

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.co.miami-dade.fl.us/oem](http://www.co.miami-dade.fl.us/oem)**

**This information is available in English, Spanish, Creole, large print and Braille. 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:<br>( <input type="checkbox"/> intermittent <input type="checkbox"/> continuous)            | <input type="checkbox"/> oxygen:<br>( <input type="checkbox"/> intermittent <input type="checkbox"/> continuous) | <input type="checkbox"/> airway suctioning |
| <input type="checkbox"/> I use medical equipment requiring electricity:<br>( <input type="checkbox"/> intermittent <input type="checkbox"/> continuous) | Specify medical equipment needing electricity:<br>_____  |  |

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> <b>Alzheimer's Disease</b><br><input type="checkbox"/> early <input type="checkbox"/> moderate <input type="checkbox"/> advanced | <input type="checkbox"/> <b>Cardiac</b><br><input type="checkbox"/> stable <input type="checkbox"/> unstable                                       | <input type="checkbox"/> <b>Cerebrovascular Accident (CVA)</b>   |
| <input type="checkbox"/> <b>Chronic Obstructive Pulmonary Disease (COPD)</b>  | <input type="checkbox"/> <b>Cystic Fibrosis</b>  | <input type="checkbox"/> <b>Dementia</b>   |
| <input type="checkbox"/> <b>Continuous Ambulatory Peritoneal Dialysis (CAPD)</b>  | <input type="checkbox"/> <b>Emphysema</b>  |  |
| <input type="checkbox"/> <b>Hip replacement</b><br><input type="checkbox"/> less than six months<br><input type="checkbox"/> more than six months         | <input type="checkbox"/> <b>Knee replacement</b><br><input type="checkbox"/> less than six months<br><input type="checkbox"/> more than six months | <input type="checkbox"/> <b>Neuro-muscular disorders</b><br><input type="checkbox"/> early <input type="checkbox"/> moderate <input type="checkbox"/> advanced |
| <input type="checkbox"/> <b>Parkinson's Disease</b><br><input type="checkbox"/> early stages <input type="checkbox"/> advanced                            | <input type="checkbox"/> <b>Psychosis</b><br><input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled                             | <input type="checkbox"/> <b>Seizures</b><br><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.)
- Public transportation (I will rely on a bus or Metrorail)  I can walk \_\_\_\_ blocks.
- 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**