

MIAMI-DADE HOUSING AGENCY

EMERGENCY EVACUATION ASSISTANCE PROGRAM

ADMISSIONS AND CONTINUED OCCUPANCY POLICY

APPENDIX III

Memorandum



Date: September 8, 2004

To: Distribution

From: Madeline Clodfeller
Chief, Administrative Support Services Division

Subject: Special Needs

The Miami-Dade County's Emergency Evacuation Assistance Program (EEAP) is designed for special needs people living at home who need assistance with evacuation. Miami-Dade residents who qualify for this service must pre-register with the EEAP. For a Miami-Dade resident to qualify, he or she must on a daily basis require skilled nursing care, assistance with daily living, or have life-saving medical equipment dependent on electricity. Residents of assisted living facilities (ALF) or nursing homes do not qualify.

These services are intended for those residents that have registered. If County residents call at the last minute, all attempts will be made to assist them, but the people on the registry will have priority.

TO REGISTER:

You can call the Miami-Dade Answer Center at 305-468-5900 [TDD 305-468-5402], and request an application to be mailed, or download an application from the Miami-Dade Portal at <http://www.miamidade.gov>, under Emergency Management. Also for your convenience, attached are the applications in English, Spanish, and Creole. Please have the eligible residents complete one of the attached applications. Vital medical information will help OEM determine the eligibility for the program and the types of services needed. The applicant must have their doctor sign the form and return it to the following address:

Miami-Dade Office of Emergency Management
9300 NW 41 Street
Miami, FL 33178

If eligible, the applicant will be assigned to an appropriate facility, and a determination will be made on the transportation type. OEM will then notify the applicant in writing of their assigned location.

Attachments

Distribution

Alphonso K. Brewster
Rudy Perez
H. Patrick Brown
John Topinka
Regional Managers
William Calderin



**Miami-Dade County
Emergency Evacuation Assistance Program**

Applicant Instructions and Information

The Emergency Evacuation Assistance Program is designed for special needs people living at home who need assistance with evacuation. Eligible applicants have a medical condition that requires nursing care or need assistance with activities of daily living. Residents of assisted living facilities or nursing homes do not qualify.

Complete all sections of the application. Indicate medical conditions, especially medical equipment requiring electricity, and any specialized transportation needs. Your physician must complete and sign the back portion of this application prior to submitting it to our office. You will be contacted on an annual basis to re-certify your need for this program. Once you are registered, you will not have to resubmit this application. If more than one person in your household needs assistance during evacuations, each one should complete a separate application.

The registry may be used for any emergency requiring evacuation, such as flooding, hurricanes or hazardous material spills (such as a gas leak.) In order for us to process your application in time for hurricane season you should submit it by April 30th. Resources are limited and those who are registered will have priority. If you wait until the evacuation begins to ask for help, it will be too late.

Hurricane evacuation centers, whether general or special needs, 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 shelter with relatives, friends or community organizations. Evacuation centers do not offer the same level of care available in a hospital or other health care facility. Only basic care and assistance are available. A caregiver must accompany you and remain with you during your stay in the evacuation center. Dialysis patients who do not have other special needs should go to general evacuation centers and carefully follow instructions from your dialysis center. An emergency renal diet plan is available on the OEM website listed below.

Medications, 24-hour skilled nursing care and life support equipment, including oxygen, are not available in hurricane evacuation centers, and continuous electricity cannot be guaranteed. If your condition requires this level of care we will attempt to find placement for you in a health care facility that participates in this program.

Supplies at hurricane evacuation centers are limited to food, water and first aid kits. You must bring with you a hurricane kit that includes bedding, medications and personal supplies. It is highly recommended that you eat a meal prior to leaving your home and bring with you special dietary foods. Special instructions and a registration card will be mailed to you once your application has been processed. Read these instructions carefully and keep them in a safe place. Prepare wisely and stay alert to the media for evacuation times during emergencies.

If you have any questions or need further information, please call (305) 513-7700. Return the completed application to:

**Miami-Dade Office of Emergency Management, 9300 NW 41 Street, Miami, FL 33178
www.miamidade.gov/oem**

This information is available in English, Spanish, Creole. Call the Miami-Dade Office of Emergency Management at (305) 513-7700 for special requests. If you need disaster preparedness tips, contact the Team-Metro hotline at (305) 468-5900 M-F 8:00am-5:00pm. TTY/TDD users call (305) 468-5402 for both requests.

