

Attachment 5 INDIVIDUALS WITH FUNCTIONAL NEEDS REGISTRATION

Functional needs Shelter Name: _____ Date Opened _____ Time
Opened _____

Supervising RN Name _____ Date Closed _____ Time Closed _____

Arrival Date and Time	Functional needs Individual Name	Address City, State, Zip	Caregiver Name and Phone Number	Emergency Contact Name and Phone Number	Diagnosis Special Need	Method of Arrival	Departure Date and Time (Permanent or Temporary)

TRANSPORTATION TYPES:

- T1 - Private Vehicle
- T2 - Public Transportation
- T3 - Standard Bus Pick-up
- T4 - Wheelchair Accessible vehicle