



MEDICAL SHELTER TOOLKIT

2013

Medical Needs Planning Toolkit Overview

Purpose:

1. Provide a reference tool for jurisdictions needing to plan for the evacuation, reception, sheltering and re-entry of individuals with Medical Needs.
2. Define overarching roles and responsibilities to assist local jurisdictions in planning for the evacuation, reception, sheltering and re-entry of individuals with Medical Needs.
3. Provide examples of tools, forms, operating guidelines, etc. for use by local jurisdictions planning for the evacuation, reception, sheltering and re-entry of individuals with Medical Needs.

Local jurisdictions are not mandated to use any of the examples noted in this document; however, local jurisdictions are encouraged to ensure that each aspect of the evacuation, reception, sheltering, and re-entry process is addressed appropriately.

Goals:

1. To ensure processes are in place for the evacuation of individuals with Medical Needs to pre-designated areas in a safe manner and on appropriate transportation.
2. To ensure that processes are in place for the reception of individuals with Medical Needs at pre-designated areas so that individual assessment and appropriate shelter assignments can be made.
3. To ensure that processes are in place for the temporary sheltering of individuals with Medical Needs ensuring a safe and appropriate setting that has the necessary infrastructure and support systems in place.
4. To ensure that processes are in place for the return of individuals with Medical Needs to their homes or long-term shelter locations in a safe manner utilizing appropriate transportation.

Assumptions:

1. Medical Needs evacuation, reception, sheltering and re-entry are local responsibilities.
2. Support from higher levels (regional, state and federal government) is requested through proper channels when exhaustion of local assets is projected.
3. Planning will take place at the local jurisdiction level in coordination with other agencies, and organizations, involved with the evacuation, reception, sheltering and re-entry of Medical Needs individuals.
4. Planning should take place in all jurisdictions to ensure that evacuation, reception, sheltering and re-entry processes are in place within a local jurisdiction.
5. Evacuation, reception, sheltering and re-entry of Medical Needs individuals are short-term requirements.

6. Services provided to individuals with Medical Needs during an emergency or disaster should be delivered, when practical, in an environment that can sustain pre-disaster levels of health.

Planning Responsibilities:

1. Local emergency management:

- a. Be the focal point of all planning activities.
- b. Ensure that processes are in place to provide a safe, orderly and coordinated evacuation, reception, sheltering and re-entry of individuals with Medical Needs.
- c. Ensure that planning activities are well-coordinated with other agencies, jurisdictions, organizations and others that are involved with the evacuation, reception, sheltering and re-entry of individuals with Medical Needs.
- d. Ensure that guidelines for all processes associated with evacuation, reception, sheltering and re-entry are written, coordinated and exercised.

2. Local Health Departments:

- a. Support local planning efforts.
- b. Provide health and medical guidance to planning partners in relation to health and medical issues related to the evacuation, reception, sheltering and re-entry of individuals with Medical Needs.
- c. Ensure that guidelines for all processes under their jurisdictional responsibility are written, coordinated and exercised.
- d. Coordinate with jurisdictions including planning, training and exercise in order to anticipate unmet needs and support requirements.

3. Health Service Regions:

- a. Jurisdictions without local health departments:
 - i. Support local planning efforts.
 - ii. Provide health and medical guidance to planning partners in relation to health and medical issues related to the evacuation, reception, sheltering and re-entry of individuals with Medical Needs.
 - iii. Ensure that guidelines for all health and medical processes under their jurisdictional responsibility are written, coordinated and exercised.
 - iv. Coordinate with jurisdictions including planning, training and exercise in order to anticipate unmet needs and support requirements.
- b. Jurisdictions with local health departments:
 - i. Provide health and medical guidance to local health department partners.
 - ii. Support local planning efforts related to the evacuation, reception, sheltering and re-entry of individuals with Medical Needs.

- iii. Coordinate with jurisdictions including planning, training and exercise in order to anticipate unmet needs and support requirements.

4. Department of State Health Services:

- a. Provide overarching guidance related to the evacuation, reception, sheltering and re-entry of individuals with Medical Needs.
- b. Support local, regional and state level planning efforts.
- c. Ensure that state level plans are written, coordinated and exercised.

DSHS MEDICAL NEEDS EVACUATION, RECEPTION, SHELTERING AND RE-ENTRY PLANNING CHECKLIST

The purpose of this checklist is to assist local Medical Shelter planning efforts, assess readiness and to identify areas where further planning may be needed. Optimally, this checklist should be completed with the input and cooperation of the local jurisdiction, the Local Health Department and the Health Service Region. This checklist may not address all planning activities. Jurisdictions should develop their plans based on the specific capacities and capabilities existing at the local level. The end goal is a plan for addressing the evacuation, receiving, sheltering and re-entry of individuals with medical needs in a timely, well-coordinated and safe manner. This checklist contains references to materials that can be incorporated into planning efforts in the event that the local jurisdiction has not already addressed an issue.

Part A - Identification of Locality and Representative (Point Of Contact)

| | | | | | |
|----------------------------------|------|--|-----|----------------|--|
| Locality (City or County) | | | | | |
| Name of Representative | | | | | |
| Title and/or Position | | | | Address | |
| Phone Number | Work | | Fax | | |
| LHD Representative | | | | Address | |
| | Work | | Fax | | |
| HSR Representative | | | | Address | |
| | Work | | Fax | | |

Part B – Planning Checklist

| | Activities | Yes | No | Resources |
|----------|---|-----|----|-----------|
| 1 | EVACUATION | | | |
| A | Does your jurisdiction have a written plan to address the evacuation of individuals with medical needs? | | | |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |

| | Activities | Yes | No | Resources |
|----------|---|-----|----|---|
| 1 | EVACUATION | | | |
| B | Does your jurisdiction have a process in place to identify individuals with medical needs prior to evacuation? | | | <p>▶ See Tab A - “Medical/Functional Needs Community Assessment/Intake Form”.</p> <p>▶ Also consider coordinating with your local 211.</p> |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| C | Does your jurisdiction have a process in place to mobilize transportation assets to assist with the evacuation of individuals with medical needs? | | | |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| D | Is your jurisdiction familiar with the process for requesting assistance and coordinating state provided transportation assets? | | | ▶ See Tab B - “Process for Requesting State Assistance” |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| E | Does your jurisdiction have a centralized location (embarkation site) for evacuees to gather? | | | ▶ See Tab C - “Embarkation Site and Reception Center Planning Considerations.” |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| F | Does your jurisdiction have security procedures in place at the embarkation site? | | | ▶ Coordinate with your local law enforcement officials. |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| G | Does your jurisdiction have a process in place to assess individuals with medical needs at the embarkation site? | | | ▶ See Tab A - “Medical/Functional Needs Community Assessment/Intake Form”. |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |

| | Activities | Yes | No | Resources |
|----------|--|-----|----|---|
| 1 | EVACUATION | | | |
| H | Has your jurisdiction assessed the capacity to recruit volunteers to assist with the assessment and loading of transportation assets? <i>Local Jurisdiction Notes/Comments:</i> | | | ▶ See Tab D – “Medical Shelter Volunteer Application” |
| I | Does your jurisdiction have a process in place to notify and recall volunteers? <i>Local Jurisdiction Notes/Comments:</i> | | | |
| J | Has your jurisdiction provided training to volunteers that are expected to work at an embarkation site? <i>Local Jurisdiction Notes/Comments:</i> | | | ▶ Training to volunteers should be geared towards local jurisdiction plans and reflect specific processes and systems to be used. |
| K | Does your jurisdiction have a process in place to assign medical needs evacuees to buses? <i>Local Jurisdiction Notes/Comments:</i> | | | ▶ See Tab E – “Evacuation Transport Guidelines/Triage Tool” |
| L | Does your jurisdiction have a process in place to track evacuees and develop a manifest? <i>Local Jurisdiction Notes/Comments:</i> | | | ▶ See Tab F - “Sample Medical Needs Evacuee Manifest” ▶ Also, if evacuated using State assets, the “Texas Emergency Tracking Network (TXETN)” will be used. ▶ See Tab G – “Texas Emergency Tracking Network (TXETN) Overview” |
| M | Does your jurisdiction have a process in place to ensure that a copy of the manifest for each bus is sent with the bus? <i>Local Jurisdiction Notes/Comments:</i> | | | ▶ Paper copies of manifests should be available in the event technical difficulties prevent access to electronic versions. |

| | Activities | Yes | No | Resources |
|----------|---|-----|----|--|
| 1 | EVACUATION | | | |
| N | Has your jurisdiction assessed the capacity to recruit medical volunteers (nurses/CNAs/LVNs/etc.) to assist and monitor individuals with medical needs during the evacuation bus ride? | | | ► See Tab D – “Medical Shelter Volunteer Application” |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| O | Does your jurisdiction have a process in place to notify and recall the medical volunteers? | | | |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| P | Has your jurisdiction provided training to volunteers that are expected to assist and monitor individuals with medical needs during the evacuation bus ride? | | | ► Training for volunteers should be geared towards local jurisdiction plans and reflect specific processes and systems to be used. |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| Q | Do the identified medical volunteers have equipment/kits available to them during the bus trip? | | | ► See Tab H - “Sample Medical Equipment Kit for Buses” |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| R | Does your jurisdiction have a process for the medical volunteers to do a more in-depth assessment during the evacuation to identify medical conditions that would impact shelter placement at the receiving jurisdiction? | | | ► See Tab A – “Medical/Functional Needs Community Assessment/Intake Form” |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| S | Has your jurisdiction arranged for snacks and water to be available to medical needs evacuees during the bus ride? | | | |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |

| | Activities | Yes | No | Resources |
|----------|--|-----|----|--|
| 1 | EVACUATION | | | |
| T | Does your jurisdiction have a process in place to ensure medications are available during the evacuation process? <i>Local Jurisdiction Notes/Comments:</i> | | | |
| U | Does your jurisdiction have a process in place to identify and label personal equipment (wheelchairs, oxygen tanks, etc.)? <i>Local Jurisdiction Notes/Comments:</i> | | | ► Equipment can be tracked on the Medical evacuee manifest. Also, the TXETN will track equipment that belongs to the evacuee. |
| V | Has your jurisdiction coordinated a process for tracking the location and expected arrival time of transportation assets with the receiving jurisdiction? <i>Local Jurisdiction Notes/Comments:</i> | | | ► Evacuating and receiving jurisdictions should coordinate departure and arrival times. |
| W | Does your jurisdiction have a process in place to address the transportation of pets during evacuation? <i>Local Jurisdiction Notes/Comments:</i> | | | ► Pets can be tracked on the Medical evacuee manifest. Also, the TXETN will track pets that belong to the evacuee. |
| X | Is your jurisdiction a point-to-point evacuating community? <i>If NO, refer to resources in question A.</i> <i>Local Jurisdiction Notes/Comments:</i> | | | ► For information on point-to-point, go to the following website: http://www.txdps.state.tx.us/dem/downloadableforms.htm |
| Y | Has your jurisdiction coordinated planning activities for the evacuation and reception of individuals with medical needs with the receiving jurisdiction? <i>Local Jurisdiction Notes/Comments:</i> | | | ► Point-to-point evacuation cities should coordinate planning issues/needs with the State Mass Care Coordinator. |

| | Activities | Yes | No | Resources |
|----------|--|-----|----|---|
| 2 | RECEPTION | | | |
| A | Does your jurisdiction have a written plan to address the reception of individuals with medical needs? | | | <ul style="list-style-type: none"> ▶ Medical evacuees may be arriving with wristbands. ▶ See Tab G – “Texas Emergency Tracking Network Overview” |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| B | Does your jurisdiction have a centralized location (reception center) for buses to arrive at? | | | ▶ See Tab C - “Embarkation Site and Reception Center Planning Considerations” |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| C | Does your jurisdiction have security procedures in place at the reception center? | | | ▶ Coordinate with your local law enforcement officials. |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| D | Does your jurisdiction have a process in place to assess individuals with medical needs at the reception center? | | | ▶ See Tab A - “Medical/Functional Needs Community Assessment/Intake Form” |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |

| | Activities | Yes | No | Resources |
|----------|--|-----|----|---|
| 2 | RECEPTION | | | |
| E | Has your jurisdiction assessed the capacity to recruit sufficient volunteers to assist with the assessment of individuals with medical needs at the reception center? <i>Local Jurisdiction Notes/Comments:</i> | | | ► See Tab D – “Medical Shelter Volunteer Application” |
| F | Does your jurisdiction have a process in place to notify and recall volunteers? <i>Local Jurisdiction Notes/Comments:</i> | | | |
| G | Has your jurisdiction provided training to volunteers that are expected to work at the reception center? <i>Local Jurisdiction Notes/Comments:</i> | | | ► Training to volunteers should be geared towards local jurisdiction plans and reflect specific processes and systems to be used. |
| H | Does your jurisdiction have designated medical needs shelters identified? <i>Local Jurisdiction Notes/Comments:</i> | | | |
| I | Does your jurisdiction have a process in place to assign medical needs evacuees to appropriate shelters? <i>Local Jurisdiction Notes/Comments:</i> | | | ► See Tab I – “Shelter Placement Guidance and Evacuee Release Form” |
| J | Does your jurisdiction have a process in place to assign and link medical needs clients with their caregiver/family members should they be placed in different shelters? If not, how many family members will be allowed to accompany the medical needs client? <i>Local Jurisdiction Notes/Comments:</i> | | | |

