



Dear Manatee County Resident:

Hurricane Season begins June 1 and runs through the end of November. You will need to evacuate your home from a pending hurricane, if you are medically power dependent, live in an evacuation zone, or in a mobile / manufactured home. You may wish to leave the area well in advance of a pending hurricane. Residents are encouraged to use public sheltering only if no other options exist. Options may include staying with a friend, relative or at a hotel that is not in an evacuation zone. It is important to realize that shelter life is very basic and can be a difficult. Remember, using these shelters should be your last resort.

If you should need evacuation transportation or will require sheltering assistance, pre-registering will help expedite the process. The enclosed form is required to register for sheltering and/or transportation to a General Population Shelter, Special Needs Shelter, Hospital or Nursing Home. Annual registration is required. Each year you will receive a form (approximately 60 days prior to your birthday). You must update and return this form to maintain your registration. Please complete and return the enclosed form to: Manatee County Emergency Management, PO Box 1000, Bradenton, Florida 34206-1000

Transportation and shelter types vary according to medical need. During an actual evacuation, the Special Needs Operators will call to confirm your current medical and transportation information. General population shelters, managed by American Red Cross, are located in appropriately hardened Manatee County Schools. Contact your local American Red Cross at 792-8686 for information on shelters. The Special Needs Medical Committee will evaluate your application to determine if you need to go to the Special Needs Shelter or a General Population Shelter. Be sure your caregiver is with you at the shelter. Please be aware that if you mark “ambulance” as your transportation source on the enclosed form, you will be transported **ONLY** to a hospital or nursing home. You need to check with those facilities to see if you will be charged for their medical services.

The attached checklist will assist you in your evacuation preparation. If you require a special diet, you will need to bring nonperishable stable foods to any shelter, including the Special Needs Shelter. Pets are not allowed in the Special Needs Shelter and arrangements should be made early for animal care. If you have any questions, please call (941)748-4501 X 3530. For specific medical questions, please call (941)748-0747 X 1297 or X 1450.

Sincerely,

Laurie Feagans, Chief Emergency Management

EVACUATION CHECKLIST FOR SPECIAL NEEDS EVACUEES

Listed below are actions you should take **BEFORE** evacuation. You and your caregiver **MUST** be ready before your county evacuation transportation vehicle arrives. Special Needs evacuations need to be completed prior to road congestion. Even if the sun is shining, the storm is on its way! Please remember you are one of over 1200 registered citizens who will need our assistance. Manatee County Emergency Management will call to give you an estimated time of your transportation pick-up.

HERE ARE SOME THINGS YOU SHOULD DO BEFORE YOU ARE PICKED UP:

DO NOW:

1. **Make plans for your pets to be taken care of by your veterinarian, family or friend.** You will not be able to take them with you to a shelter. Make sure they have proper identification collars & immunization records.

WHEN EVACUATING:

2. Pack a bag and be ready to go with:

- Medications for 3 weeks, list of medications, & name of doctor(s)
- Medical orders including "Do Not Resuscitate" order, if applicable
- Your walker, wheel chair and other medical equipment
- Oxygen Concentrator (if on oxygen), bring all equipment. Emergency oxygen will be provided only at the Special Needs Shelter
- Clean clothes for three days
- Extra eye glasses
- Blankets and pillows
- Personal hygiene items
- House keys and car keys
- Personal phone book or list of important numbers
- Important papers, including identification, sealed in zip-lock bags
- Folding chair, lawn chair or cot
- Reading material
- Non-perishable snack items while shelters become fully operational
- Non-perishable food items if you require a special diet

3. **Call caretaker and family members including those out of state, to inform them of your evacuation plans.**
4. **It is important to turn off electricity, water and gas if possible.**
5. **Please have all pets evacuated before your evacuation transportation arrives. The emergency workers will not be able to assist you with your pets.**

WHEN STORM IS APPROACHING:

6. **Take care of all medical needs such as dialysis when you hear a storm is approaching.**

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL MANATEE
COUNTY EMERGENCY MANAGEMENT (941)748-4501 X 3530**

SpNS Final Letter & Check List 3.30.2007

MANATEE COUNTY EMERGENCY MANAGEMENT SPECIAL NEEDS PROGRAM QUESTIONNAIRE

Emergency Management is mandated by Florida Statutes to maintain a voluntary registry of persons who will need assistance during emergency evacuations. Records relating to registration of disabled citizens are exempt from the Provisions of F.S. 119.07(1), Public Records Law

Please complete this form to register for the Special Needs Program and return to: **DO NOT FAX**
Manatee County Emergency Management, P.O. Box 1000, Bradenton, FL 34206-1000 Phone: 941-748-4501 x 3500

Transportation Registration

Last Name: _____ First : _____ MI: _____ Nick Name: _____ Phone: _____

Date of Birth: ____ / ____ / ____ Age: ____ yrs. SSN: ____ -- ____ Height ____ ft. ____ in. Weight: ____ lbs.

Address: _____ City: _____ Zip: _____

1. Private Home Manufactured Housing Apartment/Condo
 HUD Housing Assisted Living Facility Independent Living Facility/Group Home Nursing Home
 Hotel Other _____

Complex Name: _____

2. Own Rent 3. Primary Language English Spanish Other _____

4. Live Alone Yes No If No, with whom do you live?: _____

5. Do you have access to a generator? Yes No Do you have access to generator fuel? Yes No

Do you know how to safely operate and refuel the generator? Yes No

TRANSPORTATION WILL ONLY BE PROVIDED TO A GENERAL POPULATION SHELTER, A SPECIAL NEEDS SHELTER OR A HOSPITAL/NURSING HOME. PLEASE BE AWARE THAT IF YOU CHOOSE AN AMBULANCE AS YOUR TRANSPORTATION SOURCE, YOU WILL BE TRANSPORTED **ONLY** TO A HOSPITAL OR NURSING HOME.

