



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:	

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.