

HERNANDO COUNTY

SPECIAL NEEDS EVACUATION ASSISTANCE PROGRAM REGISTRATION FORM

I NEED EVACUATION ASSISTANCE

I CAN EVACUATE MYSELF AND WOULD LIKE A COURTESY CALL

Name: _____ Sex: _____ DOB: _____
Last First MI mm/ dd / yyyy

Home Address: _____ Number of people to shelter: _____

Mailing Address: _____ Number of people to transport: _____

Phone: (____) _____ City: _____ Zip Code: _____

Do you live in a Mobile Home? [] Yes [] No	Do you have pets? [] Yes [] No
Which evacuation zone do you live in? (Circle One) <div style="text-align: center;"> A/B C D/E NON-EVACUATION </div>	Have you made arrangements to shelter your pets? [] Yes [] No

Support Information	Name	Phone Number
Name of Caregiver		()
Local Relative or Friend		()
Oxygen Provider		()
<input type="checkbox"/> No Assistance Needed to Walk	<input type="checkbox"/> I am Bedridden but can be moved in a Wheelchair	
<input type="checkbox"/> I use a Wheelchair	<input type="checkbox"/> I am Bedridden and cannot be moved in a Wheelchair	
<input type="checkbox"/> I need a Wheelchair but do not own one		
OXYGEN		<input type="checkbox"/> I use a Nebulizer _____ times per day
_____ Liters Per Minute _____ Hours a day		<input type="checkbox"/> I am on a Respirator
DIALYSIS		DIABETIC
_____ Times per week		<input type="checkbox"/> Insulin Dependent
<input type="checkbox"/> Hemodialysis		<input type="checkbox"/> Controlled with diet
<input type="checkbox"/> Peritoneal		<input type="checkbox"/> Visually Impaired
<input type="checkbox"/> I need Wound Care _____ times per week		<input type="checkbox"/> History of Cardiac Illness
<input type="checkbox"/> Hearing Impaired		<input type="checkbox"/> I have Low Blood Pressure
<input type="checkbox"/> I have High Blood Pressure		

Life Support Equipment :(List Type) _____

Additional Medical Condition/ Health Needs: _____

I understand the limitation on the services and level of care available. I grant permission to medical providers, transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs. I understand that **registration does not guarantee assignment** to a particular shelter type, all assignments will be made on the basis of medical need and available space at the time of evacuation. This registration is voluntary and I hereby request registration in the Special Needs Program.

Registrants Signature: _____ Date: _____

Completed By: _____ Agency: _____

PLEASE COMPLETE THE INFORMATION ON THIS FORM. INCOMPLETE FORM WILL BE RETURNED