Clay County Special Needs Registry
Personal Survey Form

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Clay County Emergency Management and the Florida Division of Emergency Management are coordinating their efforts to provide assistance to individuals with disabilities during a disaster through a unified Special Needs Registration Program. This includes individuals who require daily skilled nursing care, assistance with daily living, or have life sustaining or saving medical equipment dependent on electricity. This excludes individuals who are currently in hospitals, nursing homes or in assisted facility care (these entities are required by law to develop plans for the emergency needs of their clients through the development of mutual aid agreements with like facilities).

To receive important information from local emergency management officials about evacuations, provide as much information as possible which will allow emergency management officials to plan accordingly for future disasters. You will be e-mailed periodically to verify the information provided is correct and to make any necessary changes. Individual surveys will be archived after one year if not verified and facility surveys will be archived after six months if not verified.

Why should you register?

Registering an individual within this database does not guarantee that they will receive assistance. The purpose of this program is to provide local emergency responders with importation information concerning Clay County citizens who have special needs during a disaster such as a hurricane, flood, tornado or disease outbreak. This information allows emergency management officials to plan accordingly for future disasters.

Individuals who register within this database will also be evaluated to determine if they are candidates to utilize the county's sole Special Needs Shelter. This shelter is a refuge of last resort for individuals who have special medical needs and must evacuate. The only defining characteristics which separate this shelter from general population shelters are the availability of generated plugs for medical equipment such as oxygen concentrators, limited numbers of padded cots and limited numbers of nursing staff from the local Health Department. All other aspects of this shelter are identical to general population shelters. Individual registrations are evaluated in terms of their suitability for the Special Needs Shelter, a general population shelter or, if the individual's medical needs are great enough, a hospital or other like healthcare facility (it is the responsibility of the individual or caregiver to make arrangements with healthcare facilities). Shelter determination letters will be sent to those addresses cited on the application following receipt and review.

Completing the Florida Special Needs Registry does not automatically qualify the individual for a special needs shelter or for assistance. Additional information will be provided by your local emergency management agency regarding sheltering.

Mail completed form to:

Clay County Emergency Management
ATTN: Special Needs Registry
PO Box 1366
Green Cove Springs, FL 32043

This form may also be completed online at https://snr.floridadisaster.org/signin

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Your Personal Information

First Name: _____ **MI:**___ **Last Name:** _____**Suffix:** _____

Physical Address: _____

If your address does not reflect your actual physical location, then describe where the location is that emergency personnel can find you.

City: _____**State:**_____**Zip Code:**_____

County: _____**Municipality:**_____

Residence Type: ☐ **Single Family Home** ☐ **Multifamily** ☐ **Mobile Home**

☐ **Apartment Building** ☐ **Other:** _____

Mailing Address (if different than physical address):

Address:_____

City: _____**State:**_____**ZipCode:** _____

Primary Phone: ( )_____**Ext.: ( )**_____

Is Primary Phone TTY/TTD (Teletype Device): Yes No

Secondary Phone: ( )_____**Ext.: ( )**_____

☐ **I do not have a phone**

Email: _____

Date of Birth (MM/DD/YYYY): _____

Height: (Feet)_____ (Inches) _____ **Weight:** _____

Gender (Check one): ☐ **Male** ☐ **Female** **Eye Color:**_____

Emergency Contact Information

Please provide contact information for an individual with whom we can discuss your situation in the event that an emergency makes this necessary. If you would rather not provide an emergency contact please check:

☐ I choose not to provide emergency contact information.

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Primary Contact:

First Name: _____ **MI:** _____ **Last Name:** _____ **Suffix**: ____

Address: _____

City: _____ **State:** _____ _____ **Zip Code:** _____

Emergency contact's relationship to you (check one):

☐ None ☐ Friend ☐ Family Member ☐ Neighbor ☐ Caregiver ☐ Other

Email: _____

Primary Phone: ( ) _____ **Ext.:**_____

Secondary Phone: ( ) _____ **Ext.:**_____

Checking this box allows medical information to be shared with this emergency contact.

Secondary Contact (Please enter an out-of-area contact):

First Name: _____ **MI:** _____ **Last Name:** _____ **Suffix**: ____

Address: _____

City: _____ **State:** _____ _____ **Zip Code:** _____

Emergency contact's relationship to you (check one):

☐ None ☐ Friend ☐ Family Member ☐ Neighbor ☐ Caregiver ☐ Other

Email:_____

Primary Phone: ( ) _____ **Ext.:**_____

Secondary Phone: ( ) _____ **Ext.:**_____

Checking this box allows medical information to be shared with this emergency contact.

