State of Florida
Department of Health

Group Care Program Preparedness Toolkit
April 2013
Facility Name: __________________________________________
Group Care Program – File/Permit # ____________________________
Completed By: Name:  ________________________________________
Sign:  __________________________________________
Date: ___________________________________________

Facility Emergency Assessment: Pre-Disaster

Facility Name: __________________________________________
Facility Address: _________________________________________
Facility Phone Number: __________________________________
Facility Owner – Name ___________________________________
Contact Phone Number(s):  Work - ____________________________
Cell - ________________________  Home - ______________________
Facility Administrator (if different from owner) – Name: _________________
Contact Phone Number(s):  Work - ____________________________
Cell - ________________________  Home - ______________________
Facility Maintenance –
Name and Phone Number: __________________________________

After Hours Emergency Facility Contact and Phone Number(s) - (if different
from Owner/Administrator):
________________________________________________________________
________________________________________________________________

1. Does facility have procedures, guidelines, or a plan to follow in case of
an evacuation, sheltering in place or an emergency (fire, flood, etc.)?
   Yes ________  What type? ________________________
   No _________

2. Has facility provided training or information to its staff on facility’s
   emergency preparedness procedures and/or plan?
   Yes ________  No _________
   How often is training or information provided to staff (including new
   staff)? ________________________
   Last Day of Training: ________________________
   Who provides the training (including new staff)?
   Name: ______________________________________


3. Does facility conduct exercises or drills with both staff and residents to practice and improve the plan?
   Yes _________ No ___________
   How often? ______________
   Last Date Exercised ____________

4. How will staff be informed in case of an evacuation, sheltering in place, or emergency disaster?
   ______________________________________________________
   ______________________________________________________

5. Does facility house residents that have special needs such as visual impairment, hearing impairment, mobility impairment, etc.? See Special Considerations for Residents with Special Needs
   Yes _________ No ___________
   How many residents? _________
   How is facility prepared to accommodate these residents in case of a disaster, emergency, evacuation or shelter in place?
   ______________________________________________________
   ______________________________________________________

6. Does facility house residents that speak languages other than English?
   Yes _________ No ___________
   How many residents? _________ What language(s)? ______________
   How is facility prepared to accommodate these residents in case of a disaster, emergency, evacuation or shelter in place?
   ______________________________________________________
   ______________________________________________________

7. What is the nearest hospital and how far is it from the facility?
   Name: ___________________________ Miles: __________________

8. In case of an evacuation, would any residents need to be evacuated to the nearest hospital?
   Yes _________ No ___________
   How many? ________________
   How will resident(s) be evacuated to hospital?
   ______________________________________________________

9. Does facility have a system/method in place to identify its residents during an evacuation?
   Yes _________ No ___________
   What is the system/method? __________________________

10. Does facility have its residents assigned to designated staff in case of an evacuation or an emergency disaster?
    Yes _________ No _______
    How many residents per staff person? ______________
11. Does facility have a need for a specially equipped vehicle or accessible transportation in case of an evacuation or an emergency disaster?
   Yes _______  No _______
   Is there a contract in place? Yes _______  No _______
   If Yes, who is the contracted business? ___________________________
   Phone #: __________________

12. Has facility identified transportation services for its residents in case of health problems developing and/or need for evacuation due to the emergency or a disaster?
   Yes _______  No _______
   Name and Phone Number of Contractor ___________________________

13. Does facility have an established pharmacy or prescription provider(s)?
   Yes _______  No _______
   Provider Name and Phone #:_____________________________________

14. Has facility identified who will transport its resident’s medications in case of an evacuation or an emergency disaster?
   Yes _____ Assigned Staff: _____________________________
   Alternate Staff: _____________________________
   No _____

15. Has facility identified how the assigned staff will transport its resident’s medications in case of an evacuation or an emergency disaster?
   Yes _____ Assigned Staff: _____________________________
   No _____

16. Does facility have a plan to shelter in place?
   Yes _____  No _____
   If Yes, does facility have a three to seven day supply of food and potable (drinking) water (one gallon of water per person per day)?
   Yes _____  No _____
   • If Yes, how many residents in facility? __________
     How many gallons of potable water are available per resident (one gallon per person per day)? __________
   • If No, is there a contractor/supplier who will provide food and water for the facility?
     a. Yes _____
        Name of contractor/supplier ___________________________
        How often will food and potable water be provided?
        - Frequency:
          As Requested by Facility? Yes _____  No _____
          Every _______ Days; Every _______ Week(s)
     b. No _____
How will facility provide food and potable water for residents and staff?