| | Activities | Yes | No | Resources |
|----------|---|-----|----|---|
| 2 | RECEPTION | | | |
| K | Does your jurisdiction have a process in place to ensure the availability of emergency medical services at the reception center? | | | ► Coordinate with your local EMS |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| L | Does your jurisdiction have a process in place to accept manifests from the buses and track evacuees? | | | ► See Tab F – “Sample Medical Needs Evacuation Manifest” |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| M | Has your jurisdiction identified alternate transportation assets to move medical needs patients, if necessary? | | | ► Assets could include buses, wheelchair accessible vehicles, church vans, etc. |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| N | Is your jurisdiction a point-to-point evacuation/sheltering community? <i>If NO, refer to resources in question A.</i> | | | ► For information on point-to-point, go to the following website: http://www.txdps.state.tx.us/dem/downloadableforms.htm |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| O | Has your jurisdiction undertaken planning activities to coordinate the receiving of individuals with medical needs with the sending jurisdiction? | | | ► Point-to-point evacuation cities should coordinate planning issues/needs with the State Mass Care Coordinator. |

| | Activities | Yes | No | Resources |
|----------|--|-----|----|---|
| 3 | SHELTERING | | | |
| A | Does your jurisdiction have a shelter manual/protocols in place for operation of the medical needs shelter? | | | ▶ See Tab J - "American with Disabilities Act (ADA) Checklist Guidance" |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| B | Does your jurisdiction have protocols (Standing Delegation Orders, Operating Guidelines, etc.) in place for the care of medical needs populations? | | | |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| C | Does your jurisdiction have a medical director assigned to each shelter? | | | ▶ Coordinate with a local hospital, clinic or other medical facility |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| D | Does your jurisdiction have security procedures in place at the shelter (i.e. for medical records and medications)? | | | ▶ Coordinate with your local law enforcement officials. |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| E | Does your jurisdiction have a process in place to report daily medical needs shelter census data to DSHS? | | | ▶ WebEOC is a useful tool, coordinate with Local Health Dept or Health Service Region |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| F | Does your jurisdiction have a process in place to monitor and report medical needs shelter illness/outbreak information to public health? | | | ▶ See Tab L - "Shelter Surveillance Summary Form, Situation Report and Instructions" |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |

| | Activities | Yes | No | Resources |
|----------|--|-----|----|--|
| 3 | SHELTERING | | | |
| G | Does your jurisdiction have a process in place to register medical needs patients at the shelter? | | | <ul style="list-style-type: none"> ▶ Some evacuees may be arriving with wristbands. ▶ See Tab G - "Texas Emergency Tracking Network (TXETN) Overview" ▶ See Tab A - "Medical/Functional Needs Community Assessment/Intake Form" |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| H | Does your jurisdiction have a process in place to do an expanded assessment of medical needs patients at the shelter? | | | ▶ See Tab A - "Medical/Functional Needs Community Assessment/Intake Form" |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| I | Does your jurisdiction have a medical record form to be used in the shelter? | | | ▶ See Tab O - "Medical Clinic Evaluation Form" |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| J | Does your jurisdiction have a process in place to track medical needs patients if they are moved to a nursing home, hospital or leave the shelter for other reasons? | | | |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| L | Does your jurisdiction have the supplies necessary to stand up and operate the medical needs shelter for a minimum of 3 days? | | | ▶ See Tab M - "Suggested Supply Cache for Medical Shelters" |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| M | Are the medical needs shelters aware of the procedures for requesting assistance with volunteers, supplies, equipment, etc.? | | | ▶ See Tab B - "Process for Requesting State Assistance" |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |

| | Activities | Yes | No | Resources |
|----------|--|-----|----|---|
| 3 | SHELTERING | | | |
| N | Does your jurisdiction have arrangements made for support services (laboratory, x-ray, respiratory therapy, dialysis, social services, laundry, waste disposal, etc) for the shelter? <i>Local Jurisdiction Notes/Comments:</i> | | | ► Coordinate with a local medical facility |
| O | Does your jurisdiction have a process in place to meet the dietary needs of medical needs patients at the shelter? <i>Local Jurisdiction Notes/Comments:</i> | | | ► Coordinate with your local hospital's dietician |
| P | Does your shelter have a process in place to address mental health and substance abuse issues? <i>Local Jurisdiction Notes/Comments:</i> | | | ► Mental Health: coordinate with local mental health authority. ► Substance Abuse: coordinate with local Outreach, Screening, Assessment and Referral Provider |
| Q | Does your jurisdiction have adequate volunteers to operate your medical needs shelters for a minimum of 3 days (24 hours a day)? <i>Local Jurisdiction Notes/Comments:</i> | | | ► See Tab N - "Recommended Shelter Staffing Profiles" |
| R | Does your jurisdiction have a process in place to notify and recall volunteers? <i>Local Jurisdiction Notes/Comments:</i> | | | |
| S | Has your jurisdiction provided training to volunteers that are expected to work in medical needs shelters? <i>Local Jurisdiction Notes/Comments:</i> | | | ► Training to volunteers should be geared towards local jurisdiction plans and reflect specific processes and systems to be used. |

| | Activities | Yes | No | Resources |
|----------|--|-----|----|-----------|
| 3 | SHELTERING | | | |
| T | Does the medical needs shelter have a back-up power source? <i>Local Jurisdiction Notes/Comments:</i> | | | |
| U | Has your jurisdiction ensured that redundant communication processes have been established so that MEDICAL Shelters can communicate with support systems? <i>Local Jurisdiction Notes/Comments:</i> | | | |
| V | Have your jurisdiction's planning efforts included collaboration with local organizations for assistance in MEDICAL sheltering? (For example, American Red Cross, Salvation Army, Medical Reserve Corps, faith based volunteer organizations, hospitals, nursing homes, pharmacies, county medical society, etc.) <i>Local Jurisdiction Notes/Comments:</i> | | | |

| | Activities | Yes | No | Resources |
|----------|---|-----|----|--|
| 4 | RE-ENTRY | | | |
| A | Does your jurisdiction have a process in place to assess the condition of the medical needs evacuees to ensure that they are medically stable for travel, to transport medical records with the client, and to determine the appropriate mode of transportation? <i>Local Jurisdiction Notes/Comments:</i> | | | <ul style="list-style-type: none"> ▶ See Tab A - “Medical/Functional Needs Community Assessment/Intake Form” ▶ See Tab E – “Evacuation Transport Guidelines/Triage Tool” |
| B | Does your jurisdiction have a process in place to ensure the evacuated jurisdiction has the necessary critical infrastructure (power, water, emergency medical services) available? <i>Local Jurisdiction Notes/Comments:</i> | | | ▶ See Tab S – “Support Capabilities & Jurisdictional Checklist for Re-Entry of Evacuated Persons with Disabilities & Medical Needs” |
| C | Does your jurisdiction have a process in place to ensure that medical needs evacuee’s residences are acceptable for habitation? <i>Local Jurisdiction Notes/Comments:</i> | | | ▶ See Tab A - “Medical/Functional Needs Community Assessment/Intake Form” |
| D | Is your jurisdiction familiar with the process for requesting assistance and coordinating state provided transportation assets? <i>Local Jurisdiction Notes/Comments:</i> | | | ▶ See Tab B – “Process for Requesting State Assistance” |

| | Activities | Yes | No | Resources |
|----------|--|-----|----|---|
| 4 | RE-ENTRY | | | |
| E | Does your jurisdiction have a process in place to compile and coordinate manifests? | | | |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| F | Does your jurisdiction have a process in place to ensure that personal equipment, luggage, etc. are loaded with the medical needs evacuee? | | | ► Equipment can be tracked on the manifest. Also, the TXETN will track equipment that belongs to the evacuee. |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| G | Does your jurisdiction have a process in place to ensure that water and snacks are available to medical needs evacuees during the return trip? | | | |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| H | Has your jurisdiction assessed the capacity to recruit sufficient volunteers to assist with the assessment and loading of transportation assets? | | | ► See Tab D – “Medical Shelter Volunteer Application” |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| I | Does your jurisdiction have a process in place to notify and recall volunteers? | | | |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |
| J | Has your jurisdiction provided training to volunteers that are expected to assist with the assessment and loading of transportation assets? | | | ► Training to volunteers should be geared towards local jurisdiction plans and reflect specific processes and systems to be used. |
| | <i>Local Jurisdiction Notes/Comments:</i> | | | |

| | Activities | Yes | No | Resources |
|----------|---|-----|----|---|
| 4 | RE-ENTRY | | | |
| K | Has your jurisdiction assessed the capacity to recruit medical volunteers (nurses/CNAs/LVNs/etc.) to assist and monitor individuals with medical needs during the evacuation bus ride? <i>Local Jurisdiction Notes/Comments:</i> | | | ► See Tab D – “Medical Shelter Volunteer Application” |
| L | Has your jurisdiction provided training to volunteers that are expected to assist and monitor individuals with medical needs during the re-entry bus ride? <i>Local Jurisdiction Notes/Comments:</i> | | | ► Training to volunteers should be geared towards local jurisdiction plans and reflect specific processes and systems to be used. |
| M | Do the identified medical volunteers have equipment/kits available to them during the bus trip? <i>Local Jurisdiction Notes/Comments:</i> | | | ► See Tab H - “Sample Medical Equipment Kit for Buses” |
| N | Has your jurisdiction arranged for snacks and water to be available to medical needs evacuees upon arrival at the destination? <i>Local Jurisdiction Notes/Comments:</i> | | | |
| O | Does your jurisdiction have a process in place to ensure medications are available during the evacuation process? <i>Local Jurisdiction Notes/Comments:</i> | | | |
| P | Does your jurisdiction have a process in place to identify and label personal equipment (wheelchairs, oxygen tanks, etc.)? <i>Local Jurisdiction Notes/Comments:</i> | | | ► Equipment can be tracked on the manifest. Also, the TXETN will track equipment that belongs to the evacuee. |

| | Activities | Yes | No | Resources |
|----------|--|-----|----|--|
| 4 | RE-ENTRY | | | |
| | | | | |
| Q | Has your jurisdiction coordinated a process for tracking the location and expected arrival time of transportation assets with the receiving jurisdiction? <i>Local Jurisdiction Notes/Comments:</i> | | | ► Sheltering and receiving jurisdictions should coordinate departure and arrival times. |
| R | Does your jurisdiction have a process in place to address the transportation of pets during re-entry? <i>Local Jurisdiction Notes/Comments:</i> | | | ► Pets can be tracked on the manifest. Also, the TXETN will track pets that belong to the evacuee. |
| S | Does your jurisdiction have a process in place to coordinate the re-entry of medical needs evacuees with family members that may be housed in other shelters? <i>Local Jurisdiction Notes/Comments:</i> | | | |
| T | Is your jurisdiction a point-to-point evacuation/sheltering community? <i>If NO, refer to resources in question A.</i> <i>Local Jurisdiction Notes/Comments:</i> | | | ► For information on point-to-point, go to the following website: http://www.txdps.state.tx.us/dem/downloadableforms.htm |
| U | Does your jurisdiction have a process in place to ensure coordination with the evacuated jurisdiction during re-entry? | | | ► Point-to-point evacuation cities should coordinate planning issues/needs with the State Mass Care Coordinator. |

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Tab A - Medical & Functional Needs Community Assessment/Intake Form

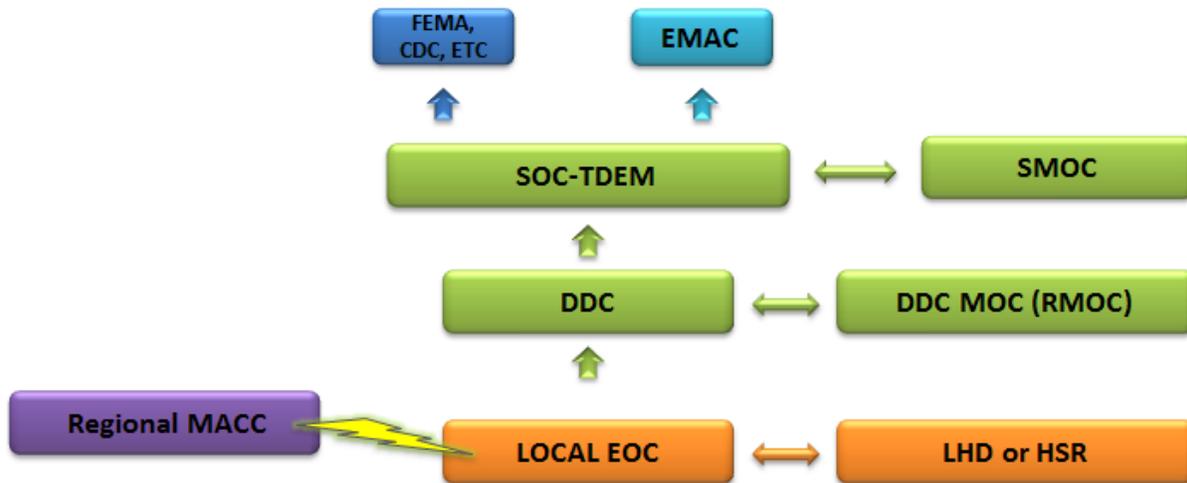
This form could be used by shelter personnel to determine the functional and access needs of the medical evacuee.

