



SEMINOLE COUNTY EMERGENCY MANAGEMENT VOLUNTARY SPECIAL NEEDS REGISTRATION FORM

The purpose of Special Needs Shelters is to provide shelter as a last resort.

(This form must be filled out completely. Please print clearly)

PERSONAL INFORMATION:				
Applicant's Last Name:	Applicant's First Name:	M.I.	Birth Date :	Sex: <input type="checkbox"/> M <input type="checkbox"/> F Height: _____ Weight: _____
Street Address:	City / Zip:	Primary Phone Number: Cell Phone Number:		
Mailing Address <i>(If different from above)</i> :	City / Zip:	Email Address:		
Name of Subdivision:	Flood Prone Area? <input type="checkbox"/> Yes <input type="checkbox"/> No Apt. or Condo? <input type="checkbox"/> Yes <input type="checkbox"/> No Mobile Home? <input type="checkbox"/> Yes <input type="checkbox"/> No		Living Situation <i>(check one)</i> <input type="checkbox"/> Lives Alone <input type="checkbox"/> With Spouse <input type="checkbox"/> With Children <input type="checkbox"/> With Parents <input type="checkbox"/> Other <i>(explain)</i>	
Primary Language:				
SHELTER TRANSPORTATION INFORMATION:		PET INFORMATION:		
Will you need transportation to shelter: <input type="checkbox"/> Yes <input type="checkbox"/> No Will you need one of the following: <input type="checkbox"/> Automobile <input type="checkbox"/> Van with wheelchair lift <input type="checkbox"/> Stretcher		Will you bring a pet with you? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Indicate type and how many</i> <input type="checkbox"/> Cat _____ <input type="checkbox"/> Service Animal / Type _____ <input type="checkbox"/> Dog _____ <input type="checkbox"/> Other _____		
If you are unable to return home due to unforeseen circumstances, such as damage or flooding, do you have a plan of where you will go? <i>(Have you talked with them about your plan?)</i>				
<input type="checkbox"/> Family (local) <input type="checkbox"/> Friend (local) <input type="checkbox"/> Will go to a hotel <input type="checkbox"/> Family (not local) <input type="checkbox"/> Friend (not local) <input type="checkbox"/> Other (explain) _____				
Number of caretaker(s) coming with applicant to the shelter: _____				
Name _____ Relationship _____ Phone Number _____				
Name _____ Relationship _____ Phone Number _____				
EMERGENCY CONTACT INFORMATION: (Local)				
First Name	Last Name	Relationship	Phone Number	
			Alt. Phone Number	
EMERGENCY CONTACT INFORMATION: (Out of State or Not Living With You)				
First Name	Last Name	Relationship	Phone Number	
			Alt Phone Number	
AUTHORIZATION/SIGNATURES				
Print Name of Person filling out this form (if different from applicant)		Signature of Person filling out this form (if different from applicant)		
Relationship to Applicant		Date		
Signature of Applicant / or Guardian	Date	Agency (if applicable)	Initial Here you've received the Notice of Privacy Form:	

PHYSICIAN/PHARMACY INFORMATION:

Physician's Last Name:	First Name:	Phone:
Pharmacy Name:	Phone:	
Home Health Care Agency:	Phone:	

LIST MEDICAL CONDITION / DIAGNOSES

MEDICATIONS TAKEN: Name, Dosage, Route, Frequency

Medications Need Refrigeration Life-Sustaining Medications Needs Assistance with Medications

MEDICAL INFORMATION: (Check and complete those that apply to your medical condition)

