



# 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.*

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### 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](http://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)

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

- |  |  |  |
|--|--|--|
| <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>Chronic Obstructive Pulmonary Disease (COPD)</b><br>(Chronic Bronchitis / Emphysema)<br><input type="checkbox"/> intermittent oxygen<br><input type="checkbox"/> continuous oxygen | <input type="checkbox"/> <b>Hip replacement</b><br><input type="checkbox"/> ambulatory<br><input type="checkbox"/> non-ambulatory        |
| <input type="checkbox"/> <b>Dementia</b>   |  | <input type="checkbox"/> <b>Cerebrovascular Accident (CVA)</b>   |
| <input type="checkbox"/> <b>Cerebral Palsy</b>   |  | <input type="checkbox"/> <b>Cystic Fibrosis</b>  |
| <input type="checkbox"/> <b>Psychosis</b><br><input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled   | <input type="checkbox"/> <b>Cardiac</b><br><input type="checkbox"/> stable <input type="checkbox"/> unstable   | <input type="checkbox"/> <b>Diabetes</b><br><input type="checkbox"/> Insulin dependent<br><input type="checkbox"/> Non-insulin dependent |
| <input type="checkbox"/> <b>Parkinson's Disease</b><br><input type="checkbox"/> early <input type="checkbox"/> moderate <input type="checkbox"/> advanced      | <input type="checkbox"/> <b>Dialysis</b>   | <input type="checkbox"/> <b>Seizures</b><br><input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled                    |
| <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>Knee replacement</b><br><input type="checkbox"/> ambulatory<br><input type="checkbox"/> non-ambulatory   | <input type="checkbox"/> <b>None</b>   |

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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