| | | | |
|--|-----|--|------|
| Mark as arrival / Check In <input type="checkbox"/> | | Accompanied by family Y/N | |
| Texas ETN# (if applicable): | | | |
| Name: | | | |
| Address: | | | |
| City: | | State: | Zip: |
| Phone Number: | | | |
| Date of birth: | | | |
| Language(s) Spoken: | | | |
| Emergency Contact: | | | |
| Relationship: | | Phone Number: | |
| -- BELOW: FUNCTIONAL/ACCESS/MEDICAL SERVICES ASSESSMENT | | | |
| ENSURE THAT ALL INDIVIDUALS UNDERSTAND THAT ANSWERING THE FOLLOWING QUESTIONS IS OPTIONAL. SELF DETERMINATION STILL APPLIES IN THIS SCENARIO. INDIVIDUALS MAY CHOOSE TO ANSWER ALL QUESTIONS, NO QUESTIONS OR SOME QUESTIONS. | | | |
| Name of person filling out form: | | Position of person filling out form: | |
| <i>Guest functional needs assessment:</i> | | | |
| <i>Are you a person who requires any of the following support services?</i> | | | |
| Communications Assistance Needed: | Y/N | Type of communications assistance needed: | |
| Durable Medical Equipment Needed: | Y/N | Type of DME needed: | |
| Electricity Dependent: | Y/N | Type of DME that requires electricity: | |
| Consumable Medical Supplies Needed: | Y/N | Type of CMS needed: | |
| Personal Assistance Services Needed: | Y/N | Needs assistance with: | |
| Specific Dietary Requirements: | Y/N | Dietary needs are: | |
| Service Animal User: | Y/N | Animal support needs: | |
| Deaf or Hard of Hearing: | Y/N | Type of hearing/communication assistance needed: | |
| Blind or Low Vision: | Y/N | Type of assistance needed: | |
| Other Functional or Access Need: | Y/N | Type of assistance needed: | |
| Other Functional or Access Need: | Y/N | Type of assistance needed: | |
| Other Functional or Access Need: | Y/N | Type of assistance needed: | |
| Other Functional or Access Need: | Y/N | Type of assistance needed: | |
| Caregiver Information; (If accompanying guest) | | | |
| Name: | | Relationship: | |
| Medical Condition: (circle one) Poor/Fair/Well | | Phone: | |

| Health Care History | | | |
|---|--|--|---|
| Ambulatory Status | | | |
| Ambulatory Status: | <input type="checkbox"/> No Limitations | <input type="checkbox"/> Walk – With Assistance (Walker/Cane/PAS) | <input type="checkbox"/> Mobility Device User Able to Transfer Y/N |
| <input type="checkbox"/> Confined to Bed | Specific Bed Requirements (if any): | | |
| Guest Healthcare Information | | | |
| Primary Doctor: | | Phone: | |
| Home Health Agency: | | Phone: | |
| Dialysis: | | Phone: | |
| Pharmacy: | | Phone: | |
| Hospice: | | Phone: | |
| Do you have Medicare/Medicaid/Insurance: | Y/N | Carrier: | |
| Do you have or have you had any of the following | | | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lesions/Pressure Sores | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Asthma/Emphysema |
| <input type="checkbox"/> Pulmonary Disease | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Incontinent | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Cardio Vascular Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Mental Health Illness | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Vascular Disorder | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> G-Tube/Feeding Tube | <input type="checkbox"/> Colostomy | <input type="checkbox"/> Dialysis/ESRD | <input type="checkbox"/> Oxygen Dependent |
| <input type="checkbox"/> Over 350 lbs | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> CVA/Stroke Survivor/TIA | <input type="checkbox"/> Other |
| <input type="checkbox"/> Other | <input type="checkbox"/> Other | <input type="checkbox"/> Other | <input type="checkbox"/> Other |
| Other Information | | | |
| <input type="checkbox"/> Have you recently waded through flood water? | | | |
| Current Medications: | | | |
| Do You Need Assistance With Taking Your Medications: | | | |
| Allergies (Food or Medicine): | | | |
| Current Triage Data: Vitals if Necessary: | | | |
| List of Equipment Brought to Shelter by Guest: | | | |
| Recommended Care: | | | |
| Additional Info: | | | |
| Physician/Nurse/Intake Coordinator Signature: | | Date & Time: | |
| Guest Signature: | | Date & Time: | |
| Check if guest has been discharged: | <input type="checkbox"/> | | |

TAB B – REQUEST FOR ASSISTANCE PROCESS

RESOURCE REQUEST PROCESS



1. All disasters are managed at the local level. Once local resources are exhausted and/or assistance is needed, the first step is to submit a resource request to the Disaster District Committee (DDC). The DDC is headed up by either a DPS Captain or Lieutenant. Note: Some regions have a Multi-Agency Coordination Center (MACC). If this is the case, locals should contact and determine if their MACC has the resource they need before submitting a request to the DDC.
2. The Health Service Region (HSR) coordinates all public health and medical for their region. There is usually an HSR representative co-located at the local EOC or DDC.
3. If the DDC can't fill the request, it goes to the State Operations Center (SOC). If it is a health and medical request, the ESF-8 desk forwards the request to the Department of State Health Services Medical Operations Center (SMOC). The SMOC is also in communication with the Health Service Region.
4. If the SOC can't fill the request, a request is made to the Federal Emergency Management Agency (FEMA) or the Centers for Disease Control and Prevention (CDC). Another route would be to request assistance through the Emergency Management Assistance Compact System (EMAC), or other forms of intrastate mutual aid.

TAB C - Embarkation Site/Reception Center Planning Considerations

During an evacuation the most efficient method of transporting people to a centralized embarkation point will likely include using vans and buses. Accessible buses and vans with wheelchair lifts will be needed to transport people who use wheelchairs, scooters, or other mobility aids. When they arrive at the embarkation site, an accessible drop-off area (also known as a passenger loading zone) is needed for people using mobility aids to get off of the bus or van and proceed to the point of embarkation or reception center.

Some individuals with a mobility disability may arrive at the reception center in a car or van. When parking areas are provided, these spaces must include accessible parking spaces. Individuals with disabilities who arrive at the embarkation site or reception center in their own car or van need to be able to park in an accessible parking space close to an accessible entrance. Accessible parking spaces need an adjacent access aisle that provides space for a person with a mobility disability to exit their vehicle. The access aisle connects directly to an accessible route that leads to an accessible building entrance. In order to be usable, the access aisle must be relatively level, clear of gravel or mud, and the surface must be in good condition without wide cracks or broken pavement.

An accessible drop-off area must have a level access aisle that is adjacent and parallel to the vehicle space. Where a curb separates the vehicle space from the access aisle or the access aisle from an accessible route, a curb ramp must be provided so people with mobility disabilities can get to the embarkation point from the reception center.

Sites should be located in an area that is easily accessible to evacuation routes and/or major road ways. This includes areas in which traffic can be rerouted with negligible impact on normal transportation, if possible.

Sites should have large parking/staging areas that can accommodate buses, ambulances, and paratransit vehicles.

Sites should have a building or shaded area large enough to accommodate the number of evacuees expected. Indoor areas offer more climate control (heat/air conditioning) and protection from the weather for the comfort and safety of both evacuees and volunteers/responders.

Sites should have electricity, running water and access to ADA accessible restrooms.

Potential Site Challenge: Parking at the shelter facility that has no accessible parking, not enough accessible parking, or accessible parking spaces are not on level ground.

Mitigation Steps: Find a fairly level parking area near the accessible entrance and mark the area for accessible parking spaces. Three regular parking spaces will make two accessible parking spaces with a shared access aisle. Provide a sign designating each accessible parking space. Ensure there is an accessible route from each access aisle to the accessible entrance. If temporary accessible spaces are used, mark the temporary accessible parking spaces with traffic cones or other temporary elements. Traffic cones can also be used to mark off an access aisle if designated accessible parking spaces lack an access aisle or if the access aisle is too narrow. At least one accessible parking space should be a van-accessible parking space with an access aisle that is at least 96 inches wide.

Tab D – Medical Shelter Volunteer Application

| Contact Information | |
|---------------------|--|
| Name | |
| Street Address | |
| City ST ZIP Code | |
| Home Phone | |
| Work Phone | |
| Mobile Phone | |
| Alternate Phone | |
| E-Mail Address | |

| Criminal Background | |
|--|-------|
| Have you been convicted of, or are you currently under indictment for, a felony? | Y / N |

| Availability | | |
|---|---|---|
| During which hours are you available for volunteer assignments? | | |
| <input type="checkbox"/> Weekday mornings | <input type="checkbox"/> Weekday afternoons | <input type="checkbox"/> Weekday evenings |
| <input type="checkbox"/> Weekend mornings | <input type="checkbox"/> Weekend afternoons | <input type="checkbox"/> Weekend evenings |

| Interests | |
|---|--------|
| Tell us in which areas you are interested in volunteering | |
| AREA: | NOTES: |
| <input type="checkbox"/> Administration | |
| <input type="checkbox"/> Registering Residents | |
| <input type="checkbox"/> Feeding/Kitchen | |
| <input type="checkbox"/> Security | |
| <input type="checkbox"/> Volunteer Recruiting | |
| <input type="checkbox"/> Medical Support <input type="checkbox"/> Shelter <input type="checkbox"/> During Transport | |
| <input type="checkbox"/> Custodial Support | |

Special Skills or Qualifications

Summarize special skills and qualifications you have. Include any medical experience or licensures.

| |
|--|
| |
|--|

Previous Sheltering Experience

Summarize any previous experience in shelters, disaster response, or working with people with medical needs.

| |
|--|
| |
|--|

Person to Notify in Case of Emergency

| | |
|------------------|--|
| Name | |
| Street Address | |
| City ST ZIP Code | |
| Home Phone | |
| Work Phone | |
| E-Mail Address | |

Agreement and Signature

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal.

| | |
|----------------|--|
| Name (printed) | |
| Signature | |
| Date | |

FOR OFFICE USE ONLY:

It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

Thank you for completing this application form and for your interest in volunteering with us.

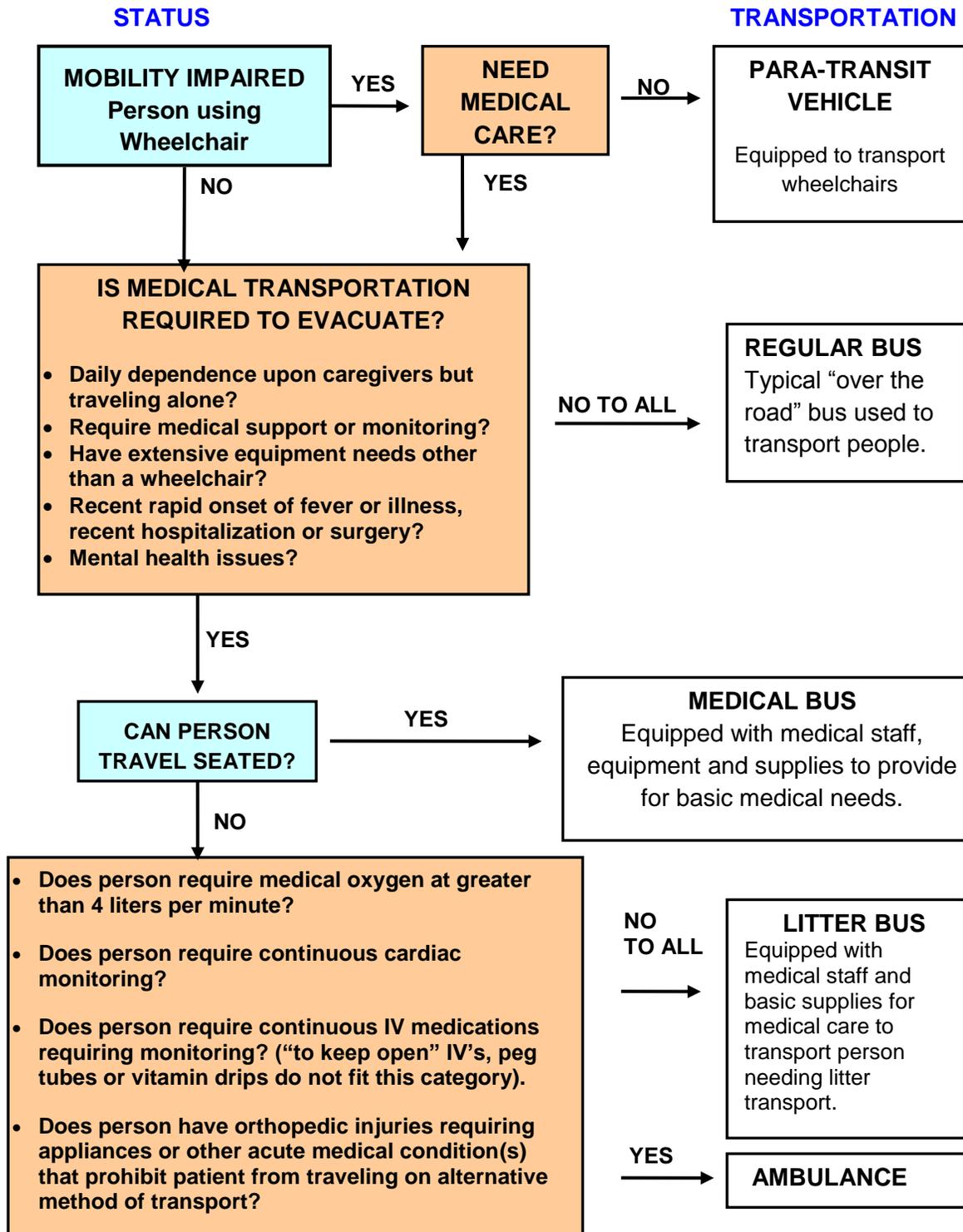
Tab E - Evacuation Transport Guidelines/Triage Tool

EVACUATION/ RE-ENTRY TRANSPORTATION ASSESSMENT/TRIAGE

**DOES THIS PERSON REQUIRE
EMERGENCY MEDICAL TREATMENT?**



911-HOSPITAL



TAB F SAMPLE Medical Needs Evacuee Manifest

"Event Name" Re-entry Log - "Medical Shelter Location"

Date

Time

| ARRIVAL | | | | RETURNING HOME | | | | | | | | | |
|---------|---|----------|-------------------------------|----------------|----------------------------|--|---------------------------------------|--|---|----------------|---|--------|-------------|
| | Evacuee Name (Last Name, First Name) | Location | Current Health Care Condition | Transit Number | Evacuee's Originating City | Name(s) of Accompanying Attendant/ Caregiver | If accompanied by Pets, Name and Type | Medical Supplies Needed During Return Trip | Does evacuee currently have medical supplies? | Transport Type | Names of Other Family Members Evacuated | Age(s) | Destination |
| 1 | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | |
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| 41 | | | | | | | | | | | | | |

Location Codes
 A - Example High School
 B - Example Civic Center
 C - Example Nursing Home

Medical Supply Codes
 WC - Wheelchair
 C - Cane
 O - Oxygen
 List Meds on form

Transport Codes
 B - Bus
 V - Van
 A - Ambulance
 P - Para Transit
 AIR - Air Transport

TAB G - TEXAS EMERGENCY TRACKING NETWORK (TXETN) OVERVIEW

WHAT IS THE TEXAS EMERGENCY TRACKING NETWORK (TXETN)?