________________________________________________________________________________

17. Does facility have an established contract with a sanitation company to provide portable toilets and handwashing stations for staff and residents if sheltering in place?
   Yes __________
   Company contracted: _________________________
   Phone: _________________________________
   Number of Days contracted? __________
   Pick up/Removal of Portable Toilets Date? ______________________

18. Does facility have residents that medically need the use of oxygen tanks on premises?
   Yes _____
      • If Yes, how many residents need them? ______
      • What type? __________________
      Supplier Name and Phone Number: _________________________
   No _____

19. Does facility have a designated primary staff, and 2 alternate staff, to obtain residents’ extra prescription refills in preparation for, an evacuation, or in an emergency disaster (overnight and on weekends too)?
   Yes _______
   Designated staff ________________________________
   First Alternate staff ________________________________
   Second Alternate staff ________________________________

20. Has facility staff identified and kept in working condition necessary tools and equipment needed before, during, and after a disaster? Tools and equipment include flashlights, batteries, tarps, radios, old fashion cord (land) phone, cell phones and respective chargers (wall and car), fans, NOAA weather radio, etc.
   Yes _____  No _____

21. Is facility prepared for a loss of power or blackout?
   Yes _______
   Describe how: ______________________________________________
   _________________________________________________________
   _________________________________________________________
   No _________ If No, see Attachment H: Considerations for Power Loss
22. Does facility provide alternative means for handwashing?
   Yes _____  No _______
   Method: __________________________________________________________

23. Does facility provide alternative means for personal sanitation (bathing,
   flushing toilets, etc.)?
   Yes _____  No _______
   If Yes, what is the method? __________________________________________
   Contracted Company: _____________________ Phone: ________________

24. Does facility have First Aid kit(s)?
   Yes _____  No _______
   How many? ______
   Are all staff aware of location of first aid kit? ______
   Location of the First Aid Kit – see Attachment D

25. Does facility have Fire Extinguishers?
   Yes _____  No _______
   How many? ______  Date when last time tested: ________________
   Location throughout the facility - see Attachment D

26. Does facility have smoke alarms?
   Yes _____  No _______
   How many? ______  Date when last time tested: ________________
   Location throughout the facility - see Attachment D

27. Does facility have carbon monoxide detectors?
   Yes _____  No _______
   How many? ______  Date when last time tested: ________________
   Location throughout the facility - see Attachment D

28. Does facility maintain a reserve supply of linen?
   Yes _____  No _______
   If No, are residents responsible to have their own reserve supply of
   linens? Yes _____  No _______

29. During an emergency or disaster, how will facility handle:
   Trash? __________________________________________________________
   Debris? __________________________________________________________
   Soiled linen? _____________________________________________________
   Biomedical waste? ________________________________________________
   Other waste material? _____________________________________________
30. Does facility have any residents, or staff, that require the need of a service animal?
   Yes ______   No ______
   If Yes, does facility have a plan to cover the service animal needs in case of an emergency or in case of an evacuation?
   Describe plan including water, food, vaccinations, vet contact (please include any attachments if needed)
   __________________________________________________
   __________________________________________________
   __________________________________________________

31. If service animal is required by staff or resident, will service animal be evacuated to same facility?
   Yes ______   No ______ Not Applicable ________

32. Has facility provided its staff with family personal preparedness tools and/or information in the event of an emergency?
   Yes ______   No ______
   Are staff allowed to shelter in place at facility with family members?
   - Yes ______
     - For how many days? _________
   - No ______
     - Are staff allowed to communicate with family members while sheltering in place at facility? Yes ______ No ______

33. Does facility have a back-up system to cover for each staff member in preparation for an emergency (absence, illness, or affected by the disaster themselves)? Yes ______ No ______

34. Has facility provided training or information to its residents and the residents’ families on its emergency preparedness procedures?
   Yes _____ How often? _________________________________
   No _____ How and when will they be prepared or informed?
   _________________________________

35. Has facility provided its residents, and their families, with personal preparedness tools and/or in the event of an evacuation or emergency disaster?
   Yes ______ No ______

36. Are residents allowed to shelter in place at facility with their family members?
   Yes ______ No ______
   For how many days? _________
   If Yes, does facility have a three to seven day supply of food and potable (drinking) water (one gallon of water per person per day)?
   Yes _____ No _____
Facility Name: __________________________________________
Group Care Program – File/Permit # ____________________________
Completed By: Name: ________________________________________
Sign: ____________________________________________________
Date: ____________________________________________________

Facility Emergency Assessment Form: Post-Disaster

Facility Address: _____________________________________________
Facility Phone Number: _________________________________
Facility Administrator – Name ___________________________________
Phone Number(s): Work - ________________________________
Cell - ________________________  Home - ____________________________

Facility Maintenance –
Name and Phone Number: _____________________________________

After Hours Emergency Facility Contact and Phone Number(s) - (if different
from Administrator): __________________________________________

1. Is facility currently open and operating?
   Yes _____  No _____

2. Was it necessary to evacuate the facility?
   Yes* _______      No _______
   * See Evacuation Considerations and Attachment E
   If Yes, where? ______________________________________________

3. Did facility shelter in place?
   Yes _____
   Does facility have a three to seven day supply of food, potable
   drinking water (one gallon of water per person per day)?
   Yes _____
   How many residents and staff are currently in the facility? _________
   No _____
   Is there a contractor/supplier who will provide food and potable
   water to the facility (residents and staff – one gallon per day per
   person for 3 to 7 days)?
   Yes _____  No _____
   Name of contractor/supplier ________________________________
   Phone #: _______________________________________________

4. How often will food and potable water be provided?
   - Frequency:
   As Requested by Facility?
   Yes _____  No _____
   Every _______ Days; Every _______ Week(s)
5. If facility is currently open and operating, has facility experienced loss of power?
   Yes ______    No ______
   Is there an emergency back up plan, or method, to restore power?
   Yes ________
   What is the back-up method? ____________________________

