Broward County Pediatric Special Needs Shelter Application

APPLICATION DATE:________________

PEDIATRIC SHELTER INFORMATION

Thank you for your interest in the Broward County Pediatric Special Needs Shelter. Please understand that the shelter is a place of refuge of last resort from dangerous weather or other emergencies. While basic services such as food, electricity, and medical supervision will be provided; clients and caregivers must provide supplemental food and all medications for the first three days.

Please remember: Cots are provided for clients. Caregivers must provide their own sleeping arrangements.

Return form to: Florida Department of Health in Broward County Special Needs Shelter Program, 780 SW 24th Street, Fort Lauderdale, FL 33315 OR Fax (954) 767-5155. For more information, call (954) 847-8136

CHILD IDENTIFICATION

LAST:____FIRST: ___________________________

DATE OF BIRTH: _____/_____ /_____ HEIGHT: _____FEET_____INCHES WEIGHT: _____

GENDER: □ MALE or □ FEMALE LANGUAGE SPOKEN:_________________________

HOME PHONE:__________________________________ CELL PHONE: ____________________

CHILD RESIDENCE INFORMATION

ADDRESS:____APT/LOT #: _________

CITY:_______________________________ZIP:____________E-MAIL:____

MAILING ADDRESS: □ SAME AS ABOVE ____

CITY:____ZIP:____________

Do you live above the ground level? □ YES If yes, what floor? __________

DEVELOPMENT NAME:_______________________GATE CODE:__________

DWELLING TYPE:
□ SINGLE FAMILY □ DUP/MULTIPLEX
□ MOBILE HOME □ APT/CONDO

PARENT/GUARDIAN INFORMATION

Children must be accompanied by their guardian at all times.

NAME:__________________________________RELATIONSHIP:____________________

EMAIL: ____

HOME PHONE:___________________________CELL PHONE: ____________________

ADDRESS: ____APT__________________

CITY:____STATE:______________ZIP CODE:________________________

EMERGENCY CONTACTS

NAME: ____RELATIONSHIP: ______________PHONE: ________________

NAME: ____RELATIONSHIP: ______________PHONE: ________________

IS THE CHILD A CLIENT OF CHILDREN'S MEDICAL SERVICES (CMS) MANAGED CARE PLAN?
□ YES or □ NO

MEDICAL SUPPORT INFORMATION

PRIMARY DOCTOR:____PHONE:____________________

HOME HEALTH AGENCY:____PHONE: ____________________

HOSPICE PROVIDER ____PHONE: ___________________

HOME MEDICAL EQUIPMENT PROVIDER:_______________________________PHONE: ____________________

DIALYSIS CENTER:____PHONE: ____________________

OXYGEN SUPPLIER:____PHONE: ____________________

TRANSPORTATION

Does the child need transportation to a special needs shelter? □ YES or □ NO

ASSISTANCE WITH DAILY LIVING NEEDED (Check all that Apply)

1. **Assistance with Daily Living:**
   □ Toileting □ Taking Medications □ Feeding/Eating □ Walking more than 50 ft. □ Getting out of bed □ Dressing
2. **Can the child sleep on a cot?** □ YES or □ NO

SPECIAL NEEDS (check all that apply)

Electrical Needs	Mobility Assessment	Specialized Equipment
□ Apnea Monitor □ Bi-Pap or C-Pap □ Cardiac Monitor □ Feeding Pump □ IV Medication □ Medication requiring refrigeration □ Nebulizer □ Suction Pump □ Oxygen Concentrator □ Oxygen: _____of hours daily at _____liters per minute □ IV Medication	□ Child can walk- **or Child uses a:** □ Cane □ Walker □ Wheelchair/scooter □ Lift used to get out of bed □ Other: ____________________ □ Bedridden	□ Feeding Tube □ IV Equipment □ Service Animal □ Other______________________ □ Ventilator PB ______________________ $F1O_2$ ______________________ Pressure Control ____________ Rate ______________________ Ti ________________________
Cognitive Assessment	**Neurologic/Sensory**	**Special Care/Considerations**
□ ADD/ADHD □ Anxiety □ Autism □ Conduct Disorder □ Depression □ Developmental Delay □ Obsessive Compulsive Disorder □ Psychosis Controlled □ Psychosis Uncontrolled	□ Blind □ Deaf □ Hearing Impaired □ Seizures Controlled □ Seizures Uncontrolled □ Visually Impaired	□ Foley Catheter □ Open wounds/Decubitus □ Ostomy □ Wears Diapers □ Dialysis: (#)_____days per week □ Special Diet Please Specify: ________________________ ________________________