Texas Emergency Tracking Network (TXETN) is a tracking system provided by the Texas Division of Emergency Management (TDEM). This unique tracking system enables jurisdictions to match each evacuee with a unique wristband prior to evacuation. The TXETN registration process allows the wristband to then be matched with wristbands assigned to those who may be traveling with the evacuee. Examples would include TXETN wristbands that link together children evacuating with parents, siblings evacuating with other family members and caregivers evacuating with individuals and families. The system is also capable of linking evacuees with pets and durable medical equipment (DME) such as wheelchairs, walkers and crutches.

TXETN wristbands utilize Radio Frequency Identification (RFID) technology and also traditional UPC barcodes to facilitate accurate data transfer during periods of high-volume evacuee traffic. At key points along the evacuee's journey, your jurisdiction can identify where an evacuee was last "seen" by the network. Evacuee enrollment information is securely stored in a database at the University of Texas Center for Space Research in Austin, Texas and can be accessed from the cloud by an authorized TXETN user or Texas State Guard personnel from any location with internet connectivity.

How can your jurisdiction participate in TXETN?

Any evacuating or sheltering jurisdiction may participate in the TXETN system by issuing an official request in writing through your regional DPS District Coordinator (DC).

What are the functions associated with participating in TXETN as a sheltering jurisdiction?

Sheltering jurisdictions who choose to utilize TXETN will participate in two primary ways:

1. To receive evacuees and scan them into state-supported shelters. This allows state officials and evacuating jurisdiction personnel to confirm safe arrival.
2. To assist with re-entry of evacuees by electronically manifesting them for their return trip home.

What does your jurisdiction need in order to participate?

At a minimum, your jurisdiction will need the following components in order to participate in the TXETN program:

- Laptop with USB attachable barcode reader
- Internet access
- Login access to the TXETN web interface (provided through Radiant RFID)
- State of Texas RFID wristbands and pet/medical asset tags
- Bus tags for any locally-provided buses (State-provided bus assets are pre-tagged with TXETN)
- Standard PC- or LAN-attached printer for printing of manifest documents
- Other miscellaneous items, as described below.

Optional components which your jurisdiction may use are:

- USB attachable magnetic stripe readers (MSR): MSRs speed the entry of enrollment data into the TXETN system by swiping a driver license or state-issued ID. Note: The MSR required must comply with TXETN program. Please contact Radiant to discuss specifications.
- Wireless Motorola handheld RFID scanners: These devices are highly effective when scanning evacuees onto buses so that rapid bus manifesting can be accomplished.

Homeland Security grants, if available, can be utilized to purchase TXETN components or web interface access.

What resources will the State of Texas provide for you?

Software: The State of Texas typically activates TXETN once a federal disaster declaration has been given. Once activated, the TXETN system is open for unlimited software license use by all jurisdictions.

Hardware: The State of Texas has TXETN assets (scanners, laptops, etc.) staged throughout the state. A request issued through a regional DPS District Coordinator will place your jurisdiction into a queue for allocation of TXETN equipment. The intent will be to process these requests on a priority basis and send or pre-deploy state-owned TXETN assets to geographical areas where evacuation needs are greatest. Sheltering jurisdictions will have access to Motorola Handheld Scanners with cellular connection to the TXETN database. It is important to work with the TXETN team to determine the number of scanners that may be available to your jurisdiction or region.

Wristbands and Pet/Medical Asset Tags: In order to promote a common wristband among all jurisdictions, the State of Texas will provide access to TXETN wristbands. Jurisdictions may also purchase TXETN wristbands in advance of an incident by issuing a written request through a regional DPS District Coordinator.

Please note: It is imperative to wristband evacuees with medical needs, as well as those with disabilities or functional and access needs. Hospitals and nursing homes requesting evacuation assistance should plan to have evacuees wrist banded prior to departure. ALL air evacuees should be enrolled and banded prior to leaving the jurisdiction.

Personnel: Several specialized units of the Texas State Guard have been trained in the use of the TXETN system. These teams can be requested to supplement local evacuation efforts by issuing a written request through a regional DPS District Coordinator. It is strongly recommended that your community prepare to begin TXETN enrollment independently and, if your community becomes overwhelmed by the evacuation response, Texas Military Forces (TMF) will attempt to provide equipment and personnel to assist in your local plan for TXETN enrollment and bus loading.

Can I use another shelter management system along with TXETN? How does WebEOC fit into the picture?

The intent of TXETN is tracking - not necessarily shelter management. The system will allow for shelter locations to be input into the system and evacuees can then be scanned into those shelter locations. Although shelters and receiving hospitals often want to store patient or evacuee data, the system is not designed for data sharing. Work is underway to create boards in WebEOC to allow for this functionality.

Early Start Issues:

Evacuating communities are well aware of the need to begin medical needs evacuations early – identifying evacuees well in advance. Because TXETN will not be activated by the State until a disaster is pending, communities are encouraged to consider purchasing software access which will allow them to work independently of any potential state response *prior to* a state/federal declaration.

Communities choosing to purchase TXETN access in the pre-incident setting will be able to utilize TXETN throughout the year for training, exercises and localized sheltering incidents. Communities choosing to wait will still have access to TXETN if/when the network activates the system. In these instances, use of hard copy TXETN intake forms should be retained so evacuee data can be entered when the system comes online.

Other items that will be necessary to your embarkation hub:

- Tables/chairs/cots for evacuees
- Stanchions or other ways to route people within the hub
- Electricity
- Internet (Wi-fi or wired depending on your laptop)
- Copies of the evacuation form for evacuees to fill it prior to enrollment (English and Spanish)
- Pens/pencils
- Zip ties for attaching pet/med tags

And Finally....

TXETN is a dynamic system which is being enhanced on an on-going basis. Please bookmark www.radiantrfid.com. This website will be an additional resource to you at the time of disaster to disseminate information.

Contact _____ at Radiant RFID with questions.

TAB H - SAMPLE MEDICAL EQUIPMENT KIT FOR BUSES

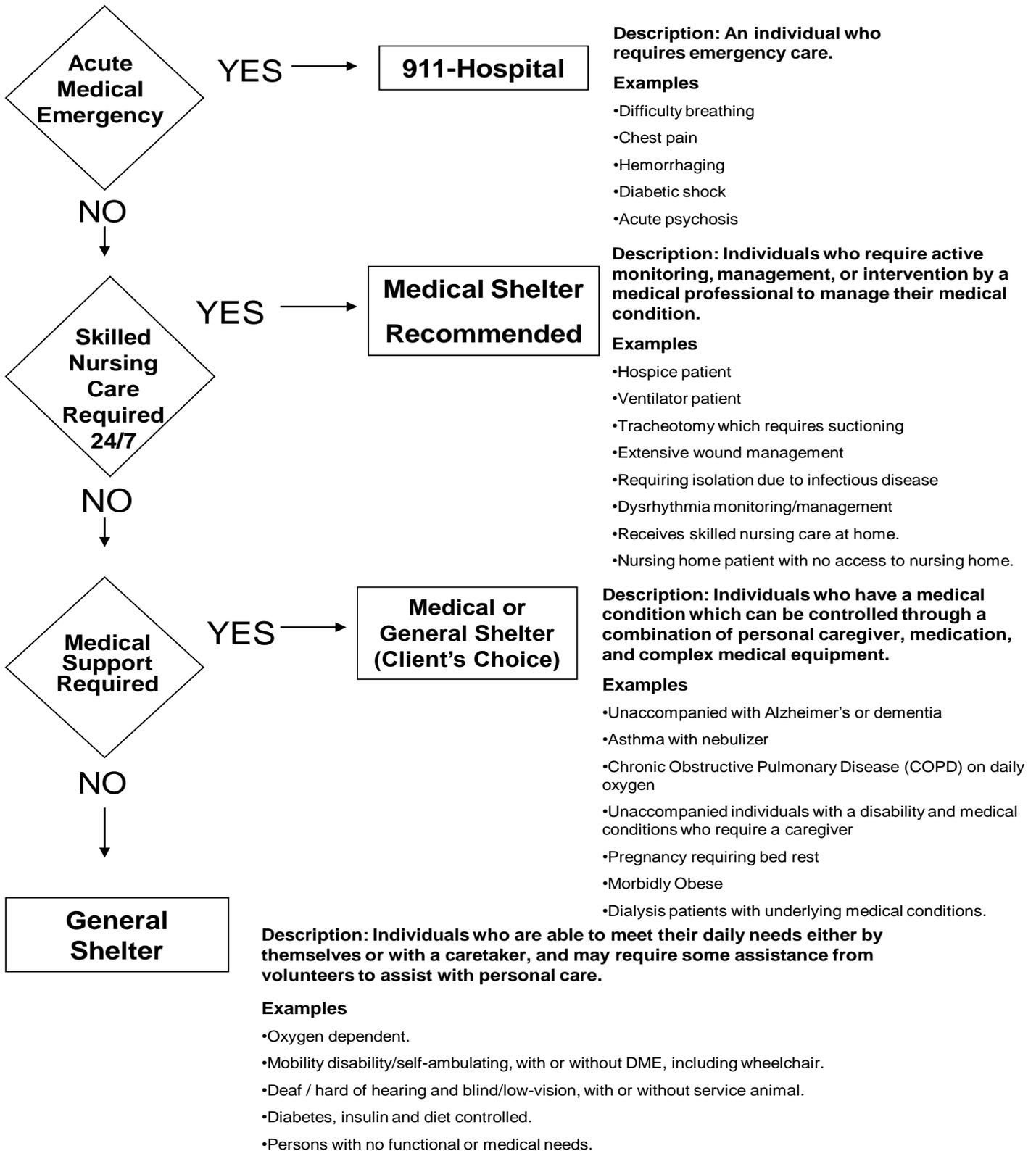
| MEDICATIONS | First-Aid/CPR Kit |
|--|---|
| Albuterol sulfate 0.083% 3 mL unit dose vial – 2 | For CPR emergencies for first responders. Kit includes bandages, CPR supplies, infection control products, et al. |
| Ammonia capsules – 2 | |
| Baby aspirin 81mg (chewable) tablets - 1 bottle | Bandages and Dressings |
| Calcium gluconate 10% 1 gram vials – 2 | · 1 - 5" x 9" ABD pad |
| Dextrose 50% for injection - 1 | · 10 - 3/4" x 3" adhesive strips |
| Diphenhydramine for injection – 2. | · 1 - 3/8oz. first-aid cream |
| Diphenhydramine PO 25 mg capsules – 5 capsules | · 2 - 2" Flexicon gauze rolls |
| Epinephrine 1:1000 1 mL ampule – 3 | · 2 - 3" Flexicon gauze rolls |
| Epinephrine 1:10:000 10 mL bristo-ject – 3 | · 2 - 4" Flexicon gauze rolls |
| Furosemide 40 mg vials – 3 | · 20 - 4" x 4" gauze pads |
| Ipratropium bromide 0.02% 2.5 mL unit dose vial – 2 | · 1 - triangular bandage |
| Methylprednisolone 125 mg act-o-vial – 1 | · 1 - first aid/CPR bag |
| Naloxone (1 mg/mL or 0.4 mg/mL concentration) – 2 | · 1 - bag mask |
| Nitroglycerin 0.4 mg SL tablets – 1 bottle | |
| Oral glucose - 1 tube | |
| Phenylephrine HCl, 0.25% for nasal instillation – 1 bottle | |
| Thiamine 100 mg – 1 | |
| Xylocaine topical jelly 2% – 2 tubes | |

PEDIATRIC TRAUMA KIT

| | |
|--------------------------------|------------------------------|
| · 6 pedi electrodes | · 10 Tempa Dot thermometers |
| · 1 pedi oxygen mask | · 2 triangle bandages |
| · 1 infant oxygen mask | · 3 conforming bandages (2") |
| · 1 child oxygen mask | · 20 gauze pads (4"x4") |
| · 1 disposable bag mask-infant | · 1 abdominal dressing |
| · 1 child airway | · 3 Dermicel tape (1/2") |
| · 1 small child airway | · 1 elastic bandage |
| · 1 infant airway | · 1 child BP cuff |
| · 10 alcohol prep pads | · 1 infant BP cuff |
| · 1 foil swaddler | · 1 newborn BP cuff |
| · 1 OB kit | · 1 stethoscope |
| · 5 cold packs | · 2 pair high-risk gloves |
| · 1 poison antidote kit | · 1 elastic bandage |
| · 1 burn sheet | |

Tab I - Shelter Placement Guidance and Evacuee Release Form

Shelter Placement Guidance



TAB J – ADA CHECKLIST GUIDANCE

ADA Best Practices Tool Kit for State and Local Governments

Chapter 7 Addendum 2:

The ADA and Emergency Shelters: Access for All in Emergencies and Disasters

One of the government's primary responsibilities is to protect residents and visitors. Providing emergency shelter during disasters and emergencies is a basic way of carrying out this duty. Shelters are sometimes operated by government entities themselves. More commonly, though, shelters are operated for the state or local government by a third party – often the American Red Cross. Regardless of who operates a shelter, the Americans with Disabilities Act (ADA) generally requires shelters to provide equal access to the many benefits that shelters provide, including safety, food, services, comfort, information, a place to sleep until it is safe to return home, and the support and assistance of family, friends, and neighbors.¹ In general, the ADA does not require any action that would result in a fundamental alteration in the nature of a service, program, or activity or that would impose undue financial and administrative burdens.² This Addendum discusses some of the key issues that emergency managers and shelter operators need to address in order to comply with the ADA when they plan for and provide shelter during emergencies and disasters. Although this Addendum focuses primarily on issues affecting shelter residents with disabilities, these medical issues are also generally applicable to volunteers and employees with disabilities.

