



## Florida Special Needs Registry Registration Information - Levy County

Instructions: Complete this form and fax or mail it to Levy County to register an individual for the Florida Special Needs Registry. This form is not required if you have already registered on line. Required fields are indicated with an asterisk (\*).

Mail: Levy County Special Needs Registry  
66 W Main St.  
Bronson, FL 32621

Fax: (352) 486-5300

PERSONAL INFORMATION ABOUT THE REGISTRANT	
*First Name	
*Last Name	
*Birth Date	
*Gender (select only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Non-Binary <input type="checkbox"/> Prefer Not To Provide
*Height	Feet:                      Inches:
*Weight (pounds)	
*Primary Language	
Are you completing this form on behalf of the registrant? If so, please indicate your relationship to the registrant (select only one)	<input type="checkbox"/> Family Member <input type="checkbox"/> Caregiver <input type="checkbox"/> Neighbor <input type="checkbox"/> Friend <input type="checkbox"/> Home Health Care Provider <input type="checkbox"/> County Emergency Management Staff <input type="checkbox"/> County Health Department Staff <input type="checkbox"/> DOH State Staff

ADDRESS FOR THE REGISTRANT (physical address is required)	
*Physical Address (cannot be a PO Box)	
Apt #, Unit #, Bldg #, Suite #, etc.	
*Physical City	
*Physical State	FL
*Physical Zip Code	

PHONE NUMBERS FOR THE REGISTRANT (a primary and at least one other phone number is required)				
*Phone Number	Extension	*Phone Type (select only one)	Primary	TTY/TDD Capable
(    ) -		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(    ) -		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(    ) -		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

PRIMARY EMERGENCY CONTACT FOR THE REGISTRANT (required)	
*Primary Emergency Contact Name	
*Contact Primary Phone Number	(    ) -                      Extension:

REGISTRANT'S EQUIPMENT



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<b>REGISTRANT'S EQUIPMENT</b>				
Please indicate the medically necessary equipment that is electric dependent for this registrant: (select all that apply)	<input type="checkbox"/> Apnea Monitor	<input type="checkbox"/> Cardiac Monitor	<input type="checkbox"/> CPAP / BiPAP	<input type="checkbox"/> Dialysis Catheter
	<input type="checkbox"/> Feeding Pump	<input type="checkbox"/> Medication that requires refrigeration	<input type="checkbox"/> Nebulizer	<input type="checkbox"/> Oxygen Concentrator
	<input type="checkbox"/> Suction Pump	<input type="checkbox"/> Ventilator	<input type="checkbox"/> Wound Vac	
Other: <input style="width: 90%;" type="text"/>				

<b>TRANSPORTATION &amp; MOBILITY</b>				
Registrant has the following transportation needs: (select all that apply)	<input type="checkbox"/> Must be transported in a wheelchair accessible vehicle	<input type="checkbox"/> Needs continuous oxygen during transport	<input type="checkbox"/> Just needs transportation to a shelter	
Registrant has the following mobility issues: (select all that apply)	<input type="checkbox"/> Is confined to a bed	<input type="checkbox"/> Is paralyzed (complete or partial)	<input type="checkbox"/> Uses a Walker	<input type="checkbox"/> Uses a Wheelchair
	<input type="checkbox"/> Uses a Motorized Wheelchair / Scooter			

<b>MEDICAL &amp; OTHER</b>				
Memory: (select all that apply)	<input type="checkbox"/> Alzheimer and related dementias			
Dialysis Frequency: (select only one)	<input type="checkbox"/> 1 time a week	<input type="checkbox"/> 2 times a week	<input type="checkbox"/> 3 times a week	<input type="checkbox"/> 4 times a week
	<input type="checkbox"/> 5 times a week	<input type="checkbox"/> 6 times a week	<input type="checkbox"/> 7 times a week (daily)	
Oxygen Type: (select only one)	<input type="checkbox"/> Gaseous		<input type="checkbox"/> Liquid	
Oxygen Liter Flow / Amount: (select only one)	<input type="checkbox"/> 1.0	<input type="checkbox"/> 1.5	<input type="checkbox"/> 2.0	<input type="checkbox"/> 2.5
	<input type="checkbox"/> 3.0	<input type="checkbox"/> 3.5	<input type="checkbox"/> 4.0	<input type="checkbox"/> 4.5
	<input type="checkbox"/> 5.0	<input type="checkbox"/> 5.5	<input type="checkbox"/> 6.0	<input type="checkbox"/> 6.5
	<input type="checkbox"/> 7.0			
Oxygen Mode of Administration: (select only one)	<input type="checkbox"/> Mask	<input type="checkbox"/> Nasal Cannula	<input type="checkbox"/> Trach Collar	
Other: (select all that apply)	<input type="checkbox"/> Vision Impaired	<input type="checkbox"/> Deaf	<input type="checkbox"/> Incontinent	
Other: <input style="width: 90%;" type="text"/>				

<b>OTHER NOTES ABOUT THE REGISTRANT</b>



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