Submit Form

SEMINOLE COUNTY
FLORIDA'S NATURAL CHOICE

Seminole County Office of Emergency Management

VOLUNTARY MEDICALLY ENHANCED SHELTER / WELL CHECK PROGRAM REGISTRATION FORM

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

By signing up for the Voluntary Medically Enhanced Shelter / Well Check Program, you are acknowledging that you have read, understood, and agree with the Notice of Privacy Practices for Protected Health information.

PERSONAL INFORMATION			
First Name:	M.I.:	Last Name:	Suffix:

CONTACT INFORMATION	
Home Phone:	Cell Phone:
Caretaker Phone (if applicable):	Email Address:

HOME ADDRESS	
Street Address:	Apartment / Unit #:
City:	Zip Code:

REGISTRATION INFORMATION		
Date of Birth: ____ / ____ / _____	Sex: ☐ M ☐ F	Type of Residence: ☑ Single Family Home ☐ Apartment / Condo ☐ Mobile/Manufactured Home

Living Status:
☐ Alone ☐ With Spouse / Relative ☐ With Caregiver ☐ Other (Please Specify): _____

Will you have a Caretaker with you at the shelter?	☐ Yes ☑ No
Do you use Oxygen?	☐ Yes (☐ Intermittent ☐ Continuous) ☐ No
Do you use medical equipment that requires electricity to operate?	☐ Yes (☐ Intermittent ☐ Continuous) ☐ No
• If Yes, please specify the equipment that requires electricity:	
Do you use medication that requires refrigeration?	☐ Yes ☐ No
Do you use an LVAD (Left Ventricular Assistance Device)?	☐ Yes ☐ No
Do you receive Dialysis?	☐ Yes (☐ At Home ☐ At Facility) ☐ No
Are you confined to a bed?	☐ Yes (☐ Hoyer Lift Required) ☐ No
Do you utilize a service animal?	☐ Yes ☐ No
Do you have pets at home?	☐ Yes ☐ No
Do you require transportation to a shelter?	☐ Yes (☐ With Wheelchair Lift) ☐ No
Do you use a wheelchair?	☐ Yes (☐ Electric ☐ Manual) ☐ No

OFFICIAL USE ONLY – DO NOT FILL OUT

☐ SpNS Shelter ☐ Well Check ☐Beyond Care

Reviewer Signature: Date:

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