A. Advance Planning

- **Equal access requires advance planning.** During emergencies and disasters, people with disabilities sometimes have different, disability-related needs than other individuals. Many of these needs cannot be met during emergencies and disasters without advance planning. For example, if a person's health will be jeopardized without access to life-sustaining medication that must be refrigerated; an emergency shelter will be of little use to him unless he has access to the required medication and a way to keep it sufficiently cold. Resources of this kind will likely be unavailable unless emergency managers and shelter operators arrange to have them available well before an emergency or disaster occurs.

To provide equal access to people with disabilities, effective advance planning requires at least two steps: (1) identify the disability-related needs of the residents and visitors likely to be housed in a shelter, and (2) make the advance arrangements necessary to meet those needs in the event an emergency or disaster strikes. The most effective way for emergency managers and shelter operators to ensure that advance planning addresses the needs of people with disabilities in their community is to involve community members with a wide variety of disabilities in the advance planning process. These individuals will be able to identify the types of disability-related needs that community residents and visitors are likely to have during emergencies as well as some of the community resources that may be available to help meet those needs.

To help in the advance planning process, the following sections of this Addendum identify some of the more common disability-related needs that shelter residents are likely to have. However, since people with different disabilities will typically have different needs, the issues addressed in this document are not exhaustive. Each community will have disability-related issues specific to its own residents and visitors that need to be identified and addressed. These issues are also

likely to change over time as residents move into and out of communities and as changes occur in the types of equipment, medication, and technology that people with disability use.

¹ 28 C.F.R. §§ 35.130, 35.149.

² 28 C.F.R. §§ 35.130(b)(7), 35.150(a)(3), 35.164.

B. Accessibility

- **Ensure that the sheltering program is accessible to people with disabilities.** Disasters and emergencies are unpredictable. Even the best emergency managers cannot say with certainty when an emergency will strike, how extensive the damage will be, and which shelters will remain available to house people who must evacuate their homes. For most people, any building designated as a shelter will meet their basic emergency needs so long as it provides a safe place to eat, sleep, and take care of personal hygiene needs. But an emergency shelter is of little use to a person using a wheelchair if it has steps at the entrance or toilet rooms she cannot use.

Under the ADA, emergency sheltering programs must not exclude or deny benefits to people with disabilities.³ Emergency managers and shelter operators should therefore seek to ensure that shelters are physically accessible to people with disabilities, including people who use wheelchairs. Before designating a facility as an emergency shelter, emergency managers and shelter operators need to determine if it is accessible. Elements such as a shelter's parking, walkway to the entrance, entrance, toilets, bathing facilities, drinking fountains, sleeping area, food distribution and dining quarters, first aid/medical unit, emergency notification system, and other activity and recreation areas need to be examined for barriers. Government facilities built since 1992 and private business facilities built since 1993 are often the best candidates for emergency shelters because they were subject to ADA requirements for physical accessibility when they were built.⁴ Some older facilities have been altered to provide physical accessibility⁵ or can be made physically accessible by using temporary measures stored on site and readily available for use in the event an emergency occurs. Other older facilities are poor candidates for emergency shelters because they have barriers that are too expensive or infeasible to remove. For guidance on emergency shelter accessibility, please see the Department of Justice's "ADA Checklist for Emergency Shelters" at www.ada.gov/pcatoolkit/chap7shelterchk.htm. The checklist includes two assessment tools to ensure that emergency shelters provide access to all: (1) a preliminary checklist that will help emergency managers and shelter operators decide if a facility has the characteristics that make it a good candidate for a potential emergency shelter, and (2) a more detailed checklist that will help identify and remove the most common barriers to physical accessibility.

Emergency managers and shelter operators need to ensure that sheltering programs are accessible to people with disabilities, including individuals who use wheelchairs.

³ 28 C.F.R. §§ 35.130, 35.149.

⁴ 28 C.F.R. § 35.151(a) (for public facilities); 28 C.F.R. § 36.406 (for private facilities that are subject to the requirements of Title III of the ADA because they are public accommodations or commercial facilities).

⁵ 28 C.F.R. § 35.151(b) (for public facilities); 28 C.F.R. §§ 36.402 - 36.405 (for private facilities that are subject to the requirements of Title III of the ADA because they are public accommodations or commercial facilities).

C. Eligibility Criteria

Shelters are usually divided into two categories: (1) “mass care” shelters, which serve the general population, and (2) “medical” shelters, which provide a heightened level of medical care for people who are medically fragile. Medical shelters are intended to house people who require the type and level of medical care that would ordinarily be provided by trained medical personnel in a nursing home or hospital.

- **House people with disabilities in mass care shelters.** Emergency managers and shelter operators sometimes wrongly assume that people need to be housed in medical shelters simply because they have a disability. But most people with disabilities are not medically fragile and do not require the type or level of medical care that medical shelters are intended to provide. The ADA requires people with disabilities to be accommodated in the most integrated setting appropriate to their needs,⁶ and the disability-related needs of people who are not medically fragile can typically be met in a mass care shelter. For this reason, people with disabilities should generally be housed with their families, friends, and neighbors in mass care shelters and not be diverted to medical needs or medical shelters.

To comply with the ADA’s integration requirement, emergency managers and shelter operators need to plan to house people with a variety of disabilities in mainstream mass care shelters, including those with disability related needs for some medical care, medication, equipment, and supportive services. Emergency managers and shelter operators must also ensure that eligibility criteria for mass care shelters do not unnecessarily screen out people with disabilities who are not medically fragile based on erroneous assumptions about the care and accommodations they require.

- **Respect the right of people with disabilities to make choices about where to shelter.** In some communities, emergency managers have designated shelters specifically for individuals with disabilities or individuals with a specific type of disability. For example, a community with a school for students who are deaf may designate that facility as an emergency shelter for people who are deaf. While the ADA does not prohibit offering these types of emergency shelters,⁷ it generally does prohibit emergency managers and shelter operators from requiring people with disabilities or people with a specific type of disability to stay in such shelters.⁸ The ADA requires emergency managers and shelter operators to accommodate people with disabilities in the most integrated setting appropriate to their needs, which is typically a mass care shelter.
- **House people with disabilities in mass care shelters even if they are not accompanied by their personal care aides.** Some people with disabilities use personal care assistance for activities of daily living, such as eating, dressing, routine health care, and personal hygiene needs. One question that frequently arises is whether people with disabilities who use attendant care can be appropriately housed in mass care shelters. In most instances, they can. Most people with disabilities who use attendant care are not medically fragile and do not require the heightened level of medical care provided in a medical shelter.

In the past, some shelter operators maintained policies that prevented people with disabilities who regularly use attendant care from entering mass care shelters unless they were accompanied by their own personal care attendants. These policies denied access to many people with disabilities.

During emergencies, many personal care attendants – like other people – evacuate or shelter with their own families instead of staying with their clients. Shelter operators should provide support services in mass care shelters to accommodate people with disabilities who are not medically fragile but need some assistance with daily living activities unless doing so would

impose an undue financial and administrative burden. Such assistance can be provided by medical personnel or trained volunteers.

Local governments and shelter operators may not make eligibility for mass care shelters dependent on a person's ability to bring his or her own personal care attendant.

- **Make arrangements in advance to ensure that medical shelters have sufficient numbers of adequately trained medical staff and volunteers.** Medical shelters house people with disabilities who require the heightened medical care that is ordinarily provided in nursing homes and hospitals. However, in the past, these shelters have often had too few qualified staff – or relied too heavily on volunteers with minimal training – to provide adequate care to the medically fragile people they house.

Advance planning is the only way emergency managers and shelter operators can secure enough trained medical personnel and adequately trained volunteers to ensure the safety and comfort of residents of medical shelters.

- **Keep families together whenever possible, even in medical shelters.** Family members provide each other the support and assistance necessary to cope with emergencies and disasters. During these difficult times, separation from family members increases loneliness, worry, and additional stress. But while most families have been able to stay together during emergencies, individuals with disabilities have often been unnecessarily separated from their families because many medical shelters do not allow them to be accompanied by more than one person.

In disasters and emergencies, people are ordinarily allowed to shelter with their families. This benefit needs to be available to persons with disabilities as it is for everyone else. Of course, some people in medical needs and medical shelters may need to be housed in medical wards apart from their families because of critical medical needs, but their families should still be housed nearby.

⁶ 28 C.F.R. § 35.130(d).

⁷ 28 C.F.R. § 35.130(b)(2) - (c).

⁸ 28 C.F.R. § 35.130(b)(2), (e)(1).

D. Reasonable Modifications

The ADA generally requires emergency managers and shelter operators to make reasonable modifications to policies, practices, and procedures when necessary to avoid discrimination.⁹ A reasonable modification must be made unless it would impose an undue financial and administrative burden.¹⁰ The following are examples of reasonable modifications that emergency managers and shelter operators will generally need to make:

- **Modify “no pets” policies to welcome people who use service animals.** Many emergency shelters do not allow residents or volunteers to bring their pets inside. But shelters must generally modify “no pets” policies to allow people with disabilities to be accompanied by their service animals.

A service animal is not a pet. Under the ADA, a service animal is any animal that is individually trained to provide assistance to a person with a disability. Most people are familiar with dogs that guide people who are blind or have low vision. But there are many other functions that service animals perform for people with a variety of disabilities. Examples include alerting people who are deaf or hard of hearing to sounds; pulling wheelchairs; carrying or retrieving items for people with mobility disabilities or limited use of arms or hands; assisting people with disabilities to maintain

their balance; and alerting people to, and protecting them during, medical events such as seizures.

How can a service animal be identified? Service animals come in all breeds and sizes. Many are easily identified because they wear medical harnesses, capes, vests, scarves, or patches. Others can be identified by the functions they perform for people whose disabilities cannot be readily observed. When none of these identifiers are present, shelter staff may ask only two questions to determine if an animal is a service animal: (1) "Do you need this animal because of a disability?" and (2) "What tasks or work has the animal been trained to perform?" If the answers to these questions reveal that the animal has been trained to work or perform tasks for a person with a disability, it qualifies as a service animal and must generally be allowed to accompany its owner anywhere other members of the public are allowed to go, including areas where food is served and most areas where medical care is provided. Questions about the nature or severity of a person's disability or ability to function may not be asked. It is also inappropriate to question a person's need for a service animal or to exclude a service animal on the grounds that shelter staff or volunteers can provide the assistance normally provided by the service animal.

- **Modify kitchen access policies for people with medical conditions that may require access to food.** Most shelter operators restrict residents' and volunteers' access to the kitchen to preserve food and beverage supplies and maintain efficient kitchen operations. But people with medical conditions such as diabetes may need immediate access to food to avoid serious health consequences. Shelter operators need to make reasonable modifications to kitchen policies so that residents and volunteers with disability-related needs can have access to food and beverages when needed.
- **Modify sleeping arrangements to meet disability-related needs.** To maximize efficiency, shelter operators typically provide one standard type of cot or mat for use by shelter residents. However, some people have disability-related needs for cots to be modified or may need to sleep on cots or beds instead of on mats placed on the floor. For example, a person with muscular dystrophy may require a cot with a very firm mattress to provide the physical support needed to facilitate breathing. Similarly, many people with mobility disabilities will be unable to use a sleeping mat placed on the floor. For example, many people using wheelchairs or scooters will be unable to safely transfer on and off a cot or bed unless it is firmly anchored so it does not move and has a firm sleeping surface that is 17 - 19 inches above the floor. Shelter operators need to establish procedures that people with disabilities can use to request reasonable modifications to sleeping arrangements.

⁹ 28 C.F.R. § 35.130(b)(7).

¹⁰ 28 C.F.R. § 35.130(b)(7).