6. Does facility have potable water supply for cooking, drinking, and sanitation?
   Yes ______    No ______

   What type of water supply system?
   Municipal/city ______
   Well ____  What type? ______________
   Permit Number: ____________________
   • Is well functioning properly? Yes _____    No _____
   If No, is it flooded? Yes _____    No _____
   - If Yes:
     Water samples taken? Yes _____    No _____
   - Is there a boil water notice in effect for your facility area?
     Yes _____    No _____
   - Does facility have bottled water for residents and staff (one gallon of water per person per day)?
     Yes _____    No _____

7. Does facility have power?
   Yes _____    No** _____  ** Also see Attachment J
   If No, does facility have emergency generator? Yes _____    No _____
   • If Yes, what is the generator size? ______________
   • What type of fuel does generator use?
     Gasoline _____    Diesel _____    Natural Gas _______
   • How long will the fuel last until it must be replenished?
     Amount of Hours ___________    Amount of Days __________
   • Where is fuel from (gas station or contracted from)?
     ____________________________________________________

8. What areas of the facility will the generator power be used for?
   _____________________________________________________
   _____________________________________________________
   _____________________________________________________

9. Does facility maintain a list of the serial number of medical devices, such as dialysis machine, pacemakers, respirators or electric-powered medical equipment, that may be medically necessary for residents?
   Yes _____    No _____
10. Does facility have oxygen tanks on premises medically necessary for residents?  
   Yes _____  No _____  
   - If Yes, how many? _______  What type? _________________
   
   Supplier Name and Phone Number: _______________________
   
   - If No, does facility have residents that require medically necessary oxygen tanks?  
   Yes _____  How many? _______  What type? ____________
   
   Supplier Name and Phone Number: _______________________
   
   No _____

11. Did assign staff obtain extra prescription refills for its residents in preparation for sheltering in place (overnight and on weekends too)?  
   Yes _______  No _______
   
   Provider/Supplier Name and Phone Number: _______________________

12. Has facility staff identified and kept in working condition necessary tools and equipment needed before, during, and after a disaster? Tools and equipment include flashlights, batteries, tarps, crank or battery operated radios, old fashion cord (land) phone, cell phones and respective chargers (wall and car), fans, NOAA weather radio, etc.  
   Yes _____  No _____

13. Does facility provide alternative means for handwashing?  
   Yes _____  
   What is the alternate means? _______________________________
   
   No _____

14. How is facility handling:  
   Trash? ____________________________________________________
   Soiled linen? _______________________________________________
   Biomedical waste? __________________________________________
   Other waste material? ________________________________________

15. Does facility have or allow residents to keep a service animal or pet(s)?  
   Yes _______  No _____________
   
   Is there a plan to cover service animal or pet’s needs in case of an emergency or in case of an evacuation? Yes _____  No _____
   If Yes, describe plan __________________________________________
   _________________________________________________________
16. Has facility provided training or information to its staff on facility’s emergency preparedness procedures?
   Yes _____
   - How often is training or information provided to staff (including new staff)? ___________
   No _______
   - How will staff be prepared or informed? ___________________

17. Has facility provided its staff with family personal preparedness tools and/or information in the event of an emergency?
   Yes _____ No _______
   Are staff allowed to shelter in place at facility with family members?
   - Yes ______
     - For how many days? __________
   - No ______
     - Are staff allowed to communicate with family members while sheltering in place at facility? Yes _____ No _______

18. Does facility have a “back-up” system to cover for each staff member in preparation for an emergency (absence, illness, or affected by the disaster themselves)? Yes _____ No _______

19. Has facility provided training or information to its residents and the residents’ families on its emergency preparedness procedures?
   Yes _____ How often? __________________________
   No _____ How and when will they be prepared or informed?
   __________________________________________

20. Has facility provided its residents, and their families, with personal preparedness tools and/or in the event of an emergency?
   Yes _____ No _______
   Are residents allowed to shelter in place at facility with their family members?
   - Yes ______
     - For how many days? __________
   - No ______
     - Are residents allowed to communicate with family members while sheltering in place at facility?
   - Yes _____ No ______
     - If Yes, who will ensure that residents contact their families?
   __________________________________________
ATTACHMENT A - HAZARD VULNERABILITY ANALYSIS

INSTRUCTIONS

List potential hazardous events for your facility

Evaluate each event for probability, vulnerability and preparedness

Probability and Vulnerability are rated on a three level scale from high to low. Probability and Vulnerability are ranked with a score of “3” for high, “2” for moderate and “1” for low.

In the Preparedness category, a score of “3” represents a low ranking while a score of “1” represents a high level of preparedness. A score of “2” represents a moderate ranking for preparedness

When evaluating probability, consider the frequency and likelihood an event may occur

When evaluating vulnerability, consider the degree with which the facility will be impacted, such as, infrastructure damage, loss of life, service disruption etc.

When evaluating preparedness, consider elements, such as, the strength of your preparedness plans and the facility’s previous experience with a disaster event

Multiply the ratings for each event in the area of probability, vulnerability and preparedness. The total values with the higher scores will represent the events most in need of planning for emergency preparedness. Using this method, 1 is the lowest possible score, while 27 is the highest possible score.

NOTE: The scale for preparedness is in reverse order from probability and vulnerability where by “low” =3 and “high”=1.

