



Delivering Excellence Every Day

Miami-Dade County Emergency and Evacuation Assistance Program

Applicant Instructions and Information

The Emergency and Evacuation Assistance Program (E&EAP) is designed for individuals living at home that need assistance with evacuation. Additionally, the program may also be utilized post disaster to provide other assistance. 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.

Please note that all Miami-Dade residents are expected to make their own plan to self-evacuate their families and pets. It is important that everyone be responsible for their own safety and make a plan that includes where to go, who to contact, what to bring, and how to get there. Only residents meeting one of the following categories are eligible for assistance from the County:

- Those who require specialized transportation and/or have no transportation.
- Those whose medical needs prevent them from evacuating on their own.

Please note that upon processing your application, a representative from Miami-Dade Emergency Management (MDEM) will contact you if further clarification is necessary.

The E&EAP registry may be used for any emergency requiring evacuation (flooding, hurricanes, hazardous material spills or 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. Evacuation Centers do not offer the same level of care or equipment available as health care facilities. Only basic medical care and assistance are available at evacuation centers. 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/or have advanced medical conditions will be placed in participating local hospitals. **Due to a limited number of staff, we recommend that a caregiver accompany you and remain with you during your stay at the evacuation center 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, please include their food and supplies in your disaster kit.

All sections of this application must be completed. If you require a higher level of medical care, your primary care physician (PCP) should complete and sign this application prior to submitting it to our office. If more than one person in your household requires medical 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. Should you have any questions, please call the E&EAP Hotline at (305) 513-7700. Please keep a copy of the complete application for your records and mail the original to:

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

This application is available in English, Spanish, and Haitian 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 and Evacuation Assistance Program

PLEASE PRINT CLEARLY

Please read the instructions on page one and complete this application in full or it will be returned to you.
Which type of assistance are you interested in?

- Evacuation Assistance (doctor's signature may be necessary based on medical needs.)
- Wellness Check (to have someone contact you post-disaster)

Date of Application: ___/___/___ Are you a veteran of the US Armed Forces? Yes No

Last Name: _____ First Name: _____ Middle Initial: ___ Sex: ___M ___F

Date of Birth: ___/___/___ Primary Language: _____

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

Address: _____ Apt #: _____ Building #: _____

Name of Complex or Sub-division: _____

City: _____ Zip Code: _____

Mailing Address (if different from above): _____

Home Telephone: (_____) _____ (TTY/TDD line Yes) Alternate Phone: (_____) _____

Living Situation: Alone Relative Caregiver Other _____

Will you have a companion/caretaker accompanying you to the evacuation center? Yes No

Companion's name: _____ Phone: _____

Emergency Contacts: Local: _____ Relationship: _____ Phone: _____

Non-Local: _____ Relationship: _____ Phone: _____

TRANSPORTATION requirements

Do you require that transportation to an evacuation center be provided for you? Yes No

If yes, please state why?: _____ How many people need to be evacuated? _____

- I do not have a car. I do not have anyone that can drive me.
- I am unable to walk to a bus pickup point. My medical needs prevent me from evacuating on my own.

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

- Personal care (dressing / toileting)
- Feeding
- Administering medication
- Airway suctioning
- Wound care
If yes, what type of wound: _____
- Mobility (walking/transferring)
- Visual guidance: (blind visual impairment)
- Communicating: (deaf nonverbal)
- Skilled medical care:
(intermittent continuous)
- Mental health care:
(intermittent continuous)

Other (please explain): _____

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

Other Durable Medical Equipment (specify): _____ Guide dog/Service animal

Do you require oxygen? Intermittent Continuous

Oxygen Provider: _____ Phone: _____

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 If yes, how many hours a day? _____

Agency: _____ Phone: _____

I am bed bound: Yes No

I weigh over 300 pounds: Yes No

I have the following conditions: (Please 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"/> Dementia | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Knee replacement <input type="checkbox"/> ambulatory <input type="checkbox"/> non-ambulatory | <input type="checkbox"/> Diabetes <input type="checkbox"/> Insulin dependent <input type="checkbox"/> Non-insulin dependent |
| <input type="checkbox"/> Psychosis <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> Hip replacement <input type="checkbox"/> ambulatory <input type="checkbox"/> non-ambulatory | <input type="checkbox"/> Seizures <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> early <input type="checkbox"/> moderate <input type="checkbox"/> advanced | | |
| <input type="checkbox"/> Neuro-muscular disorders <input type="checkbox"/> early <input type="checkbox"/> moderate <input type="checkbox"/> advanced | | |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) <input type="checkbox"/> intermittent oxygen <input type="checkbox"/> continuous oxygen (Chronic Bronchitis / Emphysema) | | |

Other: _____

FOR EVACUEES REQUIRING ENHANCED MEDICAL CARE, THIS SECTION SHOULD BE COMPLETED BY THE PATIENT'S PRIMARY CARE PHYSICIAN (PCP) OR HOME HEALTH CARE NURSE.

PLEASE PRINT CLEARLY

Physician/Nurse's Name: _____ Phone: (____) _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

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

Signature: _____ Date: _____

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 Emergency Management (MDEM) will determine which emergency and 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 with 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 MDEM, in order to provide me assistance during emergency evacuations. 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 MDEM has already acted in reliance on the Authorization. *To revoke this Authorization, I understand that I must do so by written request to Miami-Dade Emergency Management, 9300 NW 41 St, Miami, FL 33178. Attention: Vulnerable Populations Coordinator.*

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

Signature of Applicant: _____ Date: _____

Name of person completing this application (if not the patient's primary physician or home health care nurse):

NAME _____ Telephone: (____) _____



**Miami-Dade Emergency Management
Emergency and Evacuation Assistance Program
9300 NW 41 Street
Miami, FL 33178-2414**

