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 residents of St. Johns County who need sheltering assistance during a disaster. Shelters should be your refuge of last resort if you have nowhere else to go. Residents of nursing homes, assisted living facilities, or other group facilities, do not qualify for registration in this program. Under Florida State Statute 252 these facilities are required to have a Comprehensive 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: _____ Gender: _____

Date of Birth: _____ Age: _____ Weight:_____ lbs Does your weight require special transport: 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)

(Primary) Name:_____ Relationship:_____ Phone:_____

(Secondary) Name:_____ Relationship:_____ Phone:_____

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

MEDICAL INFORMATION: (Check all that apply)

☐ Dementia ☐ Alzheimer's Disease ☐ Mental Health Impaired

☐ Hearing Aids ☐ Deaf ☐ Legally Blind ☐ Speech Impaired

☐ Wheelchair ☐ Cane
☐ Electric ☐ Manual / Standard ☐ Walker

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

☐ Incontinence ☐ Ostomy Care ☐ Dialysis Dependent
☐ Catheter Line ☐ Feeding Tube ☐ Intravenous Line
☐ BiPAP Machine ☐ CPAP Machine ☐ Nebulizer Machine
☐ Cardiac VAD System ☐ Oxygen Concentrator | Tank ☐ Ventilator

Additional Medical Information:_____

TRANSPORTATION INFORMATION: (Check all that apply)

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

Is someone going to the Evacuation Shelter with you: ☐ Yes ☐ No Name: _____

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

SERVICE ANIMAL INFORMATION (Florida Statute: F.S 413.08 (1) d) | PET INFORMATION: (Check all that apply)

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

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

Animals not permitted at shelters: Exotics, Farm Animals, Wildlife

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, St. Johns County Emergency Management (SJCEM) 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 need advanced medical treatment during transportation to or while populating a St. Johns County evacuation shelter I understand I will be responsible for all charges incurred as a result."** I grant permission to medical providers, transportation agencies and other individuals providing me medical care to 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 SJCEM, 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 SJCEM 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 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 I will be responsible for my own evacuation.

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: _____

Date Received: _____ Date Removed:_____