEEDS QUESTIONNAIRE/page 2 of 2

Registrant's Medical Information **Select the most appropriate CATEGORY (A, B, C). Then mark ALL conditons that apply to you.**

Height _____ **Weight** _____

⬭ CATEGORY A

Anyone who can walk without assistance and needs no outside professional assistance performing the activities of daily living. Anyone who can provide their own medical care and does not have any life threatening problems. Please mark all that apply.

- ⬭ Asthma
- ⬭ Arthritis
- ⬭ Legally Blind
- ⬭ Pacemaker
- ⬭ Non-Insulin Dependent Diabetes
- ⬭ Insulin Dependent Diabetes
- ⬭ Hypertension
- ⬭ High Blood Pressure
- ⬭ Other Condition (Specify)

_____

⬭ CATEGORY B

Anyone requiring minor medical assistance to perform their activities of daily living, who is acompanied by a caregiver. Please mark all that apply.

- ⬭ Alzheimers (Early Stages)
- ⬭ Aphasia
- ⬭ CAPD-Dialysis
- ⬭ Catheter
- ⬭ Cerebral Palsy
- ⬭ COPD
- ⬭ Cancer
- ⬭ Congestive Heart Failure (CHF)
- ⬭ Cerebrovascular Accident (CVA)
- ⬭ Emphysema
- ⬭ G-Tube
- ⬭ Hemodialysis
- ⬭ Hip Replaced
- ⬭ IV
- ⬭ Knee Replaced
- ⬭ Muscular Dystrophy-Severe (MD)
- ⬭ Multiple Sclerosis (MS)
- ⬭ Osteoarthritis
- ⬭ Osteoporosis
- ⬭ Oxygen Dependent
- ⬭ Parkinson's
- ⬭ Rashes Fluid
- ⬭ Senile Dementia
- ⬭ Sores Fluid
- ⬭ Terminal
- ⬭ Wheelchair Permanenent
- ⬭ Other Conditiion (Specify)

_____

⬭ CATEGORY C

Anyone who is permanently restricted to bed with a stable medical condition and requiring ongoing medical supervision. Those people who cannot perform the activities of daily living on their own, nor have a caregiver. Anyone with an unstable medical condition and/or requiring constant medical attention. Anyone on a life support system. Please mark all that apply.

- ⬭ Alzheimers (Advanced)
- ⬭ Bed (Permanent)
- ⬭ Cardiac (Unstable)
- ⬭ Contagious (Severe)
- ⬭ Comatose
- ⬭ Cystic Fibrosis
- ⬭ Psychosis
- ⬭ Respirator
- ⬭ Seizure
- ⬭ Terminal (Endstage)
- ⬭ Ventilator
- ⬭ Other Condition (Specify)

_____

Registrant's Signature

I certify this information is correct. I understand I am responsible for all expenses associated with transportation and admittance to the hospital. I hereby grant permission to Orange County for the release of this information to emergency response agencies. I understand by signing this form, I grant emergency responders permission to enter my home and provide for my needs in an emergency.

_____ _____

Registrant's Signature **Date**

_____ _____

Case Manager Signature if completing with Client **Date**

Please send completed forms to:
Orange Co. People with Special Needs Program
4401 Vineland Road, Suite A-11
Orlando, FL 32811
Fax: 407-318-3288

Form Revised 12/1/05