



Delivering Excellence Every Day

Miami-Dade County Emergency Evacuation Assistance Program

Applicant Instructions and Information

The Emergency Evacuation Assistance Program 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 or nursing homes do not qualify.

The 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 begins to request being added to the registry.**

Shelters 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. Special Needs Shelters do not offer the same level of care or equipment available at health care facilities. Only basic care and assistance are available. Cots and beds are provided on a limited basis. A caregiver should accompany you and remain with you during your stay in the shelter.

Supplies and food at Special Needs Shelters are limited. You must bring a disaster kit that includes bedding, medications and personal supplies (food, water, and medical equipment). It is highly recommended that you eat a meal prior to leaving your home and bring special dietary foods with you.

All sections of this application must be completed. Your health care provider must complete and sign a portion of this application prior to submitting it to our office. If more than one person in your household needs assistance during evacuations, each person must complete a separate application. Special instructions 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.

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. Return the completed application to:

**Emergency Evacuation Assistance Program
9300 NW 41 Street
Miami, FL 33178**

This application is available in English, Spanish, Creole and Braille (upon request). 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: _____

communicating:

(deaf nonverbal)

guidance:

(blind visual impairment)

skilled medical or mental health care:

airway suctioning

Dialysis

(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 Office of Emergency Management (MDOEM) 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 am responsible for transportation charges for my evacuation and any costs associated with my stay at a hospital or other medical facility if I am admitted.** I grant permission to medical providers and transportation agencies and others as necessary to provide care and disclose any information required to respond to my needs.

HIPAA Privacy Rule: By signing this Authorization, I hereby allow the use or disclosure by MDOEM of my medical information pertaining to my health or me, as defined in the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996, the HIPAA Privacy Rule, to be used for my evacuation to the appropriate shelter or facility.

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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 MDOEM 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 Office 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: _____

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