For Office Use Only
Special Needs Shelter:: ____________
Red Cross Shelter: ____________

Hillsborough County Health Department Shelter Evaluation Form
(PLEASE PRINT * MUST BE COMPLETED)

Last Name*: ______________________ First Name: ______________ SSN*: ____________

*****Placement in a Special Needs Shelter cannot be guaranteed if submitted after June 1st each year.*****
I understand the limitation on the services and level of care available at a Special Needs Shelter. I grant permission to medical providers, transportation agencies, and others as necessary, to provide care and disclose any information necessary to respond to my needs. I understand that registration does not guarantee assignment to the requested special needs shelter type, all assignments will be made on the basis of medical need and available space at the time of evacuation. **I understand that I can identify one individual to be my caregiver while I am at the shelter.** This registration is voluntary and I hereby request registration in the Special Needs Program.

______________________________ ______________
Signature of Patient / Guardian Date Signed

Sex: ☐Male ☐Female Weight*: ________ Date of Birth*: ______________

Street Address: ______________________________ Phone: ______________

Lot/Apt #: __________ City: ______________________ Zip Code: __________

Do you live in a mobile home? ☐Yes ☐No **Park Name (If applicable)** ____________

Mailing Address: ____

Local Emergency Contact Name: ______________________ Phone #: ____________

Are you a seasonal/temporary resident? ☐Yes ☐No In County: __________ - __________
From Date To Date

Is there a relative/neighbor/manager who can check your residence after the storm? ☐Yes ☐No

If yes: Name: ______________________________ Phone #: ______________

Your caregiver at the shelter: ______________________________ Phone #: ____________

Your Primary Physician's Name: ______________________________ Phone #: ____________

Medical Problems: ____

Mobility: ☐Ambulatory

☐Wheelchair Do you have your own wheelchair? ☐Yes ☐No
Is your wheelchair motorized? ☐Yes ☐No
If you have a wheelchair, please bring it to the shelter.

☐Bedridden Can you be moved in a wheelchair? ☐Yes ☐No

Do you need transportation to the shelter? ☐**Yes** ☐**No**

Do you have a seeing-eye dog or other service animal? ☐**Yes** ☐**No**

Electric Dependent: ☐Yes ☐No ☐Nebulizer ☐Concentrator ☐Other __________

Oxygen Required: ☐Yes ☐No If Yes, Oxygen Provider: ______________________

Dialysis ☐Yes ☐No If Yes, Dialysis Provider: ______________________

Ongoing Wound Care ☐Yes ☐No Describe: ______________________

Home Health Agency:

Name: ______________ Address: ______________ Phone #: ____________

Other Agencies who provide you care:

Name: ______________ Address: ______________ Phone #: ____________

Name: ______________ Address: ______________ Phone #: ____________

Name: ______________ Address: ______________ Phone #: ____________

Return form to: Hillsborough County Health Department PO Box 5135 Tampa, Fl 33675-5135
Or FAX to (813) 276-8689. For more information call (813) 307-8015 Ext. 6006.