E. Effective Communication

From the moment people begin to arrive at a shelter, good communication between staff, volunteers, and residents is essential. Many shelter residents and volunteers might have communication-related disabilities, including those who are deaf or hard of hearing and those who are blind or who have low vision. People with mental retardation or psychiatric disabilities might also have communication difficulties in certain circumstances, such as registering, filling out applications for benefits, or trying to understand what benefits and services are available.

Under the ADA, shelter operators must provide "effective communication" to people with disabilities unless doing so would result in a fundamental alteration or would impose undue financial and administrative burdens.¹¹ Shelters that are part of a state or local government sheltering program must give "primary consideration" to the type of auxiliary aid or service preferred by the person with a disability;¹² they must defer to that choice unless another equally effective method of communication is

available or the preferred method would impose an undue financial and administrative burden or fundamental alteration.¹³ This requirement applies even if a third party operates the shelter under an arrangement with the state or local government.

Advance planning is critical to ensuring effective communication during an emergency. Without such planning, it may be difficult or impossible to locate auxiliary aids and services and have them ready for use at the shelter. Advance planning will also alleviate the expense and burdens associated with providing auxiliary aids.

- **Provide alternate format materials for people who are blind or who have low vision.** People who are blind or have low vision may request documents and brochures in alternate formats (Braille, large print, or audio recording). Generally, shelter supplies should include alternate format versions of documents that are routinely made available to shelter residents. Having alternate formats available for distribution during an emergency requires advance planning.

When documents are prepared on the spot and alternate formats cannot be prepared in advance or produced as needed, shelter operators are still required to provide effective communication through alternate means.¹⁴ Often, the most effective solution in an emergency is to provide a person to read printed documents and, where applicable, someone to help fill out forms. People who serve as readers or provide assistance filling out forms must be “qualified” – in the context of an emergency shelter, this means being capable of and willing to read materials and complete forms as instructed by the person with a disability.

- **Ensure that audible information is made accessible to people who are deaf or hard of hearing.** In emergency shelters, most information is conveyed through oral announcements. Shelter operators must ensure that people who are deaf or hard of hearing have access to this information in a timely and accurate manner. In some circumstances, qualified sign language or oral interpreters may be required by the ADA. In others, posting messages and announcements in written format on a centrally located bulletin board, or writing notes back and forth with residents who are deaf or hard of hearing, may suffice.

The type of auxiliary aid or service required in a specific situation depends on several factors, including the length, complexity, and importance of the communication and the person’s language skills and history. For example, handwritten notes will not communicate information effectively to a person who cannot read. Similarly, providing a sign language interpreter will not be effective for a person who is hard of hearing and does not understand sign language. If it becomes an undue financial and administrative burden to obtain qualified sign language or oral interpreters at a shelter, then the ADA does not require them. However, advance planning can significantly reduce the costs and administrative burdens of making interpreters available.

- **Provide a TTY for the use of people who are deaf or hard of hearing.** Many people in shelters use telephones to apply for disaster relief benefits, arrange for transitional housing, and speak to family and friends. People who can use standard voice telephones typically make use of shelter telephones or cellular phones for this purpose. But without access to a teletypewriter (TTY), people who are deaf or hard of hearing and those who have speech disabilities are unable to communicate with others over the telephone.

¹¹ 28 C.F.R. § 35.160.

¹² 28 C.F.R. § 35.160(b)(2).

¹³ 28 C.F.R. § 35.164.

¹⁴ 28 C.F.R. § 35.164.

F. Shelter Environment

- **Offer orientation and wayfinding assistance to people who are blind or have low vision.** Until they become familiar with the shelter layout, blind people and those with low vision may have difficulty locating different areas of the shelter. Even after they are oriented to the shelter environment, changes in furniture layout or the addition or removal of cots may be disorienting to people who rely on these landmarks to find their way around. When they arrive at a shelter, people who are blind and those with low vision might need assistance orienting themselves to the shelter layout and locating pathways to sleeping areas, toilet rooms, and other areas of the shelter they may wish to use. Offer, but do not insist, on providing orientation and wayfinding assistance. Some people who are blind or have low vision need such assistance. Others can, and prefer to, find their own way.
- **Maintain accessible routes.** Cots and other furniture need to be placed to ensure that accessible routes – routes that people who use wheelchairs, crutches, or walkers can navigate – connect all features of the shelter. For instance, accessible routes need to connect the sleeping quarters to the food distribution and dining quarters, to the toilet rooms and bathing facilities, activity areas, etc. Generally, an accessible route is 36 inches wide, except at doors and for short distances, when it can be narrower, and where it turns, when it must be wider. More guidance on accessible routes is provided in the “ADA Checklist for Emergency Shelters” at www.ada.gov/pcatoolkit/chap7shelterchk.htm.
- **Eliminate protruding objects in areas where people can walk.** Furniture and other items should be positioned to direct pedestrians who are blind or have low vision safely away from overhead or protruding objects. This requirement extends beyond the “accessible route” and applies throughout the shelter environment to any place where a person can walk. Hazards posed by protruding and overhead objects can typically be eliminated by placing a cane-detectable barrier on the floor beneath or next to them. But care should be taken so cane-detectable barriers do not block accessible routes or the clear floor space that people using mobility devices need to access common protruding objects such as drinking fountains. For more guidance on protruding objects, please see the “ADA Checklist for Emergency Shelters” at www.ada.gov/pcatoolkit/chap7shelterchk.htm.
- **Consider low-stimulation “stress-relief zones.”** The stress from the noise and crowded conditions of a shelter – combined with the stress of the underlying emergency – may aggravate some disability-related conditions, such as autism, anxiety disorders, or migraine headaches. Without periodic access to a “quiet room” or quiet space within a larger room, some people with disabilities will be unable to function in a shelter environment. In locations where a school gym serves as the emergency shelter, a nearby classroom can provide the necessary relief from noise and interaction that some shelter residents and volunteers with disabilities will need. Other shelter residents and volunteers may want a break from the noise and crowds. But quiet spaces are limited, they should be made available on a priority basis to people whose disabilities are aggravated by stress or noise.
- **Consult residents with disabilities regarding placement of their cots.** Some individuals will have disability-related needs that require accommodation when assigning the location of their cot. For instance, a person who uses a wheelchair, crutches, or a walker may need a cot located close to an accessible toilet room. Since an assigned cot may not be identifiable by touch, a blind person may need a cot placed in a location that she can easily find. A person with low vision may need his bed located close to light so he can see or away from bright light that aggravates his eyes. Likewise, someone who is deaf or hard of hearing may need a cot placed away from visual distractions that would prevent him from sleeping.

G. Supplies

- **Provide an effective way for people to request and receive durable medical equipment and medication.** Despite advance planning, some people with disabilities will find themselves in shelters without a supply of the medications or medical equipment they need. For example, some medical insurance plans prohibit people from purchasing medication until their existing supply is almost gone. Other people may be required to evacuate without medication or medical equipment or be inadvertently separated from medication or medical equipment during evacuation. Emergency managers and shelter operators need to plan and make arrangements in advance so persons with disabilities can obtain emergency supplies of medications and equipment.
- **Whenever possible, provide refrigeration for certain types of medication.** Many people with disabilities need medication that must be refrigerated. Shelters need to have a safe and secure refrigerated location where medications can be stored and accessed when needed.
- **If electricity is available, give priority to people with disabilities who use ventilators, suctioning devices, and other life-sustaining equipment.** Some people with disabilities require ventilators, suctioning devices, or other life-sustaining equipment powered by electricity. Without electrical power, many of these individuals cannot survive. When electrical power is available, access should be given to people who depend on electrically powered equipment to survive.

Many people with disabilities depend on battery-powered wheelchairs and scooters for mobility. The batteries in these mobility aids must frequently be recharged, or they will stop functioning. Without these mobility aids, many people with disabilities will lose their ability to move about, they may be unable to participate in some services offered by the shelter, and they may need to depend more heavily on assistance from others. When possible, provide these individuals the opportunity to charge the batteries that power the equipment they use for mobility and independence.

- **Provide food options that allow people with dietary restrictions to eat.** Because of disabilities, some people are unable to eat certain types of food. For example, people with diabetes must restrict their intake of carbohydrates. Other people have severe allergies to common food ingredients, such as peanut oil and byproducts. In planning food supplies for shelters, emergency managers and shelter operators need to consider foods and beverages for people with common dietary restrictions.
- **Provide emergency supplies that enable people with disabilities to care for their service animals.** Many people with disabilities rely on service animals to do things they cannot do themselves. But when evacuating during an emergency, some individuals will be unable to transport enough food and water for their service animals. Shelter operators need to make food and water available so individuals can feed and care for their service animals. Shelter operators should also make reasonable modifications to security screening procedures so that people with disabilities are not repeatedly subjected to long waits at security checkpoints simply because they have taken their service animals outside for relief.

H. Transitions Back to the Community

- **Provide people with disabilities a reasonable amount of time and assistance to locate appropriate housing.** Shelters provide temporary refuge during and after an emergency until people can return home or arrange an alternative place to live. In some instances, shelter operators have required individuals with disabilities to move to hospitals, nursing homes, or other institutions when these individuals could not locate accessible housing or the supportive services they needed to live in their own home as quickly as other individuals. As a result, some people with disabilities who once lived independently in their own homes found themselves institutionalized soon after a disaster occurred.

The ADA generally requires people with disabilities to receive services in the most integrated setting appropriate to their needs unless doing so would result in a fundamental alteration in the nature of services or impose undue financial and administrative burdens.¹⁵ To comply with this requirement and assist people with disabilities in avoiding unnecessary institutionalization, emergency managers and shelter operators may need to modify policies to give some people with disabilities the time and assistance they need to locate new homes.

I. Other Resources

As discussed above, the ADA requires that people with disabilities have equal access to shelters and the benefits they provide. Providing equal access to people with different disabilities can involve very different issues. This document discusses a few of the most common issues and how they can be addressed. Other issues are addressed in Chapter 7 of the “ADA Best Practices Tool Kit for State and Local Governments,” “The ADA Guide for State and Local Governments: Making Emergency Preparedness and Response Programs Accessible to People with Disabilities,” the “ADA Checklist for Emergency Shelters,” and other technical assistance materials that are available on the Department of Justice’s ADA Home Page at www.ada.gov.

¹⁵ 28 C.F.R. § 35.130(d).

October 26, 2009

Tab K - Medical Shelter Facility Survey

This document could be used by the entity establishing the medical shelter to evaluate the shelters essential services provided and compliance to ADA requirements.

| | |
|-------------------------|---------------------------------|
| Site Name: _____ | Construction Date: _____ |
|-------------------------|---------------------------------|

1. General Facility Information

| | |
|--------------------------------------|---|
| Site Owner: _____ | |
| Street Address: _____ | |
| Owner Point of Contact: _____ | Primary #: _____ |
| | 24 Hr#: _____ |
| Email Address: _____ | |
| | |
| Facility Mgr Point of Contact: _____ | Primary #: _____ |
| | 24 Hr#: _____ |
| Email Address: _____ | |
| | |
| Facility Size: _____ | <i>Square feet (80 square feet per person minimum)</i> |
| Facility Maximum Capacity: _____ | <i>Guests (based on 80 square feet per person)</i> |
| One main area or series of areas: | <input type="checkbox"/> Main <input type="checkbox"/> Series <input type="checkbox"/> Both |
| Support rooms/areas available: | <input type="checkbox"/> Admin <input type="checkbox"/> Isolation <input type="checkbox"/> Other: _____ |

2. Essential Services

| | |
|--|--|
| Facility Type | |
| (church, civic center, gym, store, warehouse): _____ | |
| Fire Safety | |
| Does the facility have inspected fire extinguishers? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the facility have functional fire sprinklers? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the facility have a standpipe? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Location: _____ | |
| Does the facility have a fire alarm? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, choose one: <input type="checkbox"/> Manual (pull-down) <input type="checkbox"/> Automatic | |
| Does the fire alarm directly alert the fire department? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Supplemental Fire Plan Needed? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Utilities | |
| Electric Utility Provider: _____ | |
| Service Active: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emergency Generator on Site? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| IF YES - Capacity in kilowatts _____ | |
| Power for entire facility? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Power Transfer Switch? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Transfer Switch coverage for entire building including HVAC? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If answer is No , please specify: _____ | |
| HVAC type | <input type="checkbox"/> Electric <input type="checkbox"/> Natural Gas <input type="checkbox"/> Propane <input type="checkbox"/> Combination |
| Water Utility: | <input type="checkbox"/> Municipal <input type="checkbox"/> Well(s) <input type="checkbox"/> Trapped water |
| Service Active: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Waste Water Utility: | <input type="checkbox"/> Municipal <input type="checkbox"/> Septic <input type="checkbox"/> Other: _____ |
| Gas Utility: | <input type="checkbox"/> Municipal <input type="checkbox"/> Storage Tank |
| Gas Service Provider: _____ | |
| Service Active: | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Tab K - Medical Shelter Facility Survey

3. Support Resources & Equipment

| | | | |
|---|--|--|---|
| Number of AC outlets in sleeping area(s): _____ | | | |
| Outlets in sleeping area(s) on back-up power? _____ | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Telephone Line Access | Business phones available to facility staff? _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | How Many Lines: _____ | <input type="checkbox"/> Analog | <input type="checkbox"/> Digital |
| Data Line Access | Data ports available to facility staff? _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Approx. How Many Ports: _____ | | |
| | "WiFi" Internet Access Available? _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Laundry Facilities on Site? _____ | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Number of Washers: _____ | | Number of Dryers: _____ | |
| Kitchen Facility on Site? _____ | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kitchen Facility Available for Use? _____ | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Service Line Only | | <input type="checkbox"/> Residential Style | <input type="checkbox"/> Commercial Grade |

4. Sanitation Resources

Toilets

Number of Fixed Toilets: Men _____ Women _____ Unisex _____ ADA _____

Number of Portable Toilets Needed: Men _____ Women _____ ADA _____

Area for outdoor portables? _____ Yes No

Sinks

Number of Sinks Available: Men _____ Women _____ Stand Alone _____ ADA _____

Showers

Number of Fixed Shower Heads: Men _____ Women _____ Unisex _____ ADA _____

Portable Showers Needed: Men _____ Women _____ Unisex _____ ADA _____

Area for Outdoor Portables Facilities? _____ Yes No

Description of Area (for example, parking lot on north side): _____

Exterior Hose Spigots Available? _____ Yes No

Exterior Power Outlets (Number and Location): 110v _____ 220v _____

Comments: _____

Medical Shelter Facility Survey

5. Facility Floor Plan

| |
|---|
| REQUEST FACILITY FLOOR PLAN •••• sketch facility floor plan below if diagram unavailable •••• |
|---|

Survey Completed/Updated by:

| | | |
|----------------------------|-----------|----------------|
| _____ | _____ | _____ |
| Surveyor Printed Name | Signature | Date Completed |
| _____ | _____ | _____ |
| Local Contact Printed Name | Signature | Date Completed |

Medical Shelter Facility Survey

Facility Compliance Alternative Strategies:

Medical Shelter Facility Survey

ADA Secondary Site Inspection

A. Pull Up Area - Facility Approach

A1. Is a relatively level (1:50 or 2% maximum slope in all directions) access aisle provided adjacent and parallel to the side of the vehicle pull-up area? [ADA Standards § 4.6.6]

Yes No

A2. Is the vehicle **pull-up area** relatively level (1:50 or 2% maximum slope in all directions)?

