Miami-Dade County
Emergency and Evacuation Assistance Program

Applicant Instructions and Information

The Emergency and Evacuation Assistance Program (EEAP) is designed for individuals living at home that need assistance with evacuation and sheltering. Additionally, the program may also be utilized post disaster to provide other assistance such as wellness checks. 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 County residents are expected to make their own plans to 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. However, the County realizes that some individuals may need assistance. Individuals 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 the Miami-Dade County Office of Emergency Management (OEM) will contact you if further clarification is necessary.

What You Should Know To Be Evacuation Ready:

- The EEAP registry is used for any emergency requiring evacuation.
- **Do not wait until an evacuation order is given to request being added to the Registry.**
- Resources are limited and pre-registered clients will have priority when an emergency arises.
- Evacuation centers do not offer the same level of care equipment available as 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 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 manners.**
- If you have a special diet, bring those dietary items with you so as you to ensure the highest level of comfort.
- Remember to bring a disaster kit that includes: bedding, medications, and personal supplies (food, water, and medical equipment).
- 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 semi-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 EEAP Support Line at (305) 513-7700. Please **keep a copy of the complete application for your records** and mail the **original** to:

Miami-Dade County Office of Emergency Management
Emergency and Evacuation Assistance Program
9300 NW 41 Street, Doral, 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 Miami-Dade County 3-1-1 Answer Center by dialing 3-1-1 or calling (305) 468-5900 (TTY/TDD users call (305) 468-5402). For more information or to complete on line visit: **www.miamidade.gov/fire/eeap.asp**.

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 ____________

Emergency Contacts:

Local ____________ Relationship ________ Phone (____) ________

Non-Local ____________ Relationship ________ Phone (____) ________

*****People who are only requesting a Wellness Check are encouraged but not required to continue completing the rest of the application.*****

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

Companion's name ____________ Phone (____) ________

Transportation requirements

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

If yes, please state why.

☐ I do not have a car.

☐ I am unable to walk to a bus pickup point.

How many people need to be evacuated? ________

☐ I do not have anyone that can drive me.

☐ 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)* ____________ ☐ Service animal

Do you require oxygen? ☐ Intermittent ☐ Continuous ☐ No

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 *(Check all that apply)*

- ☐ **Alzheimer's Disease**
  - ☐ *early* ☐ *moderate* ☐ *advanced*
- ☐ **Dementia**
- ☐ **Cerebral Palsy**
- ☐ **Psychosis**
  - ☐ *controlled* ☐ *uncontrolled*
- ☐ **Parkinson's Disease**
  - ☐ *early* ☐ *moderate* ☐ *advanced*
- ☐ **Neuro-muscular disorders**
  - ☐ *early* ☐ *moderate* ☐ *advanced*
- ☐ **Chronic Obstructive Pulmonary Disease (COPD)**
  (Chronic Bronchitis / Emphysema)
  - ☐ *intermittent oxygen*
  - ☐ *continuous oxygen*
- ☐ **Cardiac**
  - ☐ *stable* ☐ *unstable*
- ☐ **Dialysis**
- ☐ **Knee replacement**
  - ☐ *ambulatory*
  - ☐ *non-ambulatory*
- ☐ **Hip replacement**
  - ☐ *ambulatory*
  - ☐ *non-ambulatory*
- ☐ **Cerebrovascular Accident (CVA)**
- ☐ **Cystic Fibrosis**
- ☐ **Diabetes**
  - ☐ *Insulin dependent*
  - ☐ *Non-insulin dependent*
- ☐ **Seizures**
  - ☐ *controlled* ☐ *uncontrolled*
- ☐ **None**

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, Miami-Dade County 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 I should need emergency medical treatment while being evacuated or at an evacuation center, then I will be responsible for the applicable 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 Miami-Dade County, 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 Miami-Dade County 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 County Office of Emergency Management, 9300 NW 41 St, Miami, FL 33178. Attention: EEAP.*

I understand that if I choose to revoke this Authorization, I will not receive evacuation assistance.

Signature of Applicant: ______________________________ Date: ____________________

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

Name ______________________________ **Phone** (_____) ________________

Emergency Management
Emergency and Evacuation Assistance Program
9300 NW 41st Street
Miami Florida 33178-2312
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