Own Transportation _____ Bus/Handi-Bus _____ Ambulance is Required _____

Special Needs Shelter Application

- 1) PETS ARE NOT ALLOWED AT THE SpNS..... PRIOR ARRANGEMENTS SHOULD BE MADE.
 2) SPECIAL DIETS ARE NOT PROVIDED.BRING YOUR OWN SPECIAL DIET FOOD
 3) LIMITED NUMBERS OF ARMY COTS ARE AVAILABLE. COT WEIGHT LIMIT 250 LBS. BRING YOUR OWN COT TO ASSURE THAT YOU HAVE ONE. YOU MUST BE ABLE TO GET UP AND DOWN FROM A COT

You Need to Bring a Care Giver With You.

Caregiver's Last Name: _____ First Name: _____ Phone: _____

Are you confined to a bed YES NO Use a Wheel Chair YES NO

Use a Cane or Walker YES NO On electrical life support YES NO

C-PAP YES NO Apnea Monitor YES NO

Require Oxygen Liters/Min. ____ YES NO Have an Oxygen Regulator YES NO

Have an Oxygen Concentrator YES NO Have a portable Oxygen Tank YES NO

On a Respirator YES NO On a Ventilator YES NO

Oxygen concentrators must be brought to the Special Needs Shelter!!! Assistance Will be Provided.

Require a Nebulizer YES NO Receiving I.V. Infusion YES NO

Require Dialysis ? ____ x per Wk. YES NO Have/Require Dressing Changes YES NO

Dialysis Type Peritoneal Hemodialysis NG tubes/ colostomy YES NO

Immune Suppression YES NO Central Venous Line YES NO

Indwelling Catheter YES NO Tube Feeding YES NO

Have a Tracheostomy YES NO Suction Equipment YES NO

Incontinent YES NO Medication Requiring Refrigeration YES NO

Do Not Resuscitate (DNR) Status YES NO DNR Attached YES NO

Alzheimer's disease YES NO Dementia YES NO

Attention deficit hyper. disorder YES NO Obsessive compulsive disorder YES NO

Autism YES NO Conduct disorder YES NO

Anxiety YES NO Depression YES NO

Legally Blind Deaf Mute Assistive Device YES NO

Do you have a service animal? YES NO If yes, Type of animal: _____ Type Service: _____

I authorize emergency response personnel to enter my home for search and rescue operations YES NO

Signature of the Person Requesting Assistance and/or Sheltering _____

Date: _____

DISCHARGE PLANNING INFORMATION

In the event that your home is damaged and you are not able to return home, this information will be used to assist the Department of Elder Affairs in finding a place for you to stay.

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____ / ____ / ____ Age: ____ yrs. Social Security Number: ____ -- ____ .

Insurance Information and ID Number(s)

<input type="checkbox"/> Medicare:	<input type="checkbox"/> Medicaid:
<input type="checkbox"/> Champus:	<input type="checkbox"/> Private Insurance:
<input type="checkbox"/> TriCare for Life:	<input type="checkbox"/> Other:

Veteran Yes No

1. If someone calls to inquire if you are in this shelter, do we have permission to tell them you are here? Yes No

2. Do we have permission to tell them where you have relocated once you leave the shelter? Yes No

Signature: _____

Date: _____

POST EVENT PLANNING

1. If you can't return home when the shelter closes, do you have an alternative plan for housing? Yes No

2. If yes, where will you go? _____

Contact information for relocation site: Name: _____ Phone: _____

Street Address: _____ City: _____ State: _____

3. Do you have transportation? Yes No If yes, describe: _____

4. Do you receive services from a Physician or Outside Agency? YES NO

If Yes, Primary Physician: Yes No Physician Name: _____

Contact: _____ Phone: (____) _____ - _____

If Yes, Hospice: Yes No Agency Name: _____

Contact: _____ Phone: (____) _____ - _____

If yes, Home Health: Yes No Agency Name: _____

Contact: _____ Phone: (____) _____ - _____

If yes, Nurse Registry: Yes No Agency Name: _____

Contact: _____ Phone: (____) _____ - _____

If yes, Oxygen Provider: Yes No Agency Name: _____

Contact: _____ Phone: (____) _____ - _____

If yes, Medical Equipment Provider: Yes No Agency Name: _____

Contact: _____ Phone: (____) _____ - _____

If yes, Dialysis Provider: Yes No Agency Name: _____

Contact: _____ Phone: (____) _____ - _____

If Yes, Pharmacy: Yes No Pharmacy Name: _____

Contact: _____ Phone: (____) _____ - _____

5. Local Emergency Contact: _____ Phone: (____) _____ - _____

Relationship: _____

Address: _____ City: _____ State _____

6. Non-Local Emergency Contact: _____ Phone: (____) _____ - _____

Relationship: _____

Address: _____ City: _____ State _____

7. Do you have a pet? YES NO Type & Number Dog(s) # _____ Cat(s) # _____

Other Type _____

Veterinarian Name: _____ Phone: (____) _____ - _____

Address: _____ City: _____ State _____

8. E-mail Address: YES NO If Yes: _____

MEDICAL PROFILE

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Age: _____ yrs. Social Security Number: _____ - _____ - _____

List All Allergies: _____

List All Medical Conditions

List All Medications

Drug	Dose	Frequency	Route of Administration

Signature of Person / Agency Completing Form

Date