Yes No

A3. Is the area for the access aisle at least 5-feet wide and 20-feet long? [ADA Standards § 4.6.6].

Yes No

A4. Is there vertical clearance of at least 114 inches (9 feet 6 inches) from the site entrance to the vehicle pull-up area, the access aisle, and along the vehicle route to the exit? [ADA Standards § 4.6.5]

Yes No

A5. Is a curb ramp provided between the vehicle pull up area and the access aisle (see above) or the access aisle and the accessible route to the accessible entrance? [ADA Standards § 4.6.6]

Yes No

A6. If a curb ramp is provided, is the running slope of the ramp surface (not counting the side flares) no more than 1:12 or 8.33%? [ADA Standards § 4.7.2]

Yes No

A7. Is the width of the curb ramp surface at least 36 inches (not counting the side flares)? [ADA Standards § 4.7.3]

Yes No

A8. Does an accessible route connect the curb ramp to the shelter's accessible entrance? [ADA Standards § 4.1.2(1)]

Yes No

B. Parking

B1. When parking areas are provided at the shelter site, count the total number of parking spaces provided in each area. Is the minimum number of accessible parking spaces provided, based on the total number of available parking spaces (see table below)?

Yes No

| Total Number of Parking Spaces in Each Parking Area | Required Minimum Number of Accessible Spaces |
|---|---|
| 01-25 | 1 van-accessible space w/min. 96-inch-wide access aisle (van space) |
| 26 - 50 | 1 space w/min. 60-inch-wide access aisle + 1 van space |
| 51 - 75 | 2 spaces w/min. 60-inch-wide access aisle + 1 van space |
| 76 - 100 | 3 spaces w/min. 60-inch-wide access aisle + 1 van space |
| 101 - 150 | 4 spaces w/min. 60-inch-wide access aisle + 1 van space |

B2. Does each accessible parking space have its own, or share, an adjacent access aisle that is least 60 inches (5 feet) wide? [ADA Standards § 4.6.3]

Yes No

B3. Is there at least one van-accessible parking space provided with an access aisle that is at least 96 inches (8 feet) wide or are universal parking spaces provided that are 132 inches (11 feet) wide for vehicle space with a 60-inch (5-foot) wide access

Yes No

B4. For van-accessible spaces (particularly in a garage or parking structure), is there vertical clearance of at least 98 inches (8 feet - 2 inches) for the vehicle route to the parking space, the access aisle, and along the vehicle route?

Yes No N/A No Parking Structure

B5. Are all accessible parking spaces, including the access aisle, relatively level (1:50 or 2%) in all directions? [ADA Standards § 4.6.3]

Yes No

B6. Does each accessible parking space have a sign with the symbol of accessibility that is visible when a vehicle is parked in the space? [ADA Standards § 4.6.4]

Yes No

B7. If there is a curb between the access aisle and the accessible route to the building, is there a curb ramp that meets the following requirements: [ADA Standards § 4.7]

Yes No

B7-a. Is the curb ramp surface at least 36 inches wide, excluding flared sides? [ADA Standards § 4.7.3]

Yes No

B7-b. Is the slope (up or down the ramp) no more than 1:12? [ADA Standards § 4.7.2]

Yes No

B8. Are the accessible parking spaces serving the shelter on the shortest accessible route to the accessible entrance? [ADA Standards § 4.6.2]

Yes No

B9. Does each access aisle connect to an accessible route from the parking area to the shelter's accessible entrance? [ADA Standards § 4.6.2]

Yes No

Medical Shelter Facility Survey

C. Sidewalks and Walkways

C1-a. Is an accessible route provided from accessible parking spaces to the accessible entrance of the shelter? [ADA Standards § 4.1.2(1), 4.3]

Yes No

C1-b. Is an accessible route provided from public sidewalks and public transportation stops on the shelter site (if provided) to the accessible entrance for the shelter? [ADA Standards § 4.1.2(1)]

Yes No

C1-c. Is the accessible route at least 36 inches wide? [ADA Standards § 4.3.3]

Yes No

C1-d. Is the accessible route free of steps and abrupt level changes higher than 1/2 inch? [ADA Standards § 4.3.8]

Yes No

C1-e. Where an accessible route crosses a curb, is a curb ramp provided? [ADA Standards § 4.3.8]

Yes No

e-i. Is the curb ramp surface at least 36 inches wide, excluding flared sides? [ADA Standards § 4.7.3]

Yes No

e-ii. Is the running slope (up or down the ramp) no more than 1:12? [ADA Standards § 4.7.2]

Yes No

C1-f. If the slope of part of the accessible route is more than 1:20, does it meet the following requirements for an accessible ramp?

Yes No NA – Not More than 1:20

f-i. Is the running slope no greater than 1:12? [ADA Standards § 4.8.2]

Yes No

f-ii. Are handrails installed on both sides of each ramp segment? [ADA Standards § 4.8.5]

Yes No

f-iii. Is the ramp width, measured between the handrails, at least 36 inches? [ADA Standards § 4.8.3]

Yes No

f-iv. Does the ramp have a level landing at the top and bottom of each ramp section that is at least 60 inches long? [ADA Standards § 4.8.4]

Yes No

f-v. If a ramp is more than 30 feet long, is a level landing at least 60 inches long provided at every 30 feet of horizontal length? [ADA Standards § 4.8.4]

Yes No

f-vi. Is there a level landing, at least 60 inches x 60 inches, when a ramp changes direction? [ADA Standards § 4.8.4]

Yes No

f-vii. Are the handrails mounted 34 to 38 inches above the ramp surface? [ADA Standards § 4.8.5]

Yes No

f-viii. If the ramp or landing has a vertical drop-off on either side, is edge protection provided? [ADA Standards § 4.8.7]

Yes No

C2-1. Are all sidewalks and walkways to the shelter free of any objects (e.g., wall-mounted boxes, signs, handrail extensions) with bottom edges that are between 27 inches and 80 inches above the walkway and that extend more than 4 inches into the sidewalk?

Yes No

C2-2. Are the undersides of exterior stairs enclosed or protected with a cane-detectable barrier so that people who are blind or have low vision will not hit their heads on the underside? [ADA Standards § 4.4.2]

Yes No NA – No exposed or exterior stair cases

C2-3. Are all objects that hang over the pedestrian routes at least 80 inches above the route? [ADA Standards § 4.4.2]

Yes No

Medical Shelter Facility Survey

D. Entering the Emergency Shelter

D1. Is there at least one accessible entrance connected to an accessible route? [ADA Standards § 4.1.3(1)]

- Yes No

D2. Does at least one door or one side of a double leaf-door provide at least 32 inches clear passage width when the door is open 90 degrees? [ADA Standards § 4.13.5]

- Yes No

D3. Is hardware (e.g., lever, pull, and panic bar) usable with one hand without tight grasping, pinching, or twisting of the wrist? [ADA Standards § 4.13.9]

- Yes No

D4. On the latch, pull side of the door, is there at least 18 inches clearance provided if the door is not automatic or power-operated? [ADA Standards § 4.13.6]

- Yes No

D5. If there is a raised threshold, is it no higher than 3/4 inch at the door and beveled on both sides? [ADA Standards §§ 4.1.6(3)(d)(ii), 4.13.8]

- Yes No

D6. If an entry has a vestibule, is there a 30-inch by 48-inch clear floor space inside the vestibule where a wheelchair or scooter user can be outside the swing of a hinged door? [ADA Standards § 4.13.7]

- Yes No NA – No vestibule

Medical Shelter Facility Survey

E. Hallways and Corridors

E1-a. Is there an accessible route, at least 36 inches wide, that connects the accessible entrance to all shelter areas (it may narrow to 32 inches wide for up to 2 feet in length)? [ADA Standards § 4.3.2(3)]

Yes No

E1-b. Is the accessible route free of steps and abrupt level changes over 1/2 inch?

Yes No

E1-c. Does the accessible route from the accessible entrance to all activity areas change levels using a ramp, lift or elevator? [ADA Standards §§ 4.1.3(1), 4.3.8]

Yes No

c-i. If Yes, is a ramp or sloped hallway provided?

Yes No

c-ii. Is an elevator or lift provided?

Yes No

E1-d. Where the slope of the accessible route is greater than 1:20, does this area meet the following requirements for an accessible ramp?

Yes No NA – Slope not greater than 1:20

d-i. Is the slope no greater than 1:12? [ADA Standards § 4.8.2]

Yes No

d-ii. Are handrails installed on both sides of each ramp segment? [ADA Standards § 4.8.5]

Yes No

d-iii. Is the ramp width, measured between handrails, at least 36 inches? [ADA Standards § 4.8.3]

Yes No

d-iv. Are the handrails mounted 34 to 38 inches above the ramp surface? [ADA Standards § 4.8.5]

Yes No

d-v. If a ramp is longer than 30 feet, is a level landing at least 60 inches long provided every 30 feet? [ADA Standards § 4.8.4]

Yes No

d-vi. Does the ramp have a level landing that is at least 60 inches long at the top and bottom of each ramp section or where the ramp changes direction? [ADA Standards § 4.8.4]

Yes No

d-vii. If the ramp or landing has a vertical drop-off on either side of the ramp, is edge protection provided? [ADA Standards § 4.8.7]

Yes No

E1-e. Is an elevator provided to each of the levels on which each sheltering service or activity area is located?

Yes No

e-i. Are the centerlines of the call buttons mounted 42 inches above the floor? [ADA Standards § 4.10.3]

Yes No

e-ii. Does the floor area of the elevator car have space to enter, reach the controls, and exit? [ADA Standards § 4.10.9]

Yes No

e-iii. Can the elevator be called and operated automatically without using a special key or having to turn on the elevator from a remote location? [ADA Standards § 4.10.2]

Yes No

e-iv. Are the highest floor control buttons mounted no more than 54 inches above the floor for a side reach or 48 inches for forward reach? [ADA Standards § 4.10.12 (3)]

Yes No

e-v. Are raised letters and Braille characters used to identify each floor button and each control? [ADA Standards § 4.10.12]

Yes No

e-vi. Are signs mounted on both sides of the elevator hoist way door opening (for each elevator and at each floor) that designate the floor with 2-inch minimum-height raised letters and Braille characters centered at 60 inches above the floor? [ADA Standards § 4.10.5]

Yes No

e-vii. Is the elevator equipped with audible tones, bells or verbal annunciators announcing each floor? [ADA Standards § 4.10.13]

Yes No

E1-f. If a wheelchair lift is provided, does it meet the following?

Yes No NA – No wheelchair lift present

Medical Shelter Facility Survey

f-i. Is the lift operational at the time of the survey? [ADA Standards § 4.11.3]

Yes No

f-ii. Is the change in level from the floor to the lift surface ramped or beveled? [ADA Standards §§ 4.11.2, 4.5.2]

Yes No

f-iii. Is there at least a 30-inch by 48-inch clear floor space on the wheelchair lift? [ADA Standards §§ 4.11.2, 4.2.4]

Yes No

f-iv. Does the lift allow a person using a mobility device unassisted entry, operation (is key available, if required), and exit?

Yes No

f-v. Are the controls and operating mechanisms mounted no more than 54 inches above the floor for a side reach or 48 inches for a forward reach? [ADA Standards §§ 4.11.2, 4.27.3]

Yes No

f-vi. Are the control mechanisms usable with one hand without tight grasping, pinching, or twisting? [ADA Standards §§ 4.11.2, 4.27.4]

Yes No

E1-g. At each location on the way to each shelter activity area where the accessible route passes through a door, does at least one door meet the following requirements?

