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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):   |  | | --- | |  |   **C. General Emergency Shelter:**   |  | | --- | |  |   **D. Shelter In Place:**   |  | | --- | |  |   **E. Other: (**Describe Place)   |  | | --- | |  | | | | |
| 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:**  |  | | --- | |  | | | | |
| 1. **Participant has a Pet?  Yes  No Note: Due to health purposes, shelters are unable to transport or board pets.**   **If yes, pet will be evacuated with:**     |  | | --- | |  | | | | |
| 1. **Other Emergency Events:**   **In the event of a fire, participant will move to the point of safety which is (list below the designated place to meet outside of the home):**   |  | | --- | |  |   **If a tornado warning is issued, participant will evacuate to a designated point of safety within the home such as:**  **Hallway  Bathroom  Closet  Basement  Other (specify):**  **During an emergency, if problems arise with the Emergency Plan, the SC will assist the participant in finding alternate plans, and if necessary, contact the LGE office and local Emergency Preparedness Office.** | | | |
| 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:** |  | |  | | | | |