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| --- | --- | --- | --- |
| 1. **Demographics** | | | |
| Participant Name: | | Date of Birth | |
| Physical Address: | | Mailing Address: | |
| City | Zip Code: | City: | Zip Code: |
| Parish: | | Phone # (s): | |
| Emergency Contact Name: | | Emergency Contact Phone #: | |
| Physician’s Name: | | Physician’s Phone Number: | |
| 1. **Planned Mandatory Evacuation Place (i.e., hurricanes, floods, etc.): (**Must Select one)   **A. Home of Family or Friend** (List name, relationship & address)   |  |  |  |  | | --- | --- | --- | --- | | **Name of Family Member/Friend** | **Relationship** | **Address** | **Contact phone # (s)** | |  |  |  |  | |  |  |  |  | |  |  |  |  |   **B. Medical Special Needs Shelter (MSNS):** (Describe medical condition requiring MSNS care) Requires triage prior to admission   |  | | --- | |  |   **C. General Emergency Shelter:**   |  | | --- | |  |   **D. Shelter In Place:**   |  | | --- | |  |   **E. Other: (**Describe Place)   |  | | --- | |  | | | | |
| 1. **Transportation: (**Must select one of the options below, and complete the transportation contact information)   **A. Family or other natural support will provide transportation to evacuation place.** (List at least 1, preferably 2 or more names of persons responsible for your transportation in an emergency and their emergency contact phone numbers)   |  |  | | --- | --- | | **Name of Family Member (s) or Natural Support (s)** | **Contact Phone # (s)** | |  |  | |  |  | |  |  |   **B. Direct Service Provider agrees to provide transportation to the evacuation place and remain with participant until support arrives. [If natural support does not arrive as planned, the Direct Service Worker (DSW) will contact the Support Coordinator and stay with the participant until help arrives.]**   |  |  | | --- | --- | | **Name of Direct Support Provider Contacts** | **Direct Support Provider Contact # (s)** | |  |  | |  |  | |  |  |   **C. Alternate:** If plan depends on any other form of transportation, e.g., ambulance transportation, local emergency transportation, describe arrangements that have been made in the event that alternate transportation is required:   |  | | --- | |  |  |  |  | | --- | --- | | **Name of Alternate Transportation Agency/Service** | **Alternate Transportation Agency/Service Provider Contact # (s)** | |  |  | |  |  | |  |  | | | | |
| 1. **Personal Care Support: (**Must select one)   **A. Participant can take care of self during emergency**  **B. Family/natural (unpaid) support will provide all necessary assistance during an emergency and be responsible for support needs.**   |  |  |  | | --- | --- | --- | | **Name of Family Member (s)/Natural Support (s)** | **Relationship** | **Emergency Contact Phone # (s)** | |  |  |  | |  |  |  | |  |  |  |   **C. Direct Service Provider will continue to provide a DSW to assist during an evacuation. DSP will ensure that a DSW will be available for the full number of units he/she is authorized to receive, and the participant can remain alone safely during the times when paid supports are unavailable.**   |  |  | | --- | --- | | **Name of Direct Service Provider Contact (s)** | **Emergency Contact Phone # (s)** | |  |  | |  |  | |  |  |   **D. Direct Service Provider will continue to provide a DSW to assist during an evacuation. Direct Service Provider will ensure that a DSW will be available for the full number of units he/she is authorized to receive, AND Family/Natural Supports will care for the participant when the DSW leaves his/her shift (s).**   |  |  | | --- | --- | | **Name of Direct Service Provider Contact (s)** | **Emergency Contact Phone # (s)** | |  |  | |  |  | |  |  |  |  |  |  | | --- | --- | --- | | **Name of Family Member (s)/Natural Support (s)** | **Relationship** | **Emergency Contact Phone # (s)** | |  |  |  | |  |  |  | |  |  |  | | | | |
| 1. **Planned Support Coordinator (SC) Responsibility: (Select all that apply)**   **A. SC will locate and inform participant of the location of an open Medical Special Needs Shelter (MSNS) or General Emergency Shelter during a disaster, if listed as evacuation place.**  **B. Other Planned SC Assistance: (**Describe)   |  | | --- | |  | | | | |
| 1. **Who will ensure that medication, medical supplies, equipment, and Plan of Care are labeled and sent with participation to evacuation site?** (Must select one)   **A. Family, Friend or Unpaid Support B. Direct Service Provider C. Participant** | | | |
| 1. **Durable Medical Equipment (DME) needed for evacuation and at evacuation site. Include any DME provider name and contact information, as well as model number of equipment:**  |  | | --- | |  | | | | |
| 1. **Participant has a Pet?  Yes  No Pets, especially service animals, need their own go bag (medicine, food, water bowl, etc.)**   **If yes, pet will be evacuated with:**   |  | | --- | |  | | | | |
| 1. **Go Bag Items – Check to see if all items are available in potential emergency evacuation. Refer to the GOHSEP website.**   [**https://getagameplan.org/**](https://getagameplan.org/) | | | |
| 1. **Signatures: Individuals below agree to this Emergency Plan. Everyone who is responsible in this Emergency Plan must sign below or give verbal agreement.**  |  |  |  |  | | --- | --- | --- | --- | | **Printed Name** | **Signature** | | **Date** | | **Participant/Responsible Representative:** |  | |  | | **Natural Support:** | **OR** | **Obtained verbal agreement** |  | | **Natural Support:** | **OR** | **Obtained verbal agreement** |  | | **Natural Support:** | **OR** | **Obtained verbal agreement** |  | | **Natural Support:** | **OR** | **Obtained verbal agreement** |  | | **Direct Service Provider:** |  | |  | | **Support Coordinator:** |  | |  | | | | |