SARASOTA COUNTY PEOPLE WITH SPECIAL NEEDS (PSN) APPLICATION

Sarasota County
scgov.net | 941.861.5000 | TV

1660 Ringling Blvd., 6th Floor
Sarasota, Florida 34236
Fax (941) 861-5501

PLEASE PRINT CLEARLY

GENERAL INFORMATION

For convenience and comfort, citizens are encouraged to make their own evacuation and shelter plans if possible. As an alternative, the PSN program addresses the needs of people with medical conditions or need transportation to a shelter.

Name:________________________ ____________________ ____ Spouse: ________________________
Last First MI

____ ______________ FL ____________ ______________
Address City, St Zip Unit

Phone # (___)___________Secondary Phone #: (___)___________Email Address:_______________________

Birth Date: ____/____/____ Age: ____ Gender: Male ____ Female ____ **Weight** ____ Height ___’___”

Primary Language Spoken: _____English _____Spanish _____Other: _________________________

Phone number to be reached if not a full-time resident of Sarasota? (_____)___________________________

Sub-Division/Facility – Location Description: ____

Type of Home_________________ Type of Construction _________________Year Built ________________
(i.e.: Single Family, Apt/Condo) (i.e.: Block, Wood, Brick, **Mobile home,** Unknown etc.)

PETS

___Pet provided for ___Number of Cats ___Number of Dogs Service Animal? _____Yes _____No

TRANSPORTATION FOR PSN APPLICANT

Do you need Transportation? ____Yes ____No
___Ambulance (bedridden)
___Lift Gate Vehicle (wheelchair)
___Standard Vehicle (canes, walkers, walks without help)

TRANSPORTATION FOR OTHER EVACUEES

___Ambulance (bedridden)
___Lift Gate Vehicle (wheelchair)
___Standard Vehicle (canes, walkers, walks without help)

Offical Use Only

Fire	Evac/Flood Div #	CodeRED	***Grid***	Destination	File #	Received date: Entered Date

Emergency Management is mandated by Florida Statutes to maintain a voluntary registry of persons who will need assistance during emergency evacuations. Records relating to registration of disabled citizens are exempt from the Provisions of F.S. 119.07(1) Public Records Law

Sarasota County prohibits discrimination in all services, programs or activities on the basis of race, color, national origin, age, disability, sex, marital status, familial status, religion, or genetic information. Persons with disabilities who require assistance or alternative means for communication of program information (Braille, large print, audiotape, etc.), or who wish to file a complaint, should contact:

Sarasota County ADA/Civil Rights Coordinator
1660 Ringling Blvd.
Sarasota, Florida 34236

Phone: 941-861-5000; TTY 7-1-1 or 1-800-955-8771
Email: adacoordinator@scgov.net

CONTACTS AND EVACUEES *PSN Applicant Name* (**from front**):______________________________

_____________________ (_____)______________ Primary Doctor: Phone

_______________________ (_____)________________ Home Health Agency Info Phone:

_____________________ (_____)______________ Emergency Contact Phone

_______________________ (_____)________________ Caregiver Phone

___ Evacuate Spouse?
___ Evacuate Caregiver?

____Number of ***additional*** Evacuees (***excluding*** PSN Spouse, Caregiver)

MEDICAL INFORMATION

___Aphasia
___Arthritis
___Asthma
___Bronchitis
___Cancer
___Cerebral Palsy
___Comatose
___Contagious Disease – Type: _________________
___Dementia ____Early ____Moderate ____Late
[___unable to follow instructions ___ wanders]
___Diabetes
___Dialysis: (in-home Dialysis?) ____Yes ____No
___Difficulty Speaking
___Edema
___Emphysema/COPD
___Hearing Impaired
___Heart Condition ____Stable ____Unstable
___High Blood Pressure
___Hip/Knee Replacement: When? ____________
___Hospice ("end-of-life" diagnosis, not palliative care)

___Medical Equipment *circle any that apply:*
[Feeding tube, Ventilator, IV, Indwelling Catheter]
___Memory Loss
___Mentally Impaired
___Multiple Sclerosis
___Muscular Dystrophy
___Nebulizer
___Open Sores
___Ostomy – Type _________________
___**Oxygen** Use ____**LPM** (number on dial)
___Parkinson's: ___Early ___Moderate ___Late
___Psychosis ____Controlled ____Uncontrolled
___Seizures ____Controlled ____Uncontrolled
___Sight Impaired
___Skin Disease
___Skin Infections
___Special Diet (bring doctor-prescribed food)
___Speech Impaired
___Stroke/CVA (limitations)

List known allergies: ____
List medication: ____
Other Comments: ____

POWER DEPENDENT

[your doctor may want you to register in FPL's "Medical Essential Service Program" at 941-917-0708]

___Oxygen Concentrator
___Sleep Apnea (CPAP Machine)
___Ventilator/Respirator (machine is used to ***breathe*** for you, unlike the Oxygen Concentrator and CPAP)
___Name of Oxygen Company: ____
___Other, Please Specify: ____

MOBILITY

___I have someone assist me with all my daily activities
___I walk without help
___I use a cane
___I use a walker [walk long distances? ___Yes ___No]
___I use a wheelchair ___regular ___Wide
___I am bedridden

*** CONTACT US WITH <u>CHANGES</u> TO YOUR INFORMATION, <u>NO</u> NEED TO RE-REGISTER YEARLY**.

Revised 3.28.13