



Delivering Excellence Every Day

Miami-Dade County Emergency Evacuation Assistance Program

Applicant Instructions and Information

The Emergency Evacuation Assistance Program (EEAP) is designed for people with special needs living at home that need assistance with evacuation. Eligible applicants have a medical condition that requires specialized sheltering not available in a hurricane evacuation center. Residents of assisted living facilities (ALF) or nursing homes do not qualify for this program because, these business entities must have their own emergency plans for their clients.

The EEAP registry may be used for any emergency requiring evacuation, such as flooding, hurricanes or hazardous material spills, such as gas leaks. Resources are limited and those persons registered will have priority when an emergency arises. **Do not wait until an evacuation order is given to request being added to the Registry.**

Evacuation Centers will only be available as a last resort for people who have no other place to go. If you need to evacuate, you should first seek refuge with relatives, friends or community organizations. Special Needs Evacuation Centers (SNEC) do not offer the same level of care or equipment available at health care facilities. Only basic medical care and assistance are available. Special Needs enhanced beds and cots are provided on a limited basis. Individuals requiring a higher level of medical care such as continuous oxygen, the use of life sustaining medical equipment requiring electricity and have advanced medical conditions and needs will be placed in participating hospitals also known as Medical Management Facilities (MMF). Due to a finite number of staff, we recommend that a caregiver accompany you and remain with you during your stay at the SNEC or MMF, to ensure your needs are met in a timely manner.

It is highly recommended that if you have a special diet, that you bring those dietary items with you so as to ensure the highest level of comfort during your evacuation away from home. Please remember to bring a disaster kit that includes: bedding, medications and personal supplies (food, water, and medical equipment). Please ensure that you eat a meal prior to leaving your home. All Miami-Dade County evacuation centers accept individuals with service animals. If you have a service animal include their food and supplies in your disaster kit.

All sections of this application must be completed. Your primary care physician (PCP) must complete and sign this application prior to submitting it to our office. If more than one person in your household requires assistance during evacuations, each person must complete a separate application. Special instructions will be mailed to you once your application has been processed.

You will be contacted on an annual basis to re-certify your need for this program. You do **not** need to complete an application every year. If you have questions or need further information, please call the Special Needs Hotline at (305) 513-7700. Please keep a copy of the complete application for your records and mail the **original** to:

**Miami-Dade Department of Emergency Management
Emergency Evacuation Assistance Program
9300 NW 41 Street
Miami, FL 33178**

**This application is available in English, Spanish, and Creole.
To request this material in alternate format such as, Braille, Large Print or
electronically, please call (305) 468-5900.**

If you need disaster preparedness tips, contact the Answer Center by dialing 3-1-1 or calling (305) 468-5900 (TTY/TDD users call (305) 468-5402). You may also visit our website for more information:

www.miamidade.gov/oem

Application for the Emergency Evacuation Assistance Program

Please read the instructions and information provided before completing the form. **This form must be completed in full or it will be returned to you.**

Please print clearly.

Date of Application: ____/____/____

Last Name: _____ First Name: _____ MI: _____ Sex: ___M ___F

Date of Birth: ____/____/____ Social Security Number: _____ - _____ - _____

Are you a veteran of the US Armed Forces? Yes No

Type of Residence: House/Duplex Apt/Condo (What floor? ____) Mobile Home/Trailer

Address: _____ Apt/Lot #: _____

City: _____ Zip Code: _____

Mailing Address (if different from above): _____

Telephone: Home: (____) _____ (TTY/TDD line Yes)

Alternate Phone: (____) _____

Primary Language: _____

Name of nearest friend or relative (not living with you): _____

Home phone: (____) _____ Alternate phone: (____) _____

I certify that one companion will accompany me to the special needs shelter.

