SARASOTA COUNTY PEOPLE WITH SPECIAL NEEDS (PSN) APPLICATION

Sarasota County
scgov.net | 941.861.5000 | TV

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Sarasota, Florida 34236
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Please print clearly

GENERAL INFORMATION

For convenience and comfort, citizens are encouraged to make their own evacuation and shelter plans if possible. As an alternative, the PSN program addresses the needs of people with medical conditions or need transportation to a shelter.

Name:______________________ ___ ________________________ Spouse: ________________________
Last MI First

_______________________________________ ______________ FL ____________ ______________
Address City, St. Zip Unit

Phone # (_____)____________________ Email Address:____

Birth Date: ____/____/____ Age: ____ Gender: Male ____ Female ____ Weight ____ Height ___'___"

Primary Language Spoken: _____English _____Spanish _____Other

Phone number to be reached if not a full-time resident of Sarasota? (_____)___________________________

Sub-Division/Facility – Location Description: ____

Type of Home_________________ Type of Construction _________________Year Built ________________
(i.e.: Single Family, Apt/Condo, Mobile home) (i.e.: Block, Wood, Brick, Unknown etc.)

PETS

___Pet provided for
___Number of Cats
___Number of Dogs
Working Dog? _____Yes _____No

TRANSPORTATION FOR PSN APPLICANT

Do you need Transportation? ____Yes ____No
___Ambulance (bedridden)
___Lift Gate Vehicle (wheelchair)
___Standard Vehicle(canes, walkers, walks without help)

TRANSPORTATION FOR OTHER EVACUEES

___Ambulance (bedridden)
___Lift Gate Vehicle (wheelchair)
___Standard Vehicle (canes, walkers, walks without help)

Offical Use Only

FZ	Evac/Flood Div #	Grid	Destination	File #

Received date:	Entered Date

CONTACTS AND EVACUEES PSN Applicant Name:______________________________

_____________________ (_____)______________ Primary Doctor: Phone

_______________________ (_____)________________ Home Health Agency Info Phone:

_____________________ (_____)______________ Emergency Contact Phone

_______________________ (_____)________________ Caregiver Phone

___ Evacuate Spouse?
___ Evacuate Caregiver?

____Number of additional Evacuees (Excluding PSN Spouse, Caregiver)

MEDICAL INFORMATION

___Aphasia
___Arthritis
___Asthma
___Breathing Treatment
___Bronchitis
___Cancer
___Cerebral Palsy
___Comatose
___Contagious Disease – Type: _________________
___Dementia ____Early ____Moderate ____Late
___Diabetes
___Dialysis: (In Home Dialysis?)____Yes ____No
___Difficulty Speaking
___Edema
___Emphysema/COPD
___Hearing Impaired
___Heart Condition ____Stable ____Unstable
___High Blood Pressure
___Hip/Knee Replacement: When? ____________
___Hospice
___Medical Equipment. Circle any that apply: (Feeding tube, Ventilator, IV, Indwelling Catheter)
___Memory Loss
___Mentally Impaired
___Multiple Sclerosis
___Muscular Dystrophy
___Nebulizer
___Open Sores
___Ostomy – Type _________________
___Oxygen Use ____LPM (Number on dial)
___Parkinson's Disease: ___Early ___Mod ___Late
___Psychosis ____Controlled ____Uncontrolled
___Seizures ____Controlled ____Uncontrolled
___Sight Impaired
___Skin Disease
___Skin Infections
___Special Diet (Bring doctor-prescribed food)
___Speech Impaired
___Stroke/CVA (Limitations)

List known allergies: ____
List medication: ____
Other Comments: ____

POWER DEPENDENT

___Electric Dependent, Why? ____
___Oxygen Concentrator
___Sleep Apnea (CPAP Machine)
___Ventilator/Respirator (Machine is used to breath for you, unlike the Oxygen Concentrator and CPAP)
___Other, Please Specify: ____

MOBILITY

___I have someone assist me with all my daily activities
___I walk without help
___I use a cane
___I use a walker. Walk long distances? ___Yes ___No
___I use a wheelchair
___I am bedridden

*** ALWAYS CONTACT EMERGENCY MANAGEMENT WITH CHANGES TO YOUR APPLICATION**.

Revised 02/09/2009