The facility should determine which values represent an acceptable risk level and which values require additional planning and preparation.
## ATTACHMENT A: HAZARD VULNERABILITY ANALYSIS

Facility Name ___________________________________________________
Date _____________ Completed By: ________________________________

<table>
<thead>
<tr>
<th>Hazard</th>
<th>Probability</th>
<th>Vulnerability</th>
<th>Preparedness</th>
<th>Score</th>
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<tbody>
<tr>
<td><strong>Natural</strong></td>
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<tr>
<td>Hurricane</td>
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<td>Tornado</td>
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<tr>
<td>Heavy Thunderstorm</td>
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<tr>
<td>Flash Flooding</td>
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<tr>
<td>High Winds</td>
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<tr>
<td>Severe Weather</td>
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<tr>
<td>Extreme Heat</td>
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<td>Wildfire</td>
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<td><strong>Man-made</strong></td>
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<tr>
<td>Tidal wave/Tsunami</td>
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<td>War (conventional, biological, chemical or nuclear)</td>
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<td>Toxic materials emissions/spill</td>
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<tr>
<td>Nuclear plant breakdown or nuclear disaster</td>
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<td>Terrorism</td>
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<td>Heating/Cooling</td>
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<tr>
<td>Communications</td>
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<td><strong>Other</strong></td>
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<tr>
<td>Disease Outbreak</td>
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<tr>
<td>Community Infrastructure (bridge collapse, road, building collapse)</td>
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<tr>
<td>Utility Failure</td>
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<tr>
<td>Transportation Failure</td>
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<td>Other</td>
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## ATTACHMENT B – FACILITY’S CONTACT LIST

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<tr>
<th>EMERGENCY CONTACT</th>
<th>NUMBER</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police Department</td>
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<td>Non-Emergency #:</td>
</tr>
<tr>
<td>Sheriff’s Department</td>
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<td>Non-Emergency #:</td>
</tr>
<tr>
<td>Fire Department - local</td>
<td></td>
<td>Non-Emergency #:</td>
</tr>
<tr>
<td>Fire Department – county (if applicable)</td>
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<td>Non-Emergency #:</td>
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<tr>
<td>Ambulance Services/Company</td>
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<tr>
<td>FL Poison Control Center</td>
<td>1-800-222-1222</td>
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<tr>
<td>Hospital- Name:</td>
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<tr>
<td>Local Coroner's Office:</td>
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<td>After Hours:</td>
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<td>Funeral Home:</td>
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<td>After Hours:</td>
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<td>Solid Waste Disposal:</td>
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<td>Facility’s Plumber:</td>
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<td>Facility’s Electrician:</td>
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<td>Facility’s Heating and Air Contractor</td>
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<td>Local County Health Department</td>
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<td>Local Mental Health Center</td>
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<td>Local Dialysis Center</td>
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<td>Local Church</td>
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<td>Local Soup Kitchen</td>
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<tr>
<td>County Emergency Manager</td>
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<tr>
<td>FL Department of Health – Environmental Health</td>
<td>Office Hours:</td>
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<tr>
<td>FL Division of Emergency Management</td>
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<tr>
<td>FL Department of Elder Affairs</td>
<td>Office Hours:</td>
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<td>FL Independent Living Council</td>
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<td>FL Commission for the Transportation Disadvantaged</td>
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<td>FL Department of Education – Division of Blind Services</td>
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<td>FL Highway Patrol</td>
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<td>American Red Cross</td>
<td>Other:</td>
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ATTACHMENT C - Staff Emergency Contact List
NOTE: UPDATE EVERY TIME THERE ARE STAFF CHANGES (TURNOVER, NEW HIRES, VOLUNTEERS, ETC.)

Facility staff members should keep emergency contact information up-to-date and in a safe location that all staff can access in case of disaster(s).

<table>
<thead>
<tr>
<th>Staff Title</th>
<th>Name</th>
<th>Home #</th>
<th>Cell #</th>
<th>Email</th>
<th>Other #s</th>
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Reviewed By:
Print: ________________________  Staff Title: __________________
Signature: ________________________
Date: ____________________________
Facility Name: __________________________________________
Group Care Program – File/Permit # ____________________________
Completed By: Name:  ________________________________________
Sign:  __________________________________________
Date: ___________________________________________

ATTACHMENT D – FACILITY FLOOR PLAN with Fire Extinguisher Locations, Carbon Monoxide and Smoke Alarm Locations.
Include SAFE PLACE (Tornado Safe Room) - NOTE: When picking a safe place in your facility, consider a room inside the facility that has no windows like an inside bathroom or closet, but one that has ventilation.
ATTACHMENT E – EVACUATION FLOOR PLAN
NOTE: Your evacuation floor plan should include exit locations, who authorizes evacuation, evacuation meeting place outside facility, and staff/resident accountability.
ATTACHMENT F – EVACUATION CONSIDERATIONS
In the event of an evacuation:

If your area is ordered to evacuate, DO NOT wait until it is too late.
- Know the evacuation route for your city or county area and the Emergency information radio station to tune into for evacuation notices
- Know where the nearest approved shelters are located within your county
- Residents requiring to go to a Special Needs Shelter (SNS) should be registered ahead of time – check you local county dates for registration period
- If there is a resident that requires the use of a service animal, know what shelters in your area allow service animals. Include the animal’s needs (Food, water, medications, vaccination records) along with the resident’s in your evacuation plans
- Always consider the transportation needs of residents and staff evacuating. In most cases those residents that are ambulatory may be evacuated first. Staff should be familiar with the specific capabilities of residents and their mobility limitations.