Additional Contact Information:

Physician Information:

Name: _____ Phone: **( )** _____

Home Health Care Information:

Name: _____Phone: **( )** _____

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Pharmacy Information:

Name: _____ Phone: **( )** _____

Home Medical Equipment Provider Information:

Name: _____ Phone: **( )** _____

Dialysis Information:

Name: _____ Phone: **( )** _____

Evacuation Information

If there were an emergency requiring evacuation, you may have difficulty evacuating or being notified of the need for evacuation because of the following conditions (check all that apply):

- ☐ Blind/Low Vision
- ☐ Deaf/Hard of Hearing
- ☐ Speech Impediment
- ☐ Bedridden
- ☐ Mentally/Memory Impaired
- ☐ Dialysis
- ☐ Dementia/ Alzheimer's (Full-time caregiver must be present at all times during stay at shelter)
- ☐ Requires Constant Skilled Nursing Care (e.g., open wounds)
- ☐ Assistance with Medications
- ☐ Assistance Needed with Insulin
- ☐ Requires Refrigerated Medications
- ☐ Autism
- ☐ Physical Disability (Please Explain): _____
- ☐ Special Dietary Needs/Restrictions (Please Explain):_____
- ☐ Other Reason for Needed Assistance:_____

Transportation Needs:

If transportation assistance is required, please check all vehicle types that can be used for transportation.

- ☐ Car
- ☐ Wheelchair Van
- ☐ Bus
- ☐ Ambulance

I have difficulty walking and require:

- ☐ Walker/cane
- ☐ Motorized wheelchair
- ☐ Standard wheelchair
- ☐ Motorized Scooter
- ☐ Attendant to Assist in Ambulating
- ☐ Requires Stretcher Transportation

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Communication Needs (Check all that apply):

☐ I do not have a radio

☐ I do not have a telephone, TTY or VRI

☐ I do not have a television

☐ I do not have access to the Internet

☐ I do not speak English (List Language(s) You Speak):_____

How do you receive emergency notifications? _____

Oxygen Dependent:

Check all that apply and supply detailed information (02 Type, Liters Flow, 02 Company, and contact information):

☐ 24 Hour:_____

☐ Only Overnight:_____

☐ Nebulizer:_____

☐ CPAP:_____

☐ Other:_____

Requires medical equipment that is not easily transportable:

☐ Ventilator

☐ Catheters

☐ Suction machine

☐ Feeding Tube

☐ Other equipment (Please Specify):_____

Required Assistance

This information will be helpful in determining the assistance you may require.

1. Are ALL of the support needs resulting in the need for evacuation assistance temporary? (Example: you are bedridden due to pregnancy difficulties, but are expected to be fully recovered after the baby is delivered.) Check one.

   ☐ Yes ☐ No, the condition(s) are expected to be permanent.

   If the condition is temporary, please provide an estimated date of recovery:

   Month:_____ Year:_____

2. Are you a seasonal resident? ☐ Yes ☐ No

   Date From:_____ Date To:_____

3. Do you require evacuation assistance 24 hours a day? ☐ Yes ☐ No

4. If you do not require evacuation assistance 24 hours a day, when do you need help?

Time To: _____ ☐ a.m. ☐ p.m. **Time To:** _____ ☐ a.m. ☐ p.m.

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5. Do you have a caregiver? ☐ Yes ☐ No

   Will the caregiver travel and stay with you? ☐ Yes ☐ No

6. Do you have medications that must be taken with you if relocated? ☐ Yes ☐ No

Service Animals/Pets:

According to Florida Statute 413.08 a "service animal" means an animal that is trained to perform tasks for an individual with a disability. The tasks may include, but are not limited to, guiding a person who is visually impaired or blind, alerting a person who is deaf or hard of hearing, pulling a wheelchair, assisting with mobility or balance, alerting and protecting a person who is having a seizure, retrieving objects, or performing other special tasks. A service animal is not a pet. For further information and to download the Clay County Animal Care & Control Shelter Registry, please visit http://claycountygov.com/departments/animal-care-control/disaster-preparedness.

Please list any service animals/pets in your care that will also require assistance. Enter up to 2 (two) in the table below:

Service Animal Y/N	Name:	Type	Breed/Description	Weight	Carrier/Cage Y/N	Leash Y/N	Muzzle Y/N

Additional Comments/Information

Please enter any additional information that may be useful for our emergency personnel who will be assisting you during an evacuation.

_____

_____

By signing this form I give my authorization for medical information contained herein to be released to the Florida Department of Health, State and County emergency management agencies, and receiving facilities for the purpose of evaluating my needs and providing emergency transportation and sheltering. Records relating to registration of disabled citizens are exempt from the provisions of F.S. 119.07 (1), Public Records Law. The information contained here will be kept confidential.

Signature of applicant**:** _____ Date: _____

Print Name: _____