



Department of Public Safety

Division of Emergency Management

20 S. Military Trail

West Palm Beach, FL 33412

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Board of County
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Special Care Unit or Special Needs Shelter Information Letter:

In the event that Palm Beach County is threatened by a hurricane, the normal environment of a hurricane shelter does not lend itself to the proper care of citizens that have medical problems.

With the support of area hospitals, the Health Department and Red Cross, we have developed a Special Program. Prior to the arrival of a hurricane, citizens who meet the specific medical criteria may be taken to one of two centrally located facilities where they will be under the medical supervision of physicians and registered nurses. Admittance to these facilities may be restricted to the following:

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.

All persons not meeting the above criteria will be referred to a Red Cross shelter. If you do not meet the criteria and live in an evacuation zone or mobile home park and are disabled with no other type of transportation you may register with Palm Tran at 561-649-9838. They will transport you to a Red Cross Shelter at no charge.

We will try to assist anyone who needs transportation to the best of our ability. We need to know, however, if you are transportation dependent

We also need to know about your care during day to day activities. It is very important that we know what level of care you require. If you are receiving care from an agency or caregiver, you will need that same type of care at the shelter. If possible, please make arrangements for someone to come to the shelter with you, so that they can assist you during your stay.

*"An Equal Opportunity
Affirmative Action Employer"*

We do provide you with three meals and two snacks a day, if you are on a special diet please bring that food with you. We are attaching a supply list with this application, if you have any questions about this list be sure to call us and we will give you the assistance that you need. Please be selective with what you bring, our facility is designed to accommodate people that need medical care, so please be considerate of that and not bring items that require electricity or space. Only bring the things that you need most. Bedding is provided for you, and only for the caregiver if there are extra beds available after all of the patients have checked in. So be sure that your caretaker or companion has their own bedding, including an air mattress or portable cot. Let us know if you need assistance with your pets, we now have a pet friendly shelter in Palm Beach County and may be able to assist you with those preparations.

Please make sure that you have considered all of your options before settling on a shelter. There are many ways to protect yourself during a disaster. Make your home a safe place by preparing ahead of time, having shutters, water, perishable food items and knowing multiple routes out of the area if an evacuation is needed. Be prepared by stocking up on supplies throughout the year, keeping medications updated and filled. There is always information regarding "Disaster Preparedness" in your local grocery stores.

If you are on oxygen, always make sure that your supplier knows where you are in the event that you may need extra oxygen cylinders. Talk to your physician about staying home, different ways to keep your medication cool, if refrigeration is needed. Be sure to always let your family know about your "Hurricane Plan" and where you will be. Check with your office or clubhouse; if you have one and find out what they may have planned. If you live above the first floor, try to make arrangements with a neighbor or friend that may live on the first floor. "A shelter is safe, but there is no place like home". If you have any other questions about Hurricane Preparedness, please do not hesitate by calling me at the number below.

Sincerely,

Sally Waite
EMS Manager
Palm Beach County
Division of Emergency Management
Office: 561-712-6400

PALM BEACH COUNTY SPECIAL NEEDS APPLICATION

PLEASE COMPLETE AND SIGN THE APPLICATION WITH YOUR PHYSICIAN.

Name _____

Address _____ City _____ APT# _____

Zip Code: _____ Phone #: _____ Age: _____ DOB: _____ 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? (circle one) Yes or No

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

Does your caregiver need special accommodations? (circle one) Yes or No

If yes, please explain: _____

Please list the name and phone number of a relative, neighbor, or an emergency contact:

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.**

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? _____

****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 ___

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.

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 S. Military Trail, West Palm Beach, Fl 33415

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 ___ 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? 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: _____

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 name, address, phone & fax # (Please print clearly)**

Physician's signature: _____ **Date:** _____

Applicant's Signature: _____ **Date:** _____