<input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair Bound <input type="checkbox"/> Bedridden <input type="checkbox"/> Speech Impaired (Explain) _____ <input type="checkbox"/> Hearing Impaired (Explain) _____ <input type="checkbox"/> Sight Impaired (Explain) _____ <input type="checkbox"/> G-tube Feeders <input type="checkbox"/> Colostomy or Ileostomy <input type="checkbox"/> Cardiac History <input type="checkbox"/> Seizures (Explain) _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Insulin Dependent <input type="checkbox"/> Oral Meds <input type="checkbox"/> Cancer <input type="checkbox"/> Year _____ <input type="checkbox"/> Currently on Chemotherapy/ last treatment _____ <input type="checkbox"/> Currently on Radiation/ last treatment _____ <input type="checkbox"/> Dialysis How Often? _____ Dialysis Facility Name _____ Address _____ Phone # _____ <input type="checkbox"/> Allergies _____ <input type="checkbox"/> Do you get easily confused or disoriented? (Explain) _____ <input type="checkbox"/> Hospice Name of Hospice Provider: _____ Phone: _____ <input type="checkbox"/> DNR (Do Not Resuscitate Order) please bring with you to shelter	<input type="checkbox"/> Memory Impaired (Explain) _____ <input type="checkbox"/> Mental Health (Explain) _____ <input type="checkbox"/> Autism <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Respirator (Ventilator) <input type="checkbox"/> Cpap <input type="checkbox"/> Suction Machine <input type="checkbox"/> COPD <input type="checkbox"/> Nebulizer <input type="checkbox"/> Emphysema <input type="checkbox"/> Required or Life-Sustaining Medical Equipment (Explain) _____ <input type="checkbox"/> Oxygen - Portable <input type="checkbox"/> Oxygen Concentrator <input type="checkbox"/> Oxygen - Continuous Amount of Oxygen? _____ <input type="checkbox"/> Oxygen - Treatments Only Amount of Oxygen? _____ How Often? _____ <input type="checkbox"/> Oxygen - PRN (As Needed) Night-time-# of hours? _____ Daytime-# of hours? _____ Amount used per day? _____ <input type="checkbox"/> Oxygen Supplier _____ Phone Number _____ <p style="text-align: center;"><u>Mandatory SpNS</u> Dialysis, Oxygen, Breathing Treatment, Feeding Tube (syringe feedings or for medications only) Bring all your supplies with you. <u>A personal caregiver should accompany registered individual to the shelter.</u></p>
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EMERGENCY MANAGEMENT USE ONLY:

SpNS Shelter - (Requires electricity, medical supervision / assistance) Public Shelter Well Check
 Consult Healthcare Provider (Services needed beyond care provided at a shelter)
Reviewer Signature: _____ Date: _____

Mail Form to: Seminole County Department of Public Safety
Office of Emergency Management
150 Bush Blvd., Sanford, FL 32773 (407) 665-5102 Fax (407) 665-5048

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Seminole County Department of Public Safety, EMS/Fire/Rescue Division, provides medical transportation, fire protection services, and related services. Seminole County Emergency Management provides emergency management services, particularly in times of disaster, to protect life, health, property and the environment. These services include the establishment and maintenance of a registry of persons who may have special needs in time of emergency or disaster. The Seminole County EMS/Fire/Rescue Division and Emergency Management are hereinafter referred to collectively as "department," "we," "our," or "us." Due to the nature of these services, we are required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information (PHI), and to provide you with a notice of our legal duties and privacy practices with respect to your PHI.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Permitted Uses and Disclosures of PHI: We may use your PHI for the purposes of treatment, payment and health care operations, without your written permission or opportunity to object. The following categories and examples illustrate permitted uses and disclosures of PHI but not every way is listed.

- **Disclosures to you.** The County must disclose PHI to you unless it has been determined by a medical authority that the disclosure would be harmful to you or others.
- **To Personal Representatives.** To parents, guardians and persons acting in a similar legal status as required by Florida law. To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection, and in certain other circumstances, such as an emergency, where we are unable to obtain your agreement and believe the disclosure is in your best interests.
- **For Treatment.** This includes such things as obtaining verbal and written information about your medical condition and treatment from you as well as from others, such as doctors and nurses who give orders to allow us to provide treatment to you. We may give your PHI to other health care providers involved in your treatment, and may transfer your PHI via radio or telephone to the hospital or dispatch center.
- **For Payment.** This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies, making medical necessity determinations and collecting outstanding accounts.
- **For Health Care Operations.** This includes quality assurance activities, licensing and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, as well as certain other management functions.
- **For the following public interest and benefit activities:**
 1. As required by federal or state law;
 2. To public health authorities or other appropriate government authority for the purpose of preventing or controlling disease, injury, child abuse, or disability;
 3. To a government authority authorized by law to receive reports of such abuse, neglect, or domestic violence;
 4. For health oversight activities including audits and/or investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
 5. For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
 6. For law enforcement activities in limited situations, such as when responding to a warrant;
 7. To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
 8. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;

9. For certain limited research, subject to strict oversight and approvals;
10. To avert a serious threat to the health and safety of a person or the public at large, including to law enforcement authorities to identify and apprehend an escapee or violent criminal;
11. For military, national defense and security and other special government functions, including disclosures of an inmates' PHI to correctional institutions or law enforcement officials;
12. For workers' compensation or other similar programs, established by law.
13. In the case of the Emergency Management Special Needs Registry, to the Seminole County Health Department to implement this service.

