ST. JOHNS COUNTY EVACUATION ASSISTANCE REGISTRATION FORM

St. Johns County Emergency Management | 100 EOC Drive | St. Augustine, FL 32092
Phone (904) 824-5550 | Fax (904) 824-9920 | www.sjcemergencymanagement.org

The Evacuation Assistance Program is for citizens of St. Johns County who need sheltering assistance during a disaster situation. Shelters should be your refuge of last resort if you have absolutely nowhere else to go. Residents of nursing homes, convalescent homes, retirement homes, assisted living facilities, or other group facilities, do not qualify for this program because under Florida State Statute 252 it is required these facilities have an Emergency Plan to evacuate their residents to a predetermined location outside the evacuation area.

This form must be completed in full, and signed, or it will be returned to you. Please print clearly.

PERSONAL INFORMATION: New Registrant: Yes ☐ No ☐ Today's Date: _____

Full Name: _____ Sex: _____ Date of Birth: _____

Does your weight require special transportation: Yes / No

Physical Address: _____
Street City Zip

Mailing Address: _____
Street / Post Office Box City Zip

Telephone Number: _____ / _____
Area Code / Primary Phone Number Area Code / Secondary Phone Number

Living Situation: Alone - ☐ w/Spouse - ☐ Other: _____

Residence Type: ☐ - House / Apartment ☐ - Mobile Home/RV Primary Language: _____

EMERGENCY CONTACT INFORMATION: (List all that apply)

(Caregiver) Name: _____ Relationship: _____ Phone: _____

(Local) Name: _____ Relationship: _____ Phone: _____

Home Health / Hospice Care: No ☐ Yes ☐ Agency: _____ Phone: _____

Live in caregiver: No ☐ Yes ☐ Agency: _____ Phone: _____

☐ **I Have No Medical Needs – I Need Transportation Assistance Only**
If you have no medical needs, proceed to the transportation section on page 2.

MEDICAL INFORMATION: (Check all that apply)

☐ Dementia ☐ Alzheimer's Disease ☐ Mental Health Impaired
☐ - Moderate ☐ - Advanced ☐ - Early / Moderate ☐ - Advanced ☐ - Controlled ☐ - Uncontrolled

☐ - Hearing Aids ☐ - Deaf ☐ - Legally Blind ☐ - Speech Impaired

☐ Wheelchair
☐ - Electric ☐ - Manual / Standard

☐ Bedridden Could sleep on cot / air mattress in disaster situation: ☐ Yes ☐ No

☐ - ALS / Amyotrophic Lateral Sclerosis ☐ - Multiple Sclerosis ☐ - Parkinson's Disease

☐ Incontinence ☐ Ostomy Care ☐ Dialysis Dependent
☐ - Bladder ☐ - Bowel ☐ - Colostomy ☐ - Ileostomy ↳ times per week _____

☐ Catheter Line ☐ Feeding Tube ☐ Intravenous Line

☐ BiPAP Machine ☐ CPAP Machine ☐ Nebulizer Machine

☐ Cardiac VAD System ☐ - Oxygen Concentrator ☐ - Oxygen Tank ☐ Ventilator

Additional Medical Information: _____

TRANSPORTATION INFORMATION: (Check all that apply)

Can you / or someone drive you to a Shelter: ☐ Yes ☐ No

Is someone going to the shelter with you: ☐ Yes ☐ No Who: _____

If you need transportation, what type do you need: ☐ - Car / Bus ☐ - Wheelchair Van ☐ - Stretcher Van

SERVICE ANIMAL / PET INFORMATION: (Check all that apply)

Animals not permitted at shelters: Exotics (primates, snakes, etc.), Spiders and Insects, Farm Animals

☐ Service Animal Service Animal Type: ☐ - Dog ☐ - Miniature Horse

Do you have Pets that need to be sheltered: ☐ - No ☐ - Yes Type and number of pets: _____

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, the St. Johns County Department of Emergency Management (SJCDEM) will determine which emergency 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 should I be admitted to the hospital, while being evacuated or at an evacuation center, then I will be responsible for the 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 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 SJCDEM, 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 SJCDEM has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to:

St. Johns County Department of Emergency Management
100 EOC Drive | St. Augustine, Florida 32092
Attention: Evacuation Assistance Registry

I understand that if I choose to revoke this Authorization, I will no longer be part of the Evacuation Assistance Registry and will not be evacuated.

Registrants Signature: _____ **Date:** _____

Person Completing Form: _____ **Relationship:** _____

This Section is to be Completed by St. Johns County Emergency Management

Shelter Status: General Shelter ☐ General Pet Shelter ☐ Special Medical Needs Shelter ☐

No Assistance Needed ☐ Shelters Can't Support / Advanced Medical Care Needed ☐

Transportation Needed: ☐ - Yes ☐ - No Evac Zone: _____ Fire Zone: _____

Date Received: _____ **Date Notified:** _____ **Date Removed:** _____