



## PEOPLE WITH SPECIAL NEEDS PROGRAM EMERGENCY EVACUATION ASSISTANCE

Volusia County Health Department  
121 West Rich Avenue, DeLand, FL 32720  
1-866-600-9416

[www.volusiahealth.com/SpecialNeeds.asp](http://www.volusiahealth.com/SpecialNeeds.asp)

### Applicant Instructions and Information



This program is designed to help meet the special needs of persons who would need assistance during evacuations and sheltering because of being elderly, physically, mentally or sensory disabled, visually or hearing impaired, or requiring oxygen.

### How to Register for the PSN Program

Complete **all** sections of the application. Indicate medical conditions, especially medical equipment requiring electricity, and any specialized transportation needs. **Continuous or adequate supply of electricity cannot be guaranteed** should your condition require this level of care. **Return only the application form** to Volusia County Health Department. Keep the instructions and information portion in a safe place. If more than one person in your household needs assistance during evacuations, each one **must complete** a separate application. **The applicant or responsible person (local family member, friend, legal guardian) must sign the registration form.**

Registration for this program is on a volunteer basis (except as referenced in F.S. 252.355). All information is confidential and only will be made available to other emergency response agencies when determined by the local emergency management director.

**PLEASE completely fill out the form to avoid it being returned for additional information.**

### Processing the PSN Application

Once your application has been received and processed, you will receive a letter acknowledging receipt of your registration and any special instructions. Read these instructions carefully and keep them in a safe place.

### How to Re-certify for the PSN Program

After you are registered, you will be notified every year to re-certify for this program. If any information on your original application changes before the annual re-certification, you will need to **resubmit an application**. To obtain a PSN application form, please contact the Volusia County Health Department. **Should at anytime you no longer need to be registered in the PSN program, please notify Volusia County Health Department in writing to remove you from the PSN registry.**

### How & Where to Get Assistance

If you need to evacuate, you should first seek shelter with relatives, friends, or hotels/motels. Emergency shelters are noisy, crowded, limited in space and accommodations, and only should be used as a last resort. Be prepared by planning ahead. **PSN shelters cannot accommodate an individual requiring 24-hour dedicated care, hospital bed or ventilator, needing other complex care (as determined by the Volusia County Health Department), or is an isolation patient. You must make other emergency shelter and transportation arrangements.** All costs associated with an evacuation, including (but not limited to) the transportation and admission to a hospital or another facility (medical or non-medical) are your responsibility. You should discuss your ongoing medical needs during a disaster with your physician, healthcare service providers, or caregiver **now** to make other emergency shelter/transportation arrangements.

The registry may be used for any emergency requiring evacuation, such as flooding, hurricanes, or hazardous material spills. **If possible**, Volusia County Emergency Management will attempt to make an evacuation call to those individuals who may be impacted by an event. Applicants should stay tuned to Volusia County's official emergency public information stations to get the latest information. Those stations are: **WCEU-TV 15** public television and Black Crow radio stations (**WNDB 1150 AM, WHOG 95.7 FM, US93 93.1 FM and WVYB 103.3 FM**).



The Volusia County Emergency Management Citizen's Information Center (CIC) will provide a variety of information ranging from evacuation procedures to shelter status. Votran will provide transportation to the emergency shelter. All regular Votran bus stops are hurricane evacuation assembly points. If you cannot reach a regular Votran bus stop, **you must call Votran to arrange for transportation**. Please **call Votran to cancel your pickup** should you decide not to use their service. This will save precious time during an emergency.

## Things to Remember or Consider

### You have decided to evacuate to a PSN Shelter – REMEMBER TO:

- Know where the PSN shelters are located.
- Have maps outlined for primary and alternate routes to travel to during the evacuation.
- Be accompanied by a caregiver if you require minor medical assistance, nursing care, or assistance with daily activities.
- Bring identification, money, important papers.
- Bring your medications and medical supplies.\*
- Bring clothing, toiletry items, flashlight and extra batteries.\*
- Bring a pillow and blanket or bedding.
- Bring your own oxygen supplies or arrange with your oxygen company to deliver your oxygen supplies to the shelter.\*
- Bring your own food if you are on a special diet, and any favorite snacks or comfort food.\*
- Contact your healthcare service provider and state where you will be during an emergency event.
- Notify family or friends where you will be during the emergency event.
- Bring “Time Occupier” (books, magazines, games, cards, etc.).
- Contact Votran if you need transportation to the shelter.
- Make plans for your pet(s) during a disaster.
- Contact Animal Services if you **need information on sheltering** your pet(s).



**NOTE:** It is difficult to predict how long an emergency event could last. It is recommended that you bring enough essential supplies (\*as listed above) for several days.

## Emergency Contact & Telephone Numbers

### Family Contact:

Name: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Evening: \_\_\_\_\_

Name: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Evening: \_\_\_\_\_

### Nearest Relative:

Name: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Evening: \_\_\_\_\_

### Local Contact:

Name: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Evening: \_\_\_\_\_

### Out-of-State:

Name: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Evening: \_\_\_\_\_

**Police:** \_\_\_\_\_ **Fire:** \_\_\_\_\_ **Hospital:** \_\_\_\_\_

**Other:** \_\_\_\_\_

### Physicians/Healthcare Service Providers:

Name & Telephone: \_\_\_\_\_

Name & Telephone: \_\_\_\_\_

### Volusia County Emergency Management:

Daytona Area (386) 258-4088, West Volusia Area: (386) 736-5980,  
Southeast Volusia Area: (386) 423-3395, TDD: (386) 248-1792

**Volusia County Citizen's Information Center Hotline: Toll Free (866) 345-0345 or (386) 254-4658, 736-5902, or 423-3358**

**CIC (TDD-Telecommunications Device for the Deaf) (386) 248-1792**

**Votran (transportation): (386) 322-5100, 943-7050, or 424-6810**

**Animal Services: (386) 248-1790, 740-5241, or 423-3369**

**Volusia County Health Department: 1-866-600-9416**

**Note: Call the CIC Hotline only during a disaster event.**

**KEEP THIS PAGE FOR YOUR INFORMATION**



# APPLICATION FORM FOR PEOPLE WITH SPECIAL NEEDS (PSN)

## EMERGENCY EVACUATION REGISTRY

(Please Clearly Print Information)



If you reside at a skilled nursing facility or assisted living facility, you do not need to register since the facility is required to have a comprehensive emergency management plan for evacuation. Registration for this program is on a volunteer basis (except as referenced in F.S. 252.355). All information is confidential and only will be made available to other emergency response agencies when determined by the local emergency management director.

### SECTION I. GENERAL INFORMATION

Do you plan on evacuating to a public PSN shelter? **Circle:** Yes or No (*Selection not made = NO answer*)

Name: \_\_\_\_\_ M\_\_\_\_ F\_\_\_\_  
Last First M.I. Date of birth Sex

Address: \_\_\_\_\_  
Street Apt. or Condo # City Zip Code

Mailing Address: \_\_\_\_\_  
(if different from above) Street Apt. or Condo # City Zip Code

Applicant's Telephone Number: (\_\_\_\_\_) \_\_\_\_\_

Please **circle** the one that applies: I live at the above address: Year-round Seasonal (Apr-Sept) Seasonal (Oct-Mar)

Please **circle** type of residence: House Manuf/Mobile Home Apartment Townhouse/Duplex Condominium

Name of Apartment Complex or Condominium: \_\_\_\_\_

Please **circle** the one that applies: I live at: Group Home ICF/DD Independent Living Facility Other

Name of Facility: \_\_\_\_\_

**Do you have a caregiver whose assistance is usually needed with activities of daily living and/or someone responsible for making decisions on your behalf?** **Circle:** Yes or No (*Selection not made = NO answer*)

**If yes**, complete the following information:

The person assisting me or responsible for making decisions on my behalf is: (**circle one**)

Spouse Family Member Friend Legal Guardian Caregiver (Aid/Attendant)