DIAGNOSIS	
Chronic but Stable Illness	□ Aphasia (Difficulty communicating) □ Asthma □ Cardiac Abnormalities (Controlled with medication and requiring supervision) Please specify: ____________________ □ Cancer Please specify: ____________________ □ Continuous Ambulatory Peritoneal Dialysis (Stable, self-care) □ Cystic Fibrosis □ Diabetes/Hyperglycemia (Requiring assistance with insulin and monitoring) □ Dialysis (Peritoneal and Hemodialysis) (Dialysis not provided in shelter) □ Foley Catheter □ Fractured Bones (Pin care/dressing changes) □ Hemophilia □ Lung Disease Other Please specify: ____________________ □ Neurological Deficit Please specify: ____________________ □ Seizures Controlled □ Sickle Cell Anemia
Chronic but Stable Illness With Mobility Impairment	□ Cerebral Palsy □ Wheelchair Bound due to Chronic Illness (Such as: ALS, Cerebral Vascular Accident, Multiple Sclerosis, Muscular Dystrophy, etc.) Please specify: ____________________
Electricity Dependent	□ Electric Energized Medical Equipment
Oxygen Dependent	□ Oxygen Dependent

List any other medical problems:____________________

Allergies: □ YES or □ NO If yes, list: ____________________

____

PRESCRIPTION MEDICATION		
Medication Name:	**Dose:**	**# of times per day:**
1. ______	1. ______	1. ______
2. ______	2. ______	2. ______
3. ______	3. ______	3. ______
4. ______	4. ______	4. ______
5. ______	5. ______	5. ______
6. ______	6. ______	6. ______
7. ______	7. ______	7. ______
8. ______	8. ______	8. ______
9. ______	9. ______	9. ______
10. ______	10. ______	10. ______

State of Florida Department of Health, Broward County Health Department Special Needs Shelter and Evacuation Transportation Assistance Application

STATEMENT OF UNDERSTANDING AND SIGNATURE AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The information contained in this application along with the backup material and information I have provided will be used by the Department of Health, Broward County Health Department (BCHD) in determining which sheltering and emergency evacuation assistance, if any, this program may be able to provide for the minor child identified in this application.

The information contained herein is true and correct to the best of my knowledge. I understand that if accepted, assistance will be provided only for the duration of the emergency, and that alternative arrangements should be made in advance in the event the minor is unable to return to his/her home.

By my signature below, I give permission and authorize the BCHD to release the information contained herein, including medical information, to other emergency response personnel, human service agencies, government officials or those BCHD deems necessary for evaluating the identified child's needs and providing transportation and sheltering.

Any change in the information I am voluntarily submitting for registration for sheltering and emergency evacuation assistance requires completion of a new application and re-submittal.

I further understand that if I am accepted into the registry and the BCHD requests additional information or the requested information is not submitted in a timely fashion or if I cannot be located, the BCHD may remove the child from the registry. This authorization shall remain in effect for 12 months from the date of my signature.

Records and documents submitted for purposed of this registry are confidential and/or exempt as provided by Florida law.

Child/Patient Full Legal Name (PRINT): ____

Parent/Guardian of Child/Patient (SIGNATURE): ____

Parent/Guardian of Child/Patient (PRINT): ____

Date: ___________________________

After this application is reviewed, the parent/guardian will receive a letter assigning the child to the pediatric special needs shelter, general shelter, or higher level of care.