1. List the circumstances that would dictate an evacuation of the residents (for example: major fire, flood, or flood damage, tornado destruction, etc.):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. Identify the person/staff who will authorize the relocation of the residents if they need to be evacuated. If relocating to another facility (temporarily) it is recommended that a memorandum of understanding between facilities is established.
   Authorizing staff member: ________________________________
   1st Authorizing Alternate Staff: ________________________________
     Phone #: ________________________________
   2nd Authorizing Alternate Staff: ________________________________
     Phone#: ________________________________

   Facility Administrator: ________________________________
   Facility Owner (if different from Administrator): ________________________________
   Facility Administrator/Owner: ________________________________
   Other (specify title): ________________________________
3. Identify the person/staff who will authorize the refill of medications for the residents. If relocating to another facility (temporarily) it is recommended that a memorandum of understanding be established.

Authorizing Staff Member: ________________________________
Phone #: ______________________________

1st Authorizing Alternate Staff: ________________________________
Phone #: ______________________________

2nd Authorizing Alternate Staff: ________________________________
Phone#: _______________________________

Accounting for residents and personnel:
Important issues to consider when establishing a system for accounting for residents and staff:

1. Does the facility have a list of the types of residents that would be evacuated first, second, and third? Staff should become familiar with the list and where the list is stored for easy access in case of a disaster and/or emergency situation.
2. Are hallways and doorways wide enough or does their width present a problem to evacuate residents (wheelchairs, stretchers, etc.)?
3. If building has multiple floors, are the residents on all floors mobile enough to be evacuated through hallways and/or stairways?
4. If loss of power is experienced while evacuating, does facility have light sources/emergency lighting to continue and complete the evacuation?
5. If the residents refuse to evacuate, does facility have an alternate method to ensure residents will be safe if sheltering in place (food, water, etc.)?
6. Where are residents and staff evacuated to? See Attachment F
7. How many residents were evacuated? How were residents’ locations accounted for?
8. Who transported residents to evacuation location?
9. Where medications transported to evacuation location? By whom?
10. Make a list of potential problems found when planning for evacuation

Methods of identifying the facility:
Some considerations of methods of identification of the facility and its residents include the following:

   Clothing labels with name of resident, name of facility and address
   An identifying band (already labeled and ready to use) for residents and for residents that require special care
   A photograph, kept in the resident’s records, with pertinent information listed on the back
   Special care information should include information as name, address of facility, special medication needs and prescribed dosage, and next-of-kin and phone number, etc. (See Attachments G, H and I)
It is essential that the facility’s list of residents is up-to-date and available to accompany a group evacuated. This list of residents can be kept at the facility’s office. A staff member should be responsible for keeping lists up to date and ready to go at all times. It is suggested that the staff member assigned the responsibility for the emergency medication should also have a copy of this list.

Evacuation Sites – Off-site Locations:

1st Evacuation Location
Location:
Address:
City, State Zip:
Telephone Number:

2nd Evacuation Location
Location:
Address:
City, State Zip:
Telephone Number:

Is there an agreement established with the off-site location?
Yes ________
Name: __________________________________________________
Address: ________________________________________________
Phone Number: __________________________________________
Administrator/Manager: _________________________________

No __________

NOTE: Special Needs Shelter (SNS) - If a resident(s) is medically dependent on electricity, need transportation to evacuate, or assistance due to a disability, register the resident(s) through your county’s Special Needs Registry. Each county handles the registry of persons with specials needs and the services a little differently. Call your local county emergency management office or local law enforcement office – see Attachment C
NOTICE OF EVACUATION

DATE: ____________ TIME: ____________

FACILITY:

_____________________

RESIDENTS AND STAFF HAVE EVACUATED TO:

_____________________

ADDRESS: ____________________

_____________________

PHONE #: ____________________

TRANSPORTED BY:

_____________________

FOR UPDATE OR INFORMATION, PLEASE CONTACT <FACILITY MANAGER/ADMINISTRATOR/OWNER NAME> AT Phone #: ____________________

OR:

<ALTERNATE DESIGNATED STAFF NAME>:

AT Phone #: ____________________
**ATTACHMENT G – Daily Living Assessment Checklist**
This checklist* can be used to detail the daily living requirements and medical needs of each resident with disabilities or special needs when preparing for an evacuation or in preparation for a disaster.

