CONFIDENTIAL

This information is not subject to public disclosure under Florida Statues 252.355
LEON COUNTY DIVISION OF EMERGENCY MANAGEMENT
SPECIAL NEEDS ASSISTANCE POPULATION PROGRAM (SNAPP)
PLEASE PRINT CLEARLY OR TYPE THE INFORMATION REQUESTED
Phone: (850) 488-5921 Fax: (850) 487-3770

Date____________
Last Name: ____________________________ First Name:______________________ MI:____
Address :____
City:________________________________ State:_______________ Zip Code:_______________
Telephone Number: ( )________________ Primary Language Spoken: __________________
Height: ____________ Weight: __________ Date of Birth: ____________ Sex: ____________
Doctor's Name:____________________________________ Telephone: ( ) ________________
Pharmacy:____ Telephone: ( ) ________________
Emergency Contact:________________________________ Telephone: ( ) ________________
Attendant's Name:__________________________________ Telephone: ( ) ________________

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FILL OUT COMPLETELY:

1. Does client have family/friends who can safely evacuate client to a safe location? **Y / N**
   Or, do they need evacuation assistance? **Y / N**
2. Nature of Disability/List ALL medical Conditions:_____________________________________
   ____
3. Are you: Ambulatory______, Ambulatory with Assistance_______, Bedridden______
4. Do you need a Cane: _____ Wheelchair: ____ Walker: ____ Power chair/Scooter_____
   (a.) Do you own a wheelchair? : Yes____, No_____ (b.) Is it collapsible?: Yes____, No_______
5. Can you ride in a Regular Vehicle?: Yes_______, No_______
6. Any use of certified service animal? Yes _______, No ______
7. Do you live in a Mobile Home?: Yes_______, No________ Flood Prone Area? : Yes_____, No_____
8. **ATTACH A LIST OF ALL CURRENT MEDICATIONS AND DOSAGES YOU ARE CURRENTLY TAKING**
9. Do you require any regular medical treatments?: **Y / N** ? If yes, please list________________________
   ____
10. Are you oxygen dependent? **Y / N** What company provides your O2? ______________________________
11. Are you electric dependent? **Y / N** List electrical equipment____
12. List any special equipment needed: ____
13. Identify the **<u>number</u>** of persons that need to accompany you.__________
14. Do you have home health, homemaking, or other type of services at home? **Y / N** List__________________
15. Do you have a DO NOT RESUSCITATE ORDER (DNRO)? **Y / N** if yes, please **ATTACH**

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IF YOU ARE REPRESENTING A CLIENT PLEASE COMPLETE THE FOLLOWING INFORMATION:
(Please print)

Agency Name:____
Name of person completing form:____
Agency Address:____ City:_______ State:_____ Zip code:_________
Agency Telephone Number: ( ) ____________________
Circle one of the following:
<u>Transportation:</u> T-1A: Ambulance, T-1: Stretcher T-2: Wheelchair, T-3: Regular
<u>Destination:</u> T.M.H, C.R.M.C ALF, SHELTER

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<u>Authorization to enter residence:</u> (Check the appropriate blank.)

I do _______ or do not ________ authorize emergency personnel to enter my residence for search and rescue operations.

Client Signature:__________________________________