Uses and Disclosures of PHI Requiring Your Permission

Any other use or disclosure of PHI, other than those described above will only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Patient Rights: As a patient, you have the following rights with respect to your PHI, including:

- **Right to Access, Inspect or Copy.** You may inspect and copy most of the medical information about you that we maintain. To the extent that the information is maintained electronically you have the right to receive a copy of the information in an electronic format. We will normally provide you with access to this information within 30 days of your request, or within 60 days if the information is stored off-site. We may also charge you a reasonable fee, as state law permits, to provide a copy of any medical information you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have forms available to request access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights. If you wish to inspect or obtain a copy of your medical information, you must contact the Public Safety Department HIPAA Contact Person.
- **Right to Request Amendment.** You have the right to ask us to amend written medical information we may have about you. We are permitted by law to deny your request to amend your medical information in certain circumstances, like when we believe the information you have asked us to amend is correct. If you wish to request an amendment of the medical information we have about you, please contact the Public Safety Department HIPAA Contact Person to obtain an amendment request form. We will respond to your request within 60 days of receipt and will notify you as to whether the amendment will be made or was denied.
- **Right to Request an Accounting.** You may request an accounting from us of certain disclosures of your medical information we have made in the six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations. This includes disclosures to our business associates, such as our billing company or a medical facility from/to which we have transported you. We are also not required to give you an accounting of our uses of PHI for which you have already given us written authorization. If you wish to request an accounting, contact the Public Safety Department HIPAA Contact Person.
- **Right to Request Restriction.** You have the right to request that we restrict or limit how we use and disclose your medical information we have about you. Your request must be made in writing to the Public Safety Department HIPAA Contact Person and must describe (1) what information you want limited; (2) whether the restriction is of use, disclosures, or both; (3) to whom you want the restriction to apply, for example, disclosures to your spouse; and (4) an expiration date. We are not required to agree to any restrictions you request, except in the case where the PHI pertains to a health care item or service for which you fully paid for out of your own pocket.
- **Right to Request Confidential Communications.** You may request that we communicate with you using alternative means or an alternative location. We will not ask you the reason for your request. We will accommodate reasonable requests, when possible.

Right to Obtain a Paper Copy of the Notice on Request. The notice may be viewed electronically at www.SeminoleCountyfl.gov. To obtain a paper copy of this Notice, you may print it from the internet, or you may request a hard copy by contacting us at the address listed below. **Revisions to the Notice:** We reserve the right to change the terms of this Notice at any time. Changes will be effective immediately and will apply to all PHI we maintain. The Notice will be posted in our facilities and on our web site as well as distributed to individuals as may be required by law. You can get a copy of the latest version of this Notice by contacting our privacy official, or by viewing it on our website.

Complaints: If you believe your privacy rights have been violated you have the right to complain to Seminole County EMS/Fire/Rescue, the Seminole County Privacy Officer, the Secretary of the Florida Department of Health or the Secretary of the United States Department of Health and Human Services. You will not be retaliated against in any way for filing a complaint.

CONTACT INFORMATION

HIPAA Privacy Officer
Seminole County Human Resources Manager
Community Services Building, Suite 3180
1101 East 1st Street
Sanford, Florida 32771
407-655-7941

Public Safety Department HIPAA Contact Person
Seminole County Fire Department
150 Bush Boulevard, Sanford, FL 32773
Phone: (407) 665-5175
Fax: (407) 665-5010

Effective Date of the Notice: April 14, 2003
Revised on February 1, 2014

I, _____, on the _____ day of _____, 20____, hereby acknowledge receipt of this Notice of Privacy Practices for Protected health Information.

SIGNATURE