**Print** Name of Responsible Person: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Will the responsible person accompany you to a public shelter? **Circle:** Yes or No (*Selection not made = NO answer*)

Name of 2nd Contact Person (local) in case of emergency: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone Number of 2nd Contact Person: \_\_\_\_\_

Will the 2nd contact person accompany you to a public shelter? **Circle:** Yes or No (*Selection not made = NO answer*)

Please **circle** the provider(s) you receive service from: Hospice Home Health Agency Dialysis Center Other

Provide name and telephone number of agency providing service: \_\_\_\_\_

**SECTION II. MEDICAL INFORMATION SECTION**

|  |                             |
|--|-----------------------------|
| If any of the following applies to you, please <i>circle</i> . | If yes, provide more detail |
|--|-----------------------------|

- Yes Diabetes \_\_\_\_\_
- Yes Coronary Heart Disease \_\_\_\_\_
- Yes Alzheimer’s Disease \_\_\_\_\_
- Yes Bipolar Disorder \_\_\_\_\_
- Yes Allergies (Medications) \_\_\_\_\_
- Yes Allergies (Other) \_\_\_\_\_
- Yes Cancer (Type) \_\_\_\_\_
- Yes Vascular Disease \_\_\_\_\_
- Yes Hypertension \_\_\_\_\_
- Yes Pregnant (high risk or not) \_\_\_\_\_
- Yes Mentally Challenged \_\_\_\_\_
- Yes Physically Challenged \_\_\_\_\_
- Yes Dialysis (treatments per week) \_\_\_\_\_
- Yes Immune Disorder \_\_\_\_\_
- Yes Epilepsy \_\_\_\_\_
- Yes Tuberculosis \_\_\_\_\_
- Yes Paralyzed \_\_\_\_\_
- Yes Ventilator \_\_\_\_\_
- Yes 24 Hour Nursing Care \_\_\_\_\_

|   |
|---|
| If you have other medical conditions not listed above, please describe:<br><br><br> |
| List Medications:<br><br><br>   |
| List Medications needing refrigeration:<br><br><br>                                 |



## SECTION V. OTHER INFORMATION

I certify that this information is correct. I understand that based on this application and the data I have provided, Volusia County Health Department will determine which emergency evacuation assistance, if any, this program may be able to provide. I understand that assistance will only be provided 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.

The applicant or legal guardian will need to: (1) resubmit an application if any of the above information changes, or (2) notify Volusia County Health Department in writing to remove them from the PSN registry.

***I understand that:***

- ***PSN shelters cannot accommodate an individual requiring 24-hour dedicated care, hospital bed, ventilator, an isolation patient, or other complex care (as determined by the Volusia County Health Department).***
- ***I am responsible for making other emergency shelter and transportation arrangements.***
- ***I will be responsible for all charges and costs associated with an evacuation, including (but not limited to) the transportation and admission to a hospital or another facility (medical or non-medical).***

***I grant permission*** to disclose any information necessary to provide care or respond to my needs to other emergency response agencies.

|   |   |
|---|---|
| <b>If additional information or clarification is needed for processing this application, can Volusia County Health Department contact the "responsible person" designated on this form?</b> | <b>Circle</b> Yes    or    No<br><b>(Must Answer)</b> |
| <b>If necessary, can emergency response personnel enter your home during search and rescue operations to assure your safety and welfare following a disaster?</b>                           | <b>Circle</b> Yes    or    No<br><b>(Must Answer)</b> |

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Responsible Person: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Responsible Person: \_\_\_\_\_  
*(must match name on page one, section I)*

Complete all sections of the application and return to Volusia County Health Department. The applicant, caregiver, or responsible person must sign the registration form.

To avoid the application being returned for additional information, please ensure all sections have been completed. Please remember that **Selection not made = NO answer.**

**This form must be completed, signed and dated by applicant and responsible person (if applicable).**

Mail the form to:        Volusia County Health Department  
                                   121 West Rich Avenue  
                                   DeLand, Florida 32720