

Hernando County Emergency Management Special Needs Evacuation Assistance Registration Form



Hernando County Emergency Management orders or recommends evacuations for natural disasters, hurricane, fire, or flood; man-made incidents, rail road, or highway accidents; hazardous material release or nuclear and radiological incidents.

The Special Needs Program is voluntary and helps with transportation and shelter for residents during emergencies and disasters.

Who is Eligible for the Special Needs Program?

Hernando County residents who need:

- Care for serious medical conditions that require observation, assessment or care in a shelter
- Residents that need help with mobility, oxygen, administering medication and health monitoring.
- Residents that need transportation to a shelter or other safe location

Residents who need a greater level of assistance are encouraged to make plans through their physician, health care provider, home health agency, oxygen company, and medical equipment provider. People who need greater care may include residents who are bed-bound, in a hospital bed, weigh more than 400 pounds, are on a ventilator or have a tracheotomy, recent and unstable cardiac care, residents that depend on electricity for medical equipment, residents that are in the third trimester of pregnancy, or have a high-risk pregnancy, and children with special medical needs.

How to register for the Special Needs Program

Completed forms are confidential and Emergency Management reviews the forms with you once a year by phone call or mailed letter. You should also review your form each year with your physician, health care provider, home health agency, oxygen company, and medical equipment provider

Register for the Special Needs Shelter Program NOW!

Hernando County Emergency Management / Special Needs Program

MAIL: 18900 Cortez Blvd

Brooksville, Florida 34601

PHONE: (352)-754-4083

FAX: (352) 754-4090

EMAIL: eocops@co.hernando.fl.us

CLICK: <https://member.everbridge.net/index/453003085618351>

Hernando County Shelter Evaluation Form

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| First Name: | Middle Initial: | Last Initial: | Date of Birth: |
| Gender: M / F | Weight: | Telephone: | Primary Language: |
| Street Address: | Lot/Apt # | City: | Zip Code: |
| Living Arrangements: Alone Spouse Roommate Relative Other: | Evacuation Zone: A B C D E None | | |
| Flood Zone: | Map Feature: | Your electric Company: Duke / WREC | |
| Transportation: Do you need a ride: YES NO | # of people going to the SPN Shelter: | # of people going to the General Population Shelter: | |
| Transport Type: Self Drop Off Bus Liftgate EMS Stretcher | # of people to transport to SPN Shelter: | # of people to transport to the General Population Shelter: | |
| Mobile Home / RV: Yes No | Name of Mobile Home / RV Park: | | |
| Spouse Name: | Telephone: | | |
| Caregiver Name: | Relationship | Telephone: | |
| Local Emergency Contact Name: | Relationship: | Telephone: | |
| Out of Town Emergency Contact Name: | Relationship: | Telephone: | |
| Primary Doctor's Name: | Telephone: | | |
| Home Health Agency Name: | Telephone: | | |
| Oxygen Provider Name: | Telephone: | | |
| Medical Equipment Provider Name: | Telephone: | | |
| Mobility Assessment: (Check all that apply) | | Electric Dependent: (Check all that apply) | |
| <input type="checkbox"/> I can walk without help <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Wheelchair / Scooter <input type="checkbox"/> Bedridden | <input type="checkbox"/> Paralysis <input type="checkbox"/> Lift to get out of bed <input type="checkbox"/> Hearing Impair. / Deaf <input type="checkbox"/> Limited Vision / Blind | <input type="checkbox"/> Feeding Pump <input type="checkbox"/> Nebulizer / # of times per day <input type="checkbox"/> Apnea Monitor <input type="checkbox"/> CPAP / BPAP <input type="checkbox"/> Ventilator | <input type="checkbox"/> Suction Pump <input type="checkbox"/> Cardiac Monitor <input type="checkbox"/> Where do you get Dialysis: Dialysis Center / Home <input type="checkbox"/> # of times per week <input type="checkbox"/> Name of Dialysis Center: ____ |
| Oxygen Assessment: (Check all that apply) | | Special Care: (Check all that apply) | |
| <input type="checkbox"/> I understand I need to bring enough oxygen and supplies for my whole stay. | <input type="checkbox"/> Hrs. / day _____ <input type="checkbox"/> Liter Flow _____ <input type="checkbox"/> Concentrator <input type="checkbox"/> Portable Tank <input type="checkbox"/> Liquid Oxygen | <input type="checkbox"/> Allergies: _____ <input type="checkbox"/> Contagious Illness: _____ <input type="checkbox"/> Compromised immune sys / Susceptible: _____ <input type="checkbox"/> Wound care / dressing change <input type="checkbox"/> Recent & stable cardiac condition | <input type="checkbox"/> Catheter <input type="checkbox"/> Ostomy <input type="checkbox"/> Incontinence / Diapers <input type="checkbox"/> Diabetes and on insulin <input type="checkbox"/> Help with medicine <input type="checkbox"/> Caregiver gives medicine |
| Cognitive Assessment: (Check all that apply) | Trained Service Animal: (Check all that apply) | | |
| <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia <input type="checkbox"/> PTSD | <input type="checkbox"/> Type: Dog / Pony | | <input type="checkbox"/> The service it provides: _____ |
| | Pets: (Check all that apply) | | |
| | <input type="checkbox"/> # of animals _____ <input type="checkbox"/> Type of animal(s) _____ [NOTE: Animals are not allowed at Special Needs Shelter. Animal are sent to Animal Services!] | <input type="checkbox"/> Where have you planned to send your animal in a disaster? <input type="checkbox"/> Veterinarian / Kennel <input type="checkbox"/> Friend / Neighbor / Relative <input type="checkbox"/> Animal Services | |
| <p>By signing this form, I give my authorization for the medical information contained herein to be released to the county health department, emergency management, local fire districts, and receiving facilities for evaluating my needs and providing emergency transportation and sheltering. Records relating to registration of disabled citizens are exempt for the provisions of F.S. 119.07(1), Public Records Law. This information will be kept confidential.</p> <p>I grant permission: for emergency responders to check or enter my house in an emergency; for medical providers, transportation agencies and others as necessary to provide care and to disclose any information necessary to respond to my needs. Shelter assignment is based of medical need and available space. My request for registration at the Special Needs Shelter is voluntary.</p> | | | |
| Signature of Patient / Guardian: | | Date Signed: | |