Resident’s Name: ___________________________________

<table>
<thead>
<tr>
<th>Daily Need</th>
<th>Need</th>
<th>Have</th>
<th>Do Not Have</th>
<th>Not Applicable</th>
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<tbody>
<tr>
<td>Adaptive Feeding equipment(special utensils, feeding tubes, etc.)</td>
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<tr>
<td>Special Equipment for Respiration</td>
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<tr>
<td>Special Dietary items – non perishable food</td>
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<tr>
<td>Personal Care Equipment (Shower chair, tub-transfer bench, etc.)</td>
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<tr>
<td>Communication Equipment (adaptive hearing or visual/sight devices, etc.)</td>
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<tr>
<td>Minimum two week to 30 day supply of medicine or prescriptions</td>
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<tr>
<td>Mobility Aids (wheelchair, walker, cane, etc.)</td>
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<tr>
<td>Electricity Dependent Equipment (dialysis machine, electrical lift, electrical wheelchair or scooter, etc.)</td>
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<tr>
<td>Service Animals and supplies for their feeding and care</td>
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</table>

*This checklist is not all inclusive and may be amended to fit your facility’s residents needs.
ATTACHMENT H – Resident Emergency Health Information

Date Updated:________________     Updated By: _____________________

Resident’s Name: _______________________________________________
Address: _______________________________________________________
City, State, Zip: _________________________________________________
Phone Number: _________________________________________________
Cell Phone: ____________________________________________________
Birth Date: _____________________________________________________
Health Plan: ___________________________________________________
Individual #: ______________________     Group #: _________________
Family member/Relative: _________________________________________
Phone #: _______________________________________________________
E-mail: ________________________________________________________

Special Conditions:
Medications/Dosages – see Attachment I: Medication Log
Allergies: _______________________________________________________
Communications/Devices/ Equipment:
______________________________________________________________
Other: __________________________________________________________

Doctor’s Name: _________________________________________________
Address: _______________________________________________________
City, State, Zip: _________________________________________________
Office Phone: ________________________   After Hours: ______________
Fax: _____________________________________
E-mail: ___________________________________

Pharmacy/ Prescription Provider- Name: ____________________________
Address: _______________________________________________________
City, State, Zip: _________________________________________________
Phone: ______________________________ Fax: ______________________
E-mail: ________________________________________________________

Emergency Contact #1: __________________________________________
Relationship: __________________________________________________
Address: _______________________________________________________
City, State, Zip: _________________________________________________
Day Phone: ____________________Cell Phone: _____________________
E-mail: ________________________________________________________

Emergency Contact #2: __________________________________________
Relationship: __________________________________________________
Address: _______________________________________________________
City, State, Zip: _________________________________________________
Day Phone: ____________________Cell Phone: _____________________
E-mail: ________________________________________________________
## ATTACHMENT I – MEDICATION LOG – Prescription and Non-Prescription

**Resident’s Name** ___________________________  **Drug Allergies** ___________________________

**Physician’s Name** ___________________________  **Food Allergies** ___________________________

**Symptom Treated:** __________________________________________________________

**Month/Year** _____________________________

| Medication & Dosage | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---------------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| A.M.                |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Noon               |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| P.M.               |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Bed Time           |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| A.M.               |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Noon              |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| P.M.              |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Bed Time          |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| A.M.           |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Noon         |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| P.M.         |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Bed Time       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
ATTACHMENT J- CONSIDERATIONS FOR LOSS OF POWER

Before there is a loss of power in the event of a disaster, facilities should consider the following:

Do your facility rely on battery powered equipment (hearing aids, alarms, phone alerts).
  • If yes, do you have spare batteries for them?

Can facility get replacement batteries easily or do they have to be special ordered?

Does anyone in the facility use any electrical equipment that is critical to their well-being?

Does facility have electrical extension cords? (i.e. 9 foot, 10 foot, 15 foot)

What will happen if you lose power?

Is there a manual or battery operated substitute that you can use?

Suggestions to Better Prepare:

1. Assemble essential supplies such as:
   • Flashlight (s)
   • Batteries (for flashlights, radios, alarms and detectors)
   • Portable Radio(s)
   • Standard corded telephone
   • Food Thermometer
   • Fire Extinguisher(s)
   • Clean Plastic containers to fill with water to freeze (as water expands when it freezes, it’s important to leave room inside the container for the water to expand: do not fill to top!)
   • Stock up on Ready to Eat food that DOES NOT require refrigeration – see Attachment L
   • Power converter: for laptop, cell phone that may be operated from the cigarette lighter of a vehicle

NOTE: If facility loses power and/or is evacuated, can you call-forward the facility’s landline to an administrator, manager, or staff supervisor’s cell phone?

• High quality surge protector for your office equipment
• Hard copy of staff contacts lists – see Attachment C
• Hard copy of residents information – see Attachments G, H, and I

Specific Information for Persons with Disabilities:

• Have electrical back-up for any medical equipment
• If facility has residents that require the use of a battery-operated wheelchair, or scooter, or other power-dependent type of equipment, contact your local utility company to inform them that your facility has power-dependent residents
• An extra battery for the motorized equipment. A car battery can also be used, but may not last as long
- Manual wheelchair(s) for back-up
  - Can these fit through the hallways, or in case of, down the stairs?
- If facility has visually impaired, or blind, residents, store a talking or Braille clock, or a large-print clock with extra batteries
- If facility has hearing impaired, or deaf, residents, consider having a portable battery-operated television set