Companion's name _____

What type of assistance do you require on a daily basis? (Check all that apply)

personal care (dressing/toileting)

mobility (walking/transferring)

feeding

taking medication

wound care If yes, what type of

wound: _____

guidance:

(blind visual impairment)

communicating:

(deaf nonverbal)

airway suctioning

Dialysis

skilled medical care:

(intermittent continuous)

mental health care:

(intermittent continuous)

Do you require oxygen? Yes No If yes, how many hours a day? _____

Oxygen Provider: _____

Do you use medical equipment requiring electricity? Yes No (intermittent continuous)

Specify equipment requiring electricity: _____

Are you receiving hospice or home health care? Yes No

Agency: _____ Phone: _____

Do you require that transportation to a shelter be provided for you? Yes No

I use: Wheelchair (I can transfer myself: Yes No) Walker/Cane

Crutches

Guide dog/Service animal

I am bed bound: Yes No

I weigh over 300 pounds: Yes No

I have the following conditions: (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Alzheimer's Disease
<input type="checkbox"/> early <input type="checkbox"/> moderate <input type="checkbox"/> advanced | <input type="checkbox"/> Cardiac
<input type="checkbox"/> stable <input type="checkbox"/> unstable | <input type="checkbox"/> Cerebrovascular accident (CVA) |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) | <input type="checkbox"/> Continuous ambulatory peritoneal dialysis (CAPD) | <input type="checkbox"/> Cystic fibrosis |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Diabetes
<input type="checkbox"/> Insulin dependent
<input type="checkbox"/> Non-insulin dependent |
| <input type="checkbox"/> Knee replacement
<input type="checkbox"/> less than six months
<input type="checkbox"/> more than six months | <input type="checkbox"/> Hip replacement
<input type="checkbox"/> less than six months
<input type="checkbox"/> more than six months | <input type="checkbox"/> Neuro-muscular disorders
<input type="checkbox"/> early <input type="checkbox"/> moderate <input type="checkbox"/> advanced |
| <input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> early stages <input type="checkbox"/> advanced | <input type="checkbox"/> Psychosis
<input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> Seizures
<input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |

Other: _____

Name of person filling out form: _____ Telephone Number: (____) _____

_____ ***This section must be completed patient's primary physician. Please print.*** _____

Physician Name: _____ Phone: (____) _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

To the best of my knowledge and belief, the information provided on this form is correct and complete.

Physician's Signature: _____ Date: _____

Physician's License Number: _____

Applicant Signature & Health Insurance Portability and Accountability Act (HIPAA)

I certify that this information is correct. I understand that based on this application and the data I have provided, the Miami-Dade County Department of Emergency Management (MDC DEM) will determine which emergency evacuation assistance, if any, this program may be able to provide. **I understand that there is no cost associated with using any of the County's disaster evacuation centers or disaster transportation services. However, should my medical condition deteriorate and should I be admitted to the hospital, while being evacuated or at an evacuation center, then I will be responsible for the charges incurred once I am "admitted as a patient" of a hospital.** I grant permission to medical providers, transportation agencies and other individuals providing me medical care and disclose any information required to respond to my needs.

HIPAA Privacy Rule: As defined in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule of 1996, by signing this Authorization, I hereby allow the use or disclosure of my medical information by MDC DEM, in order to provide me assistance during emergency evacuations.

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I understand that information used or disclosed pursuant to this Authorization, may be subject to disclosure by the recipient for the purposes of evacuation, sheltering, transportation and any medical care pursuant to these services.

I understand that I have the right to revoke this Authorization at any time except to the extent that MDC DEM has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to the Miami-Dade County Department of Emergency Management, 9300 NW 41 St, Miami, FL 33178, Attention: Special Needs Registry Coordinator.

I understand that if I choose to revoke this Authorization, I will no longer be part of the Special Needs Registry and will not be evacuated.

Signature of Applicant: _____

Date: _____

**MDC DEM
Miami-Dade Department of Emergency Management
9300 NW 41 Street
Miami, FL 33178**