**Appendix A**

# SOUTHBAY MEDICALLY DEPENDENT RESIDENT FORM

The SOUTHBAY Community Emergency Response Team will assist residents who are medically dependent during a government-declared emergency if we are able to do so. Please fill out the form below and arrange to review it with the Community Manager and your Zone Captain.

COMPLETION OF THIS FORM IS OPTIONAL.
Providing the information below in no way obligates SOUTHBAY to provide any services.

## Person Who Needs Assistance

| | |
|---|---|
| Last Name | First Name |
| Street Address | Full or Part Time Resident (circle one)<br>If Part time, months here: |
| Home Phone: | Cell Phone: |
| Who else lives at this address? | Relationship? |
| | |
| Have you registered with Sarasota County *Medical Needs Program?*<br>(Circle One) YES NO | |
| SOUTHBAY CERT Zone: | SOUTHBAY Zone Captain: |

## Who Should We Contact In An Emergency Or Potential Evacuation?

| | |
|---|---|
| Home Health Agency: | Phone: |
| Caregiver: | Phone: |
| Nearest Family Member (not at this address) Who Can Assist You: | Phone: |

## Reason You Need Assistance

| | |
|---|---|
| Mobility | (Circle any that apply) Bedridden Wheelchair Walker Cane |
| Power Dependent | (Circle any that apply) O2 Concentrator CPAP Ventilator Other (explain):<br>I have a source of emergency power (Generator): YES NO |
| Other | (Circle any that apply) Legally Blind Deaf Mute<br>Other (explain): |