

Participant Name:



Date of Birth:

EMERGENCY PLAN

Demographics

Physical Address:

Parish:

Participant Phone #:

Direct Service Provider Name:

Direct Service Provider Phone #:

Primary Physician's Name:

Primary Physician's Phone #:

Emergency Contacts

I have selected the following Family Member/Informal Support as my Emergency Contact(s):

Primary Contact: Relationship: Phone Number: Alt. Phone Number: Address:

Secondary Contact: Relationship: Phone Number: Alt. Phone Number: Address:

Additional Contact(s): Relationship: Phone Number: Alt. Phone Number: Address:

Evacuation Plan

(Must select one. This plan is put into action if an emergency requires you to leave your home during a hurricane, flooding etc.)

I choose to evacuate to:

Home of Family or Friend (List name, relationship, address & phone #)

Name of Family Member/Friend	Relationship	Address	Contact Phone #(s)

Participant Name:

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A Shelter:

(Note: Admittance to MNS requires screening & acceptance at the time of the emergency. If accepted into an MNS, a caregiver will need to be available to stay with the participant. Shelters Do Not Allow Pets.)

Other (Describe):

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Transportation will be provided by:

Family or Friend (List at least 1, preferably 2 or more names of persons responsible for transportation in an emergency and their emergency contact phone numbers).

Name of Family/Friend(s)	Contact Phone #(s)

Direct Service Provider (DSP) agrees to provider transportation to the evacuation place and remain with participant until natural support arrives. If natural support does not arrive as planned, the Direct Service Worker (DSW) will contact the Support Coordinator and/or the OAAS Regional Office (RO) and stay with the participant until help arrives.

Ambulance Service (Pre identification with the ambulance service should be coordinated prior to selecting this option)

Ambulance Company Name:	Name of Contact:	Phone Number:
Describe arrangements that have been made in the event that ambulance services are required:		

Other:

Type of Transportation:	Name of Contact:	Phone Number:
Describe arrangements that have been made in the event that other transportation is required:		

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Evacuation Plan for my Pet(s)

Do I need an evacuation plan for my pet(s)?

If yes, you must select one:

Pet will evacuate with me.

Pet will evacuate with a family/friend:

Name of Family or Friend(s)	Relationship	Emergency Contact Phone #(s)

Other (Describe):

Once Evacuated, I choose to receive assistance from: (Check All That Apply)

No One. I am choosing to care for myself.

Family or Friend(s) agrees to provide all necessary assistance during an emergency and will be responsible for support needs.

Name of Family or Friend(s)	Relationship	Emergency Contact Phone #(s)

Direct Support Provider (DSP) agrees to 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 that the participant is authorized to receive, and participant can remain alone safely during the times when paid supports are unavailable.

DSP agrees to 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 Family/Natural Supports will care for participant when the DSW leaves his/her shift(s).

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Durable Medical Equipment (DME)

I will need the following medical equipment/services while evacuated: (Check All That Apply)

Ambulation/Locomotion Assistive Device:

- Not Ambulatory- Bedridden Walker
- Cane Other [Specify]:
- Electric Wheelchair/Scooter
- Manual Wheelchair

Continence Devices/Supplies:

- Bedpan Ostomy Supplies
- Bladder Pads/Pant Liners Other [Specify]:
- Catheter Supplies

Nutritional Supplies:

- Abdominal Feeding Tube (PEG) Supplement(s)
- Nasogastric Feeding Thickener
- Parenteral (IV) Feeding Other [Specify]:

Medications

Do any of your medication(s) require refrigeration?

Are you insulin dependent?

Specialized Services (i.e. Dialysis, Pharmacy, DME etc) :

Service: Provider Name: Contact Person: Phone Number: Email Address:

Respiratory Equipment:

- BIPAP Machine Tracheostomy Supplies
- CPAP Machine Ventilator
- Nebulizer Other [Specify]:
- Oxygen
- Respirator
- Suction Machine

Other Equipment/Supplies [Specify] :

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I will need assistance from the following to gather specialized equipment: (Check All That Apply)

No One. I am choosing gather my own specialized equipment.

Family or Friend:

Name of Family or Friend(s)	Relationship	Emergency Contact Phone #(s)

Direct Service Provider (DSP)

Electricity Dependency

Do you have a Ventilator?

Are you dependent on electricity?

(i.e. Ventilator, Oxygen, Refrigerated Medications, Etc.)

Are you currently registered with your electric company?

Do you have any other Life Sustaining Equipment?

Name Of Utility Company:

If yes, Specify:

Utility Contact Phone Number:

Does your home have a Generator?

Shelter in Place

This plan is put into action when you choose to remain in your home during an emergency situation (i.e. winter weather, chemical release etc.)

I choose to receive assistance from the following to ensure emergency supplies are stocked *(Medications, Food, Water, Batteries, Etc.)*

Self

Family or Friend:

Name of Family or Friend(s)	Relationship	Emergency Contact Phone #(s)

Direct Service Provider (DSP)

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In the event of other emergency events I will:			
Move to the point of safety during a fire outside of the home which is (<i>list designated place to meet</i>):			
Seek shelter during a tornado warning in the following designated point of safety within the home:			
Hallway	Bathroom	Closet	Other [Specify]:

Signatures			
Individuals below agree to this Emergency Plan. Everyone who is responsible in this Emergency Plan must sign below or give verbal agreement.			
Participant/Responsible Representative Signature:	OR	<input type="checkbox"/> Obtained Verbal Agreement	Date:
Natural Support Name & Signature:	OR	<input type="checkbox"/> Obtained Verbal Agreement	Date:
Natural Support Name & Signature:	OR	<input type="checkbox"/> Obtained Verbal Agreement	Date:
Natural Support Name & Signature:	OR	<input type="checkbox"/> Obtained Verbal Agreement	Date:
Natural Support Name & Signature:	OR	<input type="checkbox"/> Obtained Verbal Agreement	Date:
DSP Representative Name & Signature:	OR	<input type="checkbox"/> Obtained Verbal Agreement	Date:
During an emergency, if problems arise with this Emergency Plan, the SC will assist the participant in finding alternate plans, and if necessary, contact the OAAS Regional Office (RO) and local Emergency Preparedness Office.			
SC Signature:			Date: