Florida Special Needs Registry
Registration Information - Broward County

Instructions: Complete this form and fax or mail it to Broward County to register an individual for the Florida Special Needs Registry. This form is not required if you have already registered on line. Required fields are indicated with an asterisk (*).

Mail: Broward County Special Needs Registry
ATTN: Special Needs Shelter Coordinator
201 NW 84th Ave
Plantation, FL 33324

PERSONAL INFORMATION ABOUT THE REGISTRANT	
*First Name	
Middle Name	
*Last Name	
Suffix	
*Birth Date	
*Gender (select only one)	☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Prefer Not To Provide
*Height	Feet: Inches:
*Weight (pounds)	
Living Situation (select only one)	☐ Live alone ☐ Live with relative or caregiver ☐ Homeless ☐ Other living situation
*Primary Language	
Secondary Language	
Veteran	☐ Yes ☐ No
Last 4 digits of SSN	
Email Address	
Are you completing this form on behalf of the registrant? If so, please indicate your relationship to the registrant (select only one)	☐ Family Member ☐ Caregiver ☐ Neighbor ☐ Friend ☐ Health Care Provider ☐ County Emergency Management Staff ☐ County Health Department Staff ☐ DOH State Staff

ADDRESS FOR THE REGISTRANT (physical address is required)	
*Physical Address (cannot be a PO Box)	
Apt #, Unit #, Bldg #, Suite #, etc.	
*Physical City	
*Physical State	FL
*Physical Zip Code	
Name of Complex, Subdivision or Mobile Home Park	
Is the home at this address a mobile home?	☐ Yes ☐ No
Is the home at this address a highrise or multi-story home?	☐ Yes ☐ No
Does this home have stairs?	☐ Yes ☐ No
Is there a code required to enter?	

Florida Special Needs Registry
Registration Information - Broward County

ADDRESS FOR THE REGISTRANT (physical address is required)	
Do you live at this address year round?	☐ Yes ☐ No If No, from month:_____ To month:_____
Mailing Address (if different from above)	
Mailing City	
Mailing State	
Mailing Zip Code	
Additional County Information	
What is the gate code?	

PHONE NUMBERS FOR THE REGISTRANT (a primary and at least one other phone number is required)				
*Phone Number	Extension	*Phone Type (select only one)	Primary	TTY/TDD Capable
( ) -		☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No	☐ Yes ☐ No
( ) -		☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No	☐ Yes ☐ No
( ) -		☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No	☐ Yes ☐ No

PRIMARY EMERGENCY CONTACT FOR THE REGISTRANT (required)	
*Primary Emergency Contact Name	
Contact Address	
Contact City	
Contact State	
Contact Zip Code	
*Contact Primary Phone Number	( ) - Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Secondary Phone Number	( ) - Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Email Address	
OTHER CONTACTS FOR THE REGISTRANT (entry is optional)	
*Other Contact Name	
*Contact Type (select only one)	☐ Secondary Emergency Contact ☐ Caregiver ☐ Family Member ☐ Neighbor ☐ Friend ☐ Physician ☐ Pharmacy ☐ Home Health Care Provider ☐ Home Medical Equipment Provider ☐ Hospice Provider ☐ Oxygen Provider ☐ Dialysis Clinic ☐ Other Medical Provider ☐ Out Of Area Contact ☐ Alternate Living Arrangement Contact
Contact Address	
Contact City	
Contact State	
Contact Zip Code	
*Contact Primary Phone Number	( ) - Extension:

Florida Special Needs Registry
Registration Information - Broward County

OTHER CONTACTS FOR THE REGISTRANT (entry is optional)	
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Secondary Phone Number	( ) - Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Email Address	
*Other Contact Name	
*Contact Type (select only one)	☐ Secondary Emergency Contact ☐ Caregiver ☐ Family Member ☐ Neighbor ☐ Friend ☐ Physician ☐ Pharmacy ☐ Home Health Care Provider ☐ Home Medical Equipment Provider ☐ Hospice Provider ☐ Oxygen Provider ☐ Dialysis Clinic ☐ Other Medical Provider ☐ Out Of Area Contact ☐ Alternate Living Arrangement Contact
Contact Address	
Contact City	
Contact State	
Contact Zip Code	
*Contact Primary Phone Number	( ) - Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Secondary Phone Number	( ) - Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Email Address	

Additional County Information	
*Will a caregiver be accompanying you to the shelter?	☐ Yes ☐ No
*Do you receive care at or have a physician with privileges at Holy Cross Hospital?	☐ Yes ☐ No

REGISTRANT'S SERVICE ANIMALS			
*Animal Type (select only one)		*Required Due to Disability	*Work or Task Animal has been trained to perform
☐ Dog	☐ Miniature Horse	☐ Yes ☐ No	
☐ Dog	☐ Miniature Horse	☐ Yes ☐ No	
☐ Dog	☐ Miniature Horse	☐ Yes ☐ No	

REGISTRANT'S EQUIPMENT	
Please indicate the medically necessary equipment that is electric dependent for this registrant: (select all that apply)	☐ Apnea Monitor ☐ Cardiac Monitor ☐ CPAP / BiPAP ☐ Dialysis Catheter ☐ Electric Insulin pump ☐ Feeding Pump ☐ Medication that requires refrigeration ☐ Nebulizer ☐ Oxygen Concentrator ☐ Suction Pump ☐ Ventilator ☐ Wound Vac Other:

Florida Special Needs Registry
Registration Information - Broward County

REGISTRANT'S EQUIPMENT	
Please indicate any medically necessary equipment that is NOT electric dependent for this registrant: (select all that apply)	☐ EpiPen ☐ Indwelling Urinary Catheter (Foley) ☐ Insulin Pump ☐ Peripheral Intravenous Line ☐ PICC Line ☐ Port-a-Cath ☐ Pulse Oximeter ☐ Tracheostomy
Additional County Information	
What type of Ventilator is used?	
What are the Ventilator settings?	
Please list any other medically necessary equipment that is NOT electric dependent for this registrant	

TRANSPORTATION & MOBILITY	
Registrant has the following transportation needs: (select all that apply)	☐ Needs transportation to a shelter ☐ Can be transported in a car ☐ Can be transported in a bus ☐ Must be transported in a wheelchair accessible vehicle ☐ Must be transported in a stretcher van ☐ Uses a wheelchair but can transfer to a van seat ☐ Weight requires special transportation ☐ Needs continuous oxygen during transport Caregiver(s) needs transportation: Other shelteree(s) needs transportation:
Registrant has the following mobility issues: (select all that apply)	☐ Needs help to walk ☐ Needs help transferring to/from cot and/or mobility device ☐ Uses a Hoyer Lift to get out of a cot ☐ Is confined to a bed ☐ Paraplegic ☐ Quadriplegic ☐ Uses a Walker ☐ Uses a Cane ☐ Uses a Wheelchair ☐ Uses a Motorized Wheelchair / Scooter Other:
Additional County Information	
*Are you registered with Broward County Paratransit (TOPS)?	☐ Yes ☐ No
If Yes, what is your TOPS Client ID Number?	
*Are you able to get to the curb outside of your residence on your own or by using your mobility aid/device?	☐ Yes ☐ No
*Does registrant require transportation to a shelter?	☐ Yes ☐ No
If you use a wheelchair, do you require help transferring?	☐ Yes ☐ No

MEDICAL & OTHER	
Behavioral: (select all that apply)	☐ Anxiety ☐ Autism ☐ Bipolar ☐ Combative / Violent ☐ Conduct Disorder ☐ Depression ☐ Developmental Delay ☐ Down Syndrome ☐ Flight Risk ☐ Obsessive / Compulsive ☐ Personality Disorder ☐ Psychosis ☐ PTSD ☐ Schizophrenia ☐ Self-injurious or danger to others ☐ Substance Abuse Other:

Florida Special Needs Registry
Registration Information - Broward County

MEDICAL & OTHER	
Memory: (select all that apply)	☐ Alzheimer's and related dementias ☐ Dementia ☐ Memory Impaired
Dialysis: (select all that apply)	☐ Hemodialysis (Facility/Home) ☐ Peritoneal Dialysis
Name of Primary Insurance Company:	
Dialysis Frequency: (select only one)	☐ 1 time a week ☐ 2 times a week ☐ 3 times a week ☐ 4 times a week ☐ 5 times a week ☐ 6 times a week ☐ 7 times a week (daily)
Insurance ID #:	
Oxygen Type: (select only one)	☐ Gaseous ☐ Liquid
Do you have a Do Not Resuscitate (DNR) order? IMPORTANT: If yes, please remember to bring the original yellow copy with you to the Special Needs Shelter.	☐ Yes ☐ No
Oxygen Liter Flow / Amount: (select only one)	☐ 0.5 ☐ 1.0 ☐ 1.5 ☐ 2.0 ☐ 2.5 ☐ 3.0 ☐ 3.5 ☐ 4.0 ☐ 4.5 ☐ 5.0 ☐ 5.5 ☐ 6.0 ☐ 6.5 ☐ 7.0 ☐ > 7.0
Oxygen Mode of Administration: (select only one)	☐ Mask ☐ Nasal Cannula ☐ Trach Collar
Medicaid #:	
Medicare #:	
Medication Allergies & Reactions (list all)	
Do you need assistance with administering your medications?	☐ Yes ☐ No
Other: (select all that apply)	☐ Vision Impaired ☐ Partially Blind ☐ Legally Blind ☐ Hearing Impaired ☐ Deaf ☐ ALS ☐ Arthritis / Osteoporosis ☐ Angina ☐ Asthma ☐ Cancer ☐ Cerebral Palsy ☐ Congestive Heart Failure ☐ COPD ☐ Cystic Fibrosis ☐ Diabetes (Type 1) ☐ Diabetes (Type 2) ☐ Incontinent ☐ IV Pump ☐ Non verbal ☐ Difficulty understanding verbal instructions ☐ Difficulty speaking ☐ Emphysema ☐ Heart Disease ☐ Hypertension (High Blood Pressure) ☐ Hypotension (Low Blood Pressure) ☐ Kidney Disease ☐ MS ☐ Muscular Dystrophy ☐ Colostomy ☐ Ileostomy ☐ Urostomy ☐ Pacemaker / AICD ☐ Parkinsons ☐ Peritoneal Dialysis Pump ☐ Stroke

Bedsore (Decubitus Ulcer):
Contagious Disease:
Food Allergies & Reactions:
Seizures:
Other:

REGISTRANT'S MEDICATION (Use additional paper if more space needed)

Florida Special Needs Registry
Registration Information - Broward County

REGISTRANT'S MEDICATION (Use additional paper if more space needed)

*Name of Medication	Dosage	Route	Requires Refrigeration
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal ☐ Inhaled	☐ Yes ☐ No
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal ☐ Inhaled	☐ Yes ☐ No
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal ☐ Inhaled	☐ Yes ☐ No
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal ☐ Inhaled	☐ Yes ☐ No
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal ☐ Inhaled	☐ Yes ☐ No
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal ☐ Inhaled	☐ Yes ☐ No
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal ☐ Inhaled	☐ Yes ☐ No

OTHER NOTES ABOUT THE REGISTRANT

Florida Special Needs Registry
Registration Information - Broward County

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