2. Facility Lost Power: Things to Do
   - Staff should assess resident’s status and ensure that all residents are accounted for and are safe
   - Turn on your battery operated, or crank, radio so that you are aware of the latest news from your emergency managers: water safety, any boil water notices, etc.
   - Turn off or disconnect any appliances, equipment or electronics that were in use when the power went out
   - Leave one light turned on so you know when the power returns
   - Leave refrigerator and freezer doors closed so that food and/or medicine stays as cold as possible
   - If the facility houses residents that take medication that requires refrigeration, ensure that those medications are kept in a refrigerator that will not be opened or used frequently. Most medications can be kept in a closed refrigerator for several hours without a problem
   - If the power is out longer than two hours, check food temperatures in the refrigerator and throw away food that has a temperature higher than 40 °F

3. Facility Lost Power: What NOT to DO:
   - Do NOT use candles during a power outage
   - NEVER use a generator, grill, or similar items, inside the facility – these items should only be used outdoors
   - Use the phone only for emergency calls. Do NOT call 9-1-1 for information
     USE ONLY to report a life threatening emergency
   - If there is an elevator in the facility, Do NOT use it

Make prior arrangements with residents' physicians or check with the oxygen supplier(s) about emergency plans for those on respirators or other electric-powered medical equipment. Be sure to have electrical back-up for any medical equipment that residents
ATTACHMENT K- Ready to Eat: NO Cook Foods Considerations Checklist

Meals Ready to Eat (MREs): heat sensitive
Energy bars (high calorie)
Sugar or sugar substitute
Salt and Pepper
Whole grain cereals
Almonds and other nuts (if no food allergies for residents or staff)
Canned ready to eat foods
Canned pasta
Peanut butter (if no food allergies for residents or staff)
Trail Mix (if no food allergies for residents or staff)
Jerky
Dried fruit
Canned fruit
Applesauce/fruit cups
Fruit leather
Rice cakes
Crackers/Triscuits/ Salt-free Crackers
Hard candies
Tuna packs
Cookies
Cheese spread in jars
Pudding cups
Breakfast bars
Sunflower seeds
Potable drinking water (1 gallon per person per day- suggested 3 to 7 day supply)
Shelf-stable juice (boxes or cans)
Gatorade mix
Cocoa mix
Instant coffee
Packets of dry milk
Shelf stable milk/almond milk/soy milk

Utensils:
Plastic utensils
Metal Cup
Metal Pans
Can Opener
ATTACHMENT L - SPECIAL CONSIDERATIONS FOR RESIDENTS WITH SPECIAL NEEDS*

*This is not an inclusive list of questions, but serves as guidance for facilities to plan ahead*

Facilities housing residents with disabilities or special needs should consider having a detailed list of daily living requirements and medical needs for its residents (see Attachment A – Daily Living Assessment Checklist)

Does facility have audible and visual alarms, smoke detectors installed throughout the facility?
- Check that all of the visual and vibrating alerting devices throughout the facility have battery back-up in the event of a power outage
- Replace the batteries every six months
- If needed, install audible alarms as well as visual smoke alarms throughout the facility

I- OXYGEN/BREATHING MEDICATION DEPENDENCIES

Does the facility have residents that take any breathing prescription medicines? If yes, see Attachment I

Does the facility have residents that take any over the counter breathing medicines? If yes, see Attachment I

Does the facility/residents have at least a two week supply of breathing medications (prescription and non-prescription)?
- How will facility get breathing medications replaced or refilled (if lost or run out)?

Does the facility have residents that use any nebulizer breathing prescription medicines? If yes, see Attachment I

Does the facility/residents have at least a two week supply of breathing medications (prescription and non-prescription)?
- How will facility get breathing medications replaced or refilled (if lost or run out)?

Does the facility have residents that take medicine that need to be refrigerated? If yes, how will be done without normal power (battery-powered refrigerator, cooler with ice, with dry ice)?
- How long can you keep your medicine without regular power?

Does facility keep any spare tubing? Any spare face masks?
- How will facility get more if needed?

II- MOBILITY DEPENDENCY:

If the facility has residents who have mobility impairments, consider including the following items:

1. Are there any residents that use an electric wheelchair or scooter? If yes, are there any extra/spare batteries? Does wheelchair or scooter have an Oxygen bracket?
2. Does facility have a **manual wheel chair** or can a **substitute a manual chair** be used to replace the electric model?
   - If needed? Does it have an *Oxygen bracket* or *Oxygen bag*?
   - Keep a pair of heavy gloves in your supply kit to use while wheeling or making your way over glass and debris.
   - If you do not have puncture proof tires, keep a patch kit or can of "seal-in-air product" to repair flat tires and/or also keep an extra supply of inner tubes.
   - Store a lightweight manual wheelchair, if available

**Depending on the chair type and specific needs, here are some additional items to consider:**

- Portable Ramp
- Heavy gloves for use while possibly wheeling over broken glass and debris
- A spare battery for the chair and/or adapter for recharging your battery from a vehicle
- Tire patch kit and portable air compressor or canned "seal-in-air product" to repair flat tires
- Spare cane or walker (if appropriate) in case your chair becomes unusable
- Whistle to signal for help

**Check with the vendor to see if the wheelchair will be able to charge batteries by either connecting jumper cables to a vehicle battery or by connecting batteries to a specific type of converter that plugs into your vehicle’s cigarette lighter in the event of loss of electricity.**

Arrange and secure furniture and other items to provide paths of travel and barrier free passages. If residents spend time above the first floor of an elevator building, plan and practice using alternate methods of evacuation.

