

BRACE HOMEBOUND PROGRAM PERSONAL INFORMATION

RETURN TO:

Be Ready Alliance Coordinating for Emergencies/BRACE
 1301 West Government Street, Pensacola, FL 32501
 Phone: 850-444-7135 Fax: 850-444-7117

FOR BRACE USE ONLY

Fire District _____ Shelter Type _____
 Date Entered _____ Entered by _____
 Tapestry ID # _____

Initial: _____ Date: _____ Change: _____ Date: _____
 Do you live in an evacuation zone? Yes _____ No _____ Flood zone Yes _____ No _____
 Will you be going to a shelter in case of a mandatory evacuation? Yes _____ General _____ Special Needs _____ No _____
 Name: _____ Spouse/Significant Other: _____
 Address: _____ Apt/Lot # _____
 City: _____ ZIP: _____ Phone: _____
 Attach directions: Yes _____ No _____ Closest major intersection: _____
 Residence Type: Mobile home _____ Private home _____ Villa/Apt/Condo _____
 Date of Birth: _____ Gender: _____ SSN (last 4 digits): _____
 Language: English _____ Spanish _____ Sign _____ Other _____

Caregiver: _____ Phone: _____
 Next of Kin: _____ Phone: _____ Relationship: _____
 Emergency Contact: _____ Phone: _____ Relationship: _____
 Doctor's Name: _____ Phone: _____
 Home Health Care Agency/Hospice/Other: _____ Phone: _____
 Case Worker: _____ Phone: _____ Cell phone: _____
 Guide dog/service animal to accompany client: Yes _____ No _____ (Non-service animals noted below)
 Do you use oxygen at home: Yes _____ No _____ If yes, how many hours per day is required? _____
 Oxygen supplier name: _____ Phone: _____
 Please list other medical equipment you use at home: _____

Please list your illnesses and physical limitations (DO NOT LEAVE BLANK): _____

LIVING SITUATION	GENERAL	SPECIAL NEEDS	MEDICAL FACILITY	DISASTER PLAN
(check all that apply) <input type="checkbox"/> Dependent on electricity <input type="checkbox"/> No alternate housing <input type="checkbox"/> No emergency heat <input type="checkbox"/> Homebound <input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with spouse <input type="checkbox"/> Lives with spouse & children <input type="checkbox"/> Lives with adult children <input type="checkbox"/> Lives with minor children <input type="checkbox"/> Lives with parents <input type="checkbox"/> Lives with other relatives <input type="checkbox"/> Lives with non-relative <input type="checkbox"/> Lives in group home <input type="checkbox"/> Other: _____ _____	(check all that apply) <input type="checkbox"/> Minimal care required and not mechanically dependent <input type="checkbox"/> Perform activities of daily living without assistance <input type="checkbox"/> Insulin and diet controlled <input type="checkbox"/> Not oxygen dependent <input type="checkbox"/> History but no recent seizures <input type="checkbox"/> Not dependent on electric power <input type="checkbox"/> Blood pressure/hypertension stable <input type="checkbox"/> Hip or knee replacement within 6 months <input type="checkbox"/> Self ambulating <input type="checkbox"/> Wheelchair transferable-mobile with minimal assistance <input type="checkbox"/> Walker, cane, crutches, or wheelchair	(check all that apply) <input type="checkbox"/> Requires constant monitoring, assessment, or maintenance <input type="checkbox"/> Need periodic wound care assistance (dressing changes) <input type="checkbox"/> Needs nurse assistance with activities of daily living <input type="checkbox"/> Needs nurse assistance for medication <input type="checkbox"/> Require oxygen <input type="checkbox"/> Require electric power for medical purposes (O2, nebulizer, feeding tube) <input type="checkbox"/> Medically dependent on nebulizer or feeding tubes <input type="checkbox"/> Mental or cognitive limitations requiring assistance, accompanied by appropriate fulltime caregiver <input type="checkbox"/> Can safely sleep on cot or mat	(check all that apply) <input type="checkbox"/> Third trimester pregnancy <input type="checkbox"/> Patients requiring isolation <input type="checkbox"/> IV therapy <input type="checkbox"/> Bedridden and total care <input type="checkbox"/> Acute chest pain or shortness of breath <input type="checkbox"/> Renal dialysis <input type="checkbox"/> Ventilator patients <input type="checkbox"/> Hyperalimatin <input type="checkbox"/> Refusal to eat <input type="checkbox"/> Nonverbal <input type="checkbox"/> Nursing assistance required	<input type="checkbox"/> Staying at home <input type="checkbox"/> To any shelter <input type="checkbox"/> To special needs shelter (caregiver: _____) <input type="checkbox"/> Other (family, hotel, hospital) <input type="checkbox"/> Needs evacuation transport by: <input type="checkbox"/> Standard vehicle <input type="checkbox"/> Ambulance <input type="checkbox"/> Wheelchair lift OTHER CONCERNS: <input type="checkbox"/> Do not resuscitate order (DNRO) Location: _____ <input type="checkbox"/> Living will Location: _____ PETS: How many Pets? Number of Dog (s) _____ Number of Cat (s) _____ Other: _____ How many pet carriers? _____

Signature: _____ Date: _____

Dear Citizen,

The Be Ready Alliance Coordinating for Emergencies (BRACE) maintains a roster of persons with disabilities and those that are homebound who have unique needs that may necessitate requesting assistance during a disaster. In the event of a hurricane or other disaster, BRACE will attempt to provide support to those individuals through its partners to the extent they have capability. Please complete and sign the bottom of this application should you have a unique need that would cause you to be homebound during an emergency. With this signature, you give us permission to share your information with appropriate providers of services.

The information that you provide on the reverse side of this form will remain **confidential**. It will only be given to organizations associated with providing support to you while homebound during an emergency. Furthermore, this form pre-authorizes these same organizations to enter your home to provide those services post disaster.

It is strongly suggested that you pursue primary **evacuation plans** with family, friends, neighbors, church organizations, etc. We urge you to:

- Have a personal disaster plan to include evacuation as an option.
- Rely on local family members for your primary evacuation needs.
- Have your physician execute the necessary pre-admission procedures now if medical shelter is essential.

BRACE and its partners will provide food, water and other disaster relief supplies to registered individuals to the extent those resources are needed, available and support is available to deliver those resources. BRACE partner representatives making home visits will assess the status of homebound residents to the extent their training and expertise allow and will request the support of other partners to address unmet needs exceeding their capacity to provide assistance.

Please note that you will be responsible for all **costs** associated with medical transportation (ambulance) and medical shelter if required (ACLF, nursing home or hospital).

Due to the limited space available to safely shelter people with **special needs**, prior registration is required for those that need medical supervision of their care while in a shelter environment that exceeds the standard of care offered by general population shelters managed by the American Red Cross. If you expect to need medical supervision while sheltered, it is imperative that you contact the Escambia County Department of Public Safety at (850) 471 – 6400 to determine whether your condition makes you eligible for sheltering at the Special Needs Shelter. Additional information about the Special Needs Shelter registration process may be found on the Escambia County Public Safety website at <http://bereadyescambia.com/specialneeds.asp> .

Pets are not allowed in any type of evacuation shelter. Only service animals will be allowed in shelters. To ensure your pet's safety, arrangements for their evacuation should be made well in advance. Ask your veterinarian or local animal shelter about pet sheltering. Make sure that you have the following items on hand: current rabies and vaccination records, adequate food/water, and a properly tagged pet carrier for the caregivers of your pet(s).

I have read the information on this form and I understand the limitations on the services and level of care available. I understand that assistance will be provided only for the duration of the emergency and that alternative arrangements should be made in advance in the event I am not able to return to my home. I also understand that I will be responsible for any charges and/or costs associated with any hospital or medical facility care. I understand that this registration is voluntary and hereby request registration in the BRACE Homebound program.

I, the undersigned, give permission to (1) release the information on the reverse of this form to BRACE Partner organizations or other appropriate authority/entity for assistance with emergency needs in the event of a natural or manmade disaster/emergency. I also give BRACE and its partner organizations permission to (2) enter my home in case of a declared emergency.

Signature: _____ Print: _____

Witness: _____ Date: _____

Agency Name: _____ Phone: _____

Person completing form: _____

Additional comments: _____

Call the BRACE office at (850) 444 - 7135 for questions and information.

Or contact by email at brace@bereadyalliance.org