Application for Emergency Evacuation Assistance

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: _____-_____-_____

Type of Residence: House/Duplex Apt/Condo (What floor _____) Mobile Home/Trailer
 Group Home Nursing Home

Address: _____ Apt/Lot #: _____

City: _____ Zip Code: _____

Mailing address (if different from above): _____

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

Primary Language: _____

Do you live at the above address all year round? Yes No

Do you live here from June 1 to November 30 ? Yes No

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

Home phone: (____) _____ Work phone: (____) _____

Address: _____ City: _____ Zip: _____

In case of an emergency evacuation, where do you plan to go?

- I have made arrangements to stay with relatives, friends, a community organization, or hotel
 I am unable to make other arrangements and must go to an evacuation center.

I have a caretaker or companion* who will accompany me to the evacuation center. Yes No
* If your companion is also in need of assistance they should fill out a separate form

Number of people that must accompany you: _____ (Do not include yourself in this number. Limit the number of people who accompany you to one, as space is limited).

Do you require assistance with activities of daily living? ___ Yes ___ No

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

- | | | |
|---|--|--|
| <input type="checkbox"/> personal care (dressing/toileting) | <input type="checkbox"/> mobility (walking/transferring) | <input type="checkbox"/> taking medication |
| <input type="checkbox"/> guidance (blind/visual impairment) | <input type="checkbox"/> feeding | <input type="checkbox"/> dialysis |
| <input type="checkbox"/> communicating: (<input type="checkbox"/> deaf <input type="checkbox"/> nonverbal) | <input type="checkbox"/> wound care. If yes, what type of wound: _____ | |
| <input type="checkbox"/> skilled medical/mental health care:
(<input type="checkbox"/> intermittent <input type="checkbox"/> continuous) | <input type="checkbox"/> oxygen:
(<input type="checkbox"/> intermittent <input type="checkbox"/> continuous) | <input type="checkbox"/> airway suctioning |
| <input type="checkbox"/> I use medical equipment requiring electricity:
(<input type="checkbox"/> intermittent <input type="checkbox"/> continuous) | Specify medical equipment needing electricity:
_____ | |

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"/> Cystic Fibrosis | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Continuous Ambulatory Peritoneal Dialysis (CAPD) | <input type="checkbox"/> Emphysema | |
| <input type="checkbox"/> Hip replacement
<input type="checkbox"/> less than six months
<input type="checkbox"/> more than six months | <input type="checkbox"/> Knee 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 _____

Are you receiving hospice care? Yes No Agency: _____ Phone: _____

Are you receiving community services? Yes No Agency: _____ Phone: _____

Are you receiving home health care? Yes No Agency: _____ Phone: _____

On a day-to-day basis, what type of transportation do you use?

- Special transportation service (STS)
- Private transportation (I can drive myself, have someone who will drive me, will make my own arrangements or my building/condo association has a vehicle they will use to transport me)
- I am in a wheelchair and need a lift gate vehicle.
- I require transportation by stretcher.
- I need an ambulance for transport. My condition requires:
 Basic Life Support Advanced Life Support
- I am unable to use any of the above Reason: _____

I use: Wheelchair (self transferable Yes No) Walker/Cane Crutches Guide dog/Service animal

I am bed bound: Yes No

Name of person filling out form: _____ Telephone number: _____

Applicant Signature

I certify that this information is correct I understand that based on this application and the data I have provided, the Office of Emergency Management 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 and costs associated with hospitals or other medical facilities or transportation I grant permission to medical providers and transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs

I authorize I do not authorize emergency personnel to enter my home during search and rescue operations if necessary to assure my safety and welfare following a disaster

Signature of applicant: _____ Date: _____

Please have your personal physician complete the next section.

_____ This section to be completed by Personal Physician: (Please type) _____

Primary Physician: _____ Phone: _____

Address: _____

City: _____ Zip: _____

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 _____

Do Not Write Below This Line

Trans Sector: _____ EC: _____ Loc: _____ Evac Level: _____
TP Zone: _____ Reviewed by: _____ Date: _____ Record No: _____

FREEMG022029
Office of Emergency Management
9300 NW 41 Street
Miami, FL 33178