INTRODUCTION

The Citrus County Board of County Commissioners, acting within the Florida State Statutes, may order or recommend evacuation of specific areas of the county for reasons that include Natural Disasters (Hurricane, Fire, Flood), Man-Made Disasters (Rail, Hazardous or Transportation Incidents) or Technological Disasters (Power Loss).

Special Needs is a voluntary program that provides transportation, evacuation assistance and sheltering to residents during such times for those who do not have the means to evacuate or for those requiring health or medical considerations to the Special Needs Shelter.

The primary Special Needs Shelter is located at Forest Ridge Elementary School, 2927 N Forest Ridge Blvd, Hernando, FL 34442. However, this location may not always be used, depending on the type of incident. Follow local emergency official's announcements of shelter location.

WHO IS ELIGIBLE?

Citrus County Residents
1. Requiring transportation to and from a designated emergency shelter;
2. Residing in an ordered evacuation area, recommended evacuation area, or unsafe residence (mobile/manufactured home); or
3. Requiring, within the limits of services provided, assistance with mobility, oxygen, routine medication administration, routine health monitoring, etc.

GREATER LEVEL OF CARE or THOSE LIVING IN NURSING HOMES, ASSISTING LIVING FACILITIES OR SKILLED NURSING FACILITIES

Residents requiring greater levels of assistance than can be provided by this service such as a hospital bed, hemodialysis, life support equipment, IV chemotherapy, full ventilator, etc., are advised to make alternative plans with the assistance of a physician or health care professional.

Residents living in nursing homes, skilled nursing facilities or assisted living centers are required by law to maintain plans for the evacuation, transportation and sheltering of their residents. DO NOT apply for this program if you reside at one of these facilities.

HOW TO REGISTER

The preferred method of registration is by online registration. This can be accomplished by visiting the Citrus County Sheriff’s Office website at sheriffcitrus.org and selecting the Emergency Management tab. Those who do not have access to a computer, may complete this paper form and either fax it to: 352-249-2733 or mail to:

Citrus County Sheriff’s Office
ATTN: Special Needs Registration Coordinator
3549 Saunders Way
Lecanto, Florida 34461
Upon receipt of this application paper or online application, you will be entered into a confidential database. The Florida Department of Health (FDOH) Citrus County will then review the application to see if you meet the requirements of this program. FDOH is the ultimate authority to either accept or deny your participation.

Periodically, Citrus County Sheriff’s Emergency Management will conduct a review of all current persons on the Special Needs Registration and will make contact by either phone or mail. The purpose of the call will be to verify if the person still needs assistance and to update critical information.

**EVACUATION ORDER AND SHELTER ACTIVATION**

Citrus County Sheriff’s Office Emergency Management will coordinate evacuations and determine what areas of Citrus County will be affected.

1. Registered residents will be notified via the county’s mass notification system called AlertCitrus.
2. Registrants should have their belongings ready for travel. Registrants requiring transportation DO NOT need to call the Citrus County Sheriff’s Office Emergency Management.

The time of shelter activation will depend upon the type of event. For example, in a hurricane evacuation, the shelter may be opened as much as 24 hours prior to landfall. Citrus County Transit will pick up, transport, and return registrants who require transportation. The Florida Department of Health Citrus County will administer the operation and staffing of the Special Needs Shelter upon activation.

**WHAT SHOULD I BRING WITH ME?**

Companions may accompany registrants but due to space limitations, only one companion per registrant is permitted. Consideration must be given to what you can and cannot bring with you.

Pets are allowed at the Special Needs Shelter however the primary care for the pet rests with the resident or caregiver. Staff may be available to assist. A crate, food and other items for the pet should be brought.

Listed below are typical supplies and articles that are allowed at the shelter:

- Medication to last at least seven (7) days
- Oxygen/oxygen supplies, including oxygen concentrator with extension cord
- Special dietary foods
- Food or snacks for the first 24 hours
- Bedding (blanket, sheet, pillow)
- Air mattress or cushioned sleeping pad
- Two (2) changes of clothing
- Personal hygiene items (i.e. diapers, deodorant, toothbrush, etc.)
- Important papers in a zip-lock bag (i.e. insurance papers, credit card, money)
- Plastic bags for soiled items

**POINTS TO REMEMBER**

- Registrant’s name should be written on all personal items.
- Alcoholic beverages of any kind are not permitted at any shelter.
- There is no smoking or vaping inside the shelter.
- Firearms or other weapons, even if you have a permit, are not permitted on school property.
- Special Diets CANNOT be accommodated – You MUST bring special foods.
- Law enforcement or Florida National Guard personnel will be present at the shelter, but individuals are responsible for safeguarding their own personal items.
- Don’t wait until the last minute to assemble your personal effects and supplies.

Proper registration requires that registration forms be filled out completely. Forms that are not complete will be returned. Older versions of this form and forms from other programs do not contain the required registration data and will not be accepted. The Citrus County Sheriff’s Office webpage has the most up to date form.

Location of Primary Special Needs Shelter:
Forest Ridge Elementary School
2927 North Forest Ridge Blvd
Hernando, Florida 34442

DO NOT go to a shelter until you have been notified by Emergency Management. Not all shelters open.

Citrus County Sheriff’s Office
Emergency Management Section
3549 Saunders Way
Lecanto, Florida 34465
352-249-2700
www.sheriffcitrus.org
@sheriffcitrus
NOTICE: The following conditions cannot be accommodated and are thus not eligible for evacuation to the special needs shelter: Requires Life Support, Hemodialysis, Ventilator, IV Chemotherapy, Requires a Hospital Bed. MAKE OTHER ARRANGEMENTS IN ADVANCE – Obtain assistance from your physician or health care provider.

First Name: _________________________ MI: ______ Last Name: ________________________________________

Home Phone: _______________________________ Cell Phone: _________________________________

Email address: _________________________________________________________________

Date of Birth (MMDDYY): ________________ Sex (Circle): Male  Female

Does the applicant suffer from:  ____ Alzheimer’s  ____ Dementia  ____ Autism

Physical Address:  _________________________________________________________________

City: ____________ ZIP: ______________

Mailing Address: (if different)  _________________________________________________________________

City: ____________ ZIP: ______________

Residence Type:  ____ Private Home  ____ Apartment / Condominium  ____ Manufactured / Mobile Home

Directions to residence from nearest major intersection or landmark: _____________________________________________

Name of the complex or subdivision (if applicable): _______________________________________________________

Who is your power company:  ____ Duke Energy  ____ Sumter Electric  ____ Withlacoochee River Electric Coop.

Do you have a pet (not a service animal)?  ___ Yes  ___ No

Type and number of pets:  _________________________________________________________________

Will you bring a service animal?  ____ Yes  ____ No

Emergency Contact Person (not living with you) Name: _________________________________________________

Phone # (Must be different from your phone number): ________________________________________________

Evacuation Shelter Type Needed:  ____ General Population  ____ Special Needs

Evacuation Transportation Needed: (Select One)

I will not need assistance.

I will need assistance and can ride a bus.

I will need assistance and require a wheelchair accessible vehicle.

I will require an ambulance for transportation.

Will a caregiver accompany you?  ____ Yes  ____ No

Accompanying caregiver information: _______________________________________________________________

Are you a Hospice patient?  ____ Yes  ____ No

Name of Home Health Agency: _______________________________ Phone #: _________________________

Name of Primary Physician: _______________________________ Phone #: _________________________
Do you have any special medical equipment? What Type: __________________________________________________

Does the equipment require power to operate? ___ Yes ___ No

Name of Oxygen Provider (If applicable): ___________________________ Phone #: _____________________________

Do you require care from a nurse? ___ Yes ___ No

Mobility needs: ___ I walk without help.
___ I use a walker.
___ I use a wheelchair.
___ I am bedridden.
___ I use a cane.

Respiratory Support Needs: ___ I use oxygen support.
___ I use a nebulizer.
___ I do not use oxygen support at all.

Oxygen Support Details: Hours per day: _____ Number of liters: _______

Do you have an oxygen concentrator? ___ Yes ___ No Note: If yes, bring to shelter with you.

General Health History: (Check all that apply)
___ Arthritis ___ Heart Condition ___ High Blood Pressure ___ Diabetes
___ Partial Paralysis ___ Complete Paralysis ___ Dialysis

Other Impairments: (Check all that apply)
___ Deaf ___ Blind ___ I have open wounds
___ Incontinence ___ Ostomy Surgery ___ Contagious Condition

Additional Medical Information: __________________________________________________________________________

CERTIFICATION:
To the best of my knowledge, I certify that this information contained herein is true and accurate. I understand that based on this application and the data I have provided, the Florida Department of Health Citrus County will determine which emergency evacuation assistance, if any, this program may be able to provide. I understand that assistance will only be provided for the duration of the emergency and that alternative arrangements should be made in advance in the event I am not able to return to my home. I also understand that I will be responsible for any charges associated with any hospital stay. I understand my right to personal medical privacy under HIPAA and 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 further understand and acknowledge that this is a voluntary registration and not required by law.

Print Name: ______________________________ Signature: ______________________________ Date: ________________

Representative (If applicant unable to complete or sign)

Print Name: ______________________________ Signature: ______________________________ Date: ________________

Relationship: ___________________________ Agency: ______________________________ Phone #: ____________________

Has the patient been notified that this application was completed: ___ Yes ___ No

OFFICE USE ONLY:
Date received: ___________________ By: ___________________ Entered into Database: ___ Y ___