If residents cannot use stairs, discuss lifting and carrying techniques that will work for those residents. There will be instances where wheelchair users will have to leave their chairs behind in order to safely evacuate a structure. Sometimes transporting someone downstairs is not a practical solution unless there are at least two or more strong people to control the chair. Therefore, it is very important to discuss the safest way to transport those residents if they would need to be carried out, and alert those assisting these residents to any areas of vulnerability. For example: the traditional “fire fighter’s carry” may not be prudent for people with respiratory weaknesses. Staff needs to be able to give brief instructions to others regarding how to move those residents.

**III- HEARING OR HARD OF HEARING IMPAIRMENT:**

Facility staff should recognize that special arrangements many need to be made for those residents who are hearing impaired or hard of hearing in order to receive emergency warnings. Providing residents with the means of writing and taking down information to assist them with communication in the event of an emergency will be beneficial to residents during an emergency. Have paper, pens and markers, in addition to assistive technology and back-up power supplies for the equipment and/or technology. Example: if facility has residents who are hard of hearing, or have a deaf impairment, have index cards with pre-printed phrases that residents keep in a safe location and can use when communicating with others after a disaster.
Here are some extra suggestions:

- Store hearing aid(s) and/or cochlear implants where residents and/or staff can easily find them after a disaster. For example, you could keep them in a container by the resident’s bedside and attach the container to a nightstand or bedpost using a string or Velcro.

- Store extra batteries for hearing aids and implants. If possible, store an extra hearing aid with the facility’s emergency supplies.

- Portable TTYs and batteries.

- Keep pagers, captioned telephones and other communication equipment charged.

- Provide residents with whistles to signal for help in case of an emergency.

- Maintain batteries and store extras for the TTY and other communications equipment that residents may need. Check the owner’s manual for proper battery maintenance.

- Residents should know how to communicate with emergency personnel if there is no interpreter or if the resident does not have their hearing aids. Store paper and pens around the facility for the residents to use for this purpose.

- If evacuated, facility staff should consider having residents carry a pre-printed copy of important messages with them, such as:
  - “I use American Sign Language (ASL) and need an ASL interpreter.”
  - “I do not write or read English.”
  - “If you make announcements, I will need to have them written or signed.”

- If possible, get a battery-operated television that has a decoder chip for access to signed or captioned emergency reports.

- Facility staff should determine which broadcasting systems will provide continuous captioned and/or signed news prior to and after a disaster or emergency.

Install smoke alarms that give signals that can be both seen and heard by residents throughout the facility. At least one smoke alarm should be battery operated.

**IV- VISUAL IMPAIRMENT**

Facility staff should be aware that after a major disaster or emergency, visually impaired individuals lose the auditory cues they usually rely on after a major disaster. Mark emergency supplies with large print, fluorescent tape or Braille. In the case of an evacuation, staff assisting visually impaired residents, should mark clear the residents’ items as assistive devices and not just “baggage”.

If facility houses residents that have some vision, place security lights in each room to light paths of travel. These lights plug into electrical wall outlets and light up automatically if there is a loss of power. They will, depending on type, continue to operate automatically for 1 to 6 hours and can be turned off manually and used as a short-lasting flashlight.
In addition, to the above, here are some extra suggestions:

- Special Items such as extra folding mobility canes-keep in strategic, consistent and secured locations so residents can easily access them in case of an emergency
- Extra pair of dark glasses (if medically required)
- Tape recorder & extra batteries
- Battery operated or crank operated radio
- Flashlight and extra batteries
- Plastic Emergency whistle
- Portable assistive devices: magnifiers, communication devices, etc.
- Work gloves and sturdy shoes
- Medications: prescription and Over the Counter (OTC)

**Service/Companion Animals:**
Service or companion animals may become confused or frightened during and after a disaster: keep them confined or securely leashed or harnessed. A leash/harness is an important item for managing a nervous or upset animal. Be prepared to use alternative ways to negotiate its environment.

Create an animal supply kit and Take-Along-Bag (if necessary):
For each animal:
- Two-week supply of water (plastic gallon jugs) and food
- Non-spill food and water dishes
- Manual can opener and spoons
- Animal/Service Animal identification information, veterinary records and proof of ownership
- Cage/carrier (labeled with contact information: pet’s name, owner’s name, address and phone number and an emergency name and phone number)
- Favorite toys, treats, blankets
- Leash, collar, harness, muzzle, stakes and tie downs
- Litter, litter pan, litter scoop
- Newspaper (for bedding or litter)
- Paper towels and plastic baggies
- First aid kit and manual (call your vet)

**SPECIAL CONSIDERATIONS FOR A FACILITY IN CASE OF SERIOUS INJURY OR DEATH**
*This is to serve as considerations, and in no way is an inclusive list, or a directive that should be followed as is, but merely serves as suggestions and guidance for facilities in order to plan ahead*

- Ensure that residents remain calm and in an area away from the seriously injured and/or deceased person
- If death occurs in the facility while sheltering in place, the facility administrator (or designated supervisor or staff member) should notify law enforcement authorities and/or local Coroner’s office, by telephone, if at all possible, by calling 9-1-1 prior to notifying relatives, emergency contacts, or resident’s representative, and follow facility’s procedures for this type of incidents.
- Await instructions from law enforcement personnel and/or emergency medical staff