Yes No

g-i. Is the clear width for the door opening 32 inches measured when the door is open 90 degrees? [ADA Standards §§ 4.1.3(7), 4.13.5]

Yes No

g-ii. Is the door hardware (e.g., lever, pull, push, panic bar) usable with one hand, without tight grasping, pinching, or twisting of the wrist, to allow people who may not be able to easily use one or both hands to fully operate the hardware? [ADA Standards § 4.13.9]

Yes No

g-iii. Is there clear maneuvering floor space in front of each accessible door and, on the pull side, is there at least 18 inches clear floor space beyond the latch side of the door? [ADA Standards § 4.13.6]

Yes No

g-iv. Is no more than 5 pounds force needed to push or pull open the door? [ADA Standards § 4.13.11 (2)(b)]

Yes No

g-v. If the answers to questions g-ii thru g-iv are No, can the door be propped open?

Yes No

E2-a. Are (proposed) pedestrian routes leading to or serving each service or activity area of the shelter free of objects that protrude from the side more than 4 inches into the route with the bottom of the object more than 27 inches above the floor? [ADA Standards § 4.4.1]

Yes No

E2-b. Are (proposed) pedestrian routes leading to or serving each of the service or activity areas free of overhead objects with the bottom edge lower than 80 inches above the floor? [ADA Standards § 4.4.2]

Yes No

E2-c. Are any interior stairs along these routes configured with a cane-detectable warning or a barrier that prevents travel into the area with less than an 80-inch high head clearance so that people who are blind or who have low vision cannot hit their heads on the underside or stair frame? [ADA Standards § 4.4.2]

Yes No

F. Check-In Areas

N/A

F1. Is there an accessible route that connects the accessible entrance to areas that are likely to be used to register people as they arrive at the shelter? [ADA Standards § 4.3]

Yes No

F2. If there is a built-in reception or other type of counter, does it have a section that is at least three feet long that is no higher than 36 inches above the floor or is there a nearby surface that is not higher than 36 inches above the floor? [ADA Standards § 7.2]

Yes No

Living at the Emergency Shelter

G. Sleeping Areas

G1. Is there an accessible route, at least 36 inches wide, that connects each sleeping area with other shelter activity areas?

Yes No

G2. Is the accessible route free of steps and abrupt level changes over 1/2 inch?

Yes No

Medical Shelter Facility Survey

H. Restrooms and Showers

H1. If a sign is provided at the toilet room entrance (e.g. Men, Women, Boys, Girls, etc.), is a sign with raised characters and Braille mounted on the wall adjacent to the latch? [ADA Standards § 4.30.6]

Yes No

H2. Does the door to the toilet room provide at least 32 inches clear passage width when the door is open 90 degrees? [ADA Standards § 4.13.5]

Yes No

H3. Is the hardware (e.g., lever, pull, panic bar) usable with one hand without tight grasping, pinching, or twisting of the wrist? [ADA Standards § 4.13.9]

Yes No

H4. On the pull side of the door, is there at least 18 inches clearance provided on the latch side if the door is not automatic or power-operated? [ADA Standards § 4.13.6]

Yes No

H5. If there is a raised threshold, is it no higher than 3/4 inch at the door and beveled on both sides? [ADA Standards §§ 4.1.6(3)(d)(ii), 4.13.8]

Yes No

H6. If the entry has a vestibule, is there a 30-inch by 48-inch clear floor space inside the vestibule where a wheelchair or scooter user can be outside the door swing? [ADA Standards § 4.13.7]

Yes No

H7. Inside the toilet room, is there an area where a person who uses a wheelchair or other mobility device can turn around - either at least 60-inch diameter circle or a "T"-shaped turn area? [ADA Standards §§ 4.22.3; 4.2.3]

Yes No

H8. If lavatories are provided, does at least one have at least a 29 inch high clearance under the front apron with the top of the rim no more than 34 inches above the floor? [ADA Standards § 4.19.2]

Yes No

H9. Are the drain and hot water pipes for this lavatory insulated or otherwise configured to protect against contact? [ADA Standards § 4.19.4]

Yes No

H10. Does lavatory have controls that operate easily with one hand, without tight grasping, pinching, or twisting of the wrist? [ADA Standards § 4.19.5]

Yes No

H11. If mirrors are provided, is the bottom of the reflecting surface for the mirror at this lavatory no higher than 40 inches above the floor or is a full length mirror provided? [ADA Standards § 4.19.6]

Yes No

H12. For at least one of each type of dispenser, receptacle, or equipment, is there clear floor space at least 30 inches wide x 48 inches long adjacent to the control or dispenser (positioned either parallel to the control or dispenser or in front of it)?

Yes No

H13. Is the operating control (switch, lever, button, or pull) of at least one of each type of dispenser or built-in equipment no higher than 54 inches above the floor (if there is clear floor space for a parallel approach) or 48 inches (if there is clear floor space for a parallel approach) or 48 inches (if there is clear floor space for a front approach)? [ADA Standards §§ 4.23.7; 4.27.3; 4.2.5]

Yes No

H14. Are all built-in dispensers, receptacles, or equipment mounted so the front does not extend more than 4 inches from the wall if the bottom edge is between 27 inches and 80 inches above the floor? [ADA Standards §§ 4.23.7; 4.27; 4.4.1]

Yes No

Medical Shelter Facility Survey

Toilet Stalls

H15. Is at least one wide toilet stall provided with out swinging door, side and rear grab bars, and clear space next to the toilet? [ADA Standards § 4.17]

Yes No

H16. Is the toilet stall at least 60 inches wide, 56 inches deep (wall mounted toilet) or 59 inches deep (floor mounted toilet)? [ADA Standards § 4.17.3]

Yes No

H17. Is at least 9 inches of toe clearance provided under the front wall and at least one side wall of the toilet stall? [ADA Standards § 4.17.4]

Yes No

H18. Is the centerline of the toilet 18 inches from the adjacent side wall? [ADA Standards § 4.16.2; 4.17.3]

Yes No

H19. Is the top of the toilet seat 17 inches to 19 inches above the floor? [ADA Standards § 4.16.3]

Yes No

H20. Is the flush valve located on the wide side adjacent to the lavatory or is an automatic flush valve provided? [ADA Standards § 4.16.5]

Yes No

H21. Is a horizontal grab bar at least 40 inches long securely mounted on the adjacent side wall 33 to 36 inches above the floor with one end no more than 12 inches from the back wall 33 to 36 inches above the floor? [ADA Standards § 4.16.4; 4.17.6]

Yes No

H22. Is a second horizontal grab bar at least 36 inches long securely mounted on the back wall with one end no more than 6 inches from the side wall 33 to 36 inches above the floor? [ADA Standards § 4.16.4; 4.17.6]

Yes No

H23. Is the door to the toilet stall located diagonally opposite, not directly in front of, the toilet or on the opposite side wall from the wall with the long grab bar? [ADA Standards § 4.17.3]

Yes No

H24. Unless the wide stall is located at the end of a row of toilet stalls, does the door to this wider stall open out? [ADA Standards § 4.17.3]

Yes No

H25. Is the clear width of the door at least 32 inches (measured between the face of the door and the edge of the opening) when the door is open 90 degrees? [ADA Standards § 4.13.5]

Yes No

H26. If there are 6 or more stalls in the restroom, is one of those stalls (in addition to the wider stall noted above) exactly 36 inches wide with an out swinging stall door that provides at least 32 inches of clear width? [ADA Standards § 4.22.4]

Yes No

H27. Does this 36-inch wide stall have horizontal grab bars on both of the side partitions that are at least 36 inches long and 33 to 36 inches above the floor? [ADA Standards § 4.22.4]

Yes No

Medical Shelter Facility Survey

H28. Is the surface of the toilet seat in this 36-inch-wide stall 17 to 19 inches above the floor? [ADA Standards §§ 4.16.3; 4.22.4]

Yes No

H29. If a coat hook is provided is it mounted no higher than 54 inches above the floor for a side approach or 48 inches above the floor for a front approach? [ADA Standards § 4.25.3]

Yes No

Medical Shelter Facility Survey

I. Single-User or "Family" Toilet Room

- I1. If a sign is provided at the toilet room entrance (e.g. Men, Women, Boys, Girls, etc.), is a sign with raised characters and Braille mounted on the wall adjacent to the latch side of the door and centered 60 inches above the floor? [ADA Standards § 4.1.3(16)(a)]
 Yes No
- I2. Does the door to the toilet room provide at least 32 inches clear passage width when the door is open 90 degrees? [ADA Standards § 4.13.5]
 Yes No
- I3. Is the hardware (e.g., lever, pull, etc.) usable with one hand without tight grasping, pinching, or twisting of the wrist? [ADA Standards § 4.13.9]
 Yes No
- I4. On the latch, pull side of the door, is there at least 18 inches clearance provided if the door is not automatic or power operated? [ADA Standards § 4.13.6]
 Yes No
- I5. If there is a raised threshold, is it no higher than 3/4 inch at the door and beveled on both sides? [ADA Standards §§ 4.1.6(3)(d)(ii); 4.13.8]
 Yes No
- I6. Inside the room is there an area for a person who uses a wheelchair to turn around - either a 60-inch diameter circle or a "T"-shaped turn area? [ADA Standards §§ 4.22.3; 4.2.3]
 Yes No
- I7. If the door swings into the room, does the door swing not overlap the required clear floor space for the toilet or lavatory? [ADA Standards §§ 4.22.2; 4.2.4.1]
 Yes No
- I8. Is there at least 18 inches between the center of the toilet and the side of the adjacent lavatory? [ADA Standards § 4.16.2]
 Yes No
- I9. Does the lavatory have at least a 29-inch-high clearance under the front edge and the top of the rim no more than 34 inches above the floor? [ADA Standards § 4.19.2]
 Yes No
- I10. Are the drain and hot water pipes for the lavatory insulated or otherwise configured to protect against contact? [ADA Standards § 4.19.4]
 Yes No
- I11. Does lavatory have controls that operate easily with one hand, without grasping, pinching, or twisting of the wrist? [ADA Standards § 4.19.5]
 Yes No
- I12. If a mirror is provided, is the bottom of the reflecting surface no higher than 40 inches above the floor or is a full length mirror provided? [ADA Standards § 4.19.6]
 Yes No
- I13. For each type of dispenser, receptacle, or equipment, is there clear floor space at least 30 inches wide x 48 inches long adjacent to the control or dispenser (positioned either parallel to the control or dispenser or in front of it)? [ADA Standards §§ 4.23.7; 4.27.2; 4.2.5]
 Yes No
- I14. Is the operating control (switch, lever, button, or pull) for each type of dispenser or built-in equipment no higher than 54 inches above the floor (if there is clear floor space for a parallel approach) or 48 inches (if there is clear floor space for a parallel approach) or 48 inches (if there is clear floor space for a front approach)? [ADA Standards §§ 4.23.7; 4.27.3; 4.2.5]
 Yes No
- I15. Are all built-in dispensers, receptacles, or equipment mounted so the front does not extend more than 4 inches from the wall if the bottom edge is between 27 inches and 80 inches above the floor? [ADA Standards §§ 4.23.7; 4.27; 4.4.1]
 Yes No
- I16. Is the centerline of the toilet 18 inches from the adjacent side wall? [ADA Standards §§ 4.16.2; 4.17.3]
 Yes No
- I17. Is the top of the toilet seat 17 to 19 inches above the floor? [ADA Standards § 4.16.3]
 Yes No
- I18. Is the flush valve located on the side adjacent to the lavatory? [ADA Standards § 4.16.5]
 Yes No
- I19. Is a horizontal grab bar at least 40 inches long securely mounted on the adjacent side wall 33 to 36 inches above the floor with one end no more than 12 inches from the back wall? [ADA Standards §§ 4.16.4; 4.17.6]
 Yes No
- I20. Is there a horizontal grab bar at least 36 inches long securely mounted behind the toilet 33 to 36 inches above the floor with one end no more than 6 inches from the side wall? [ADA Standards §§ 4.16.4; 4.17.6]
 Yes No
- I21. If a coat hook is provided, is it mounted no higher than 54 inches above the floor for a side approach or 48 inches above the floor for a front approach? [ADA Standards § 4.25.3]
 Yes No

J. Drinking Fountains

J1. If the drinking fountain is a wall-mounted unit, is there clear floor space at least 30 inches wide (36 inches if it is in an alcove) x 48 inches long in front of the drinking fountain and at least 27 inches high under the fountain so that a person using a wheelchair can get close to the spout and controls? [ADA Standards § 4.15.5 (1)]

Yes No

J2. If the drinking fountain is a floor-mounted unit, is there clear floor space at least 30 inches long x 48 inches wide (60 inches if it is in an alcove) for a side approach to the drinking fountain so that a person using a wheelchair can get close to the spout and controls even though the fountain has no clear space under it? [ADA Standards § 4.15.5 (2)]

Yes No

J3. Is the top of the spout no higher than 36 inches above the floor and at the front of the fountain or water cooler? [ADA Standards § 4.15.2]

Yes No

J4. Does the water rise at least 4 inches high when no more than 5 pounds of force is applied to the controls of the fountain? [ADA Standards §§ 4.15.3 and 4.15.4]

Yes No

J5. Are the controls on or near the front of the unit and do they operate with one hand without tight grasping, pinching, or twisting of the wrist? [ADA Standards § 4.15.4]

Yes No

J6. Is the bottom of the apron of the fountain 27 inches above the floor so that it provides the space needed for a person who uses a wheelchair to pull up under it but is not a hazard to people who are blind or have low vision and use a cane to detect hazards? [ADA Standards §§ 4.15.5 (1) and 4.4.1]

Yes No

K. Eating Areas

N/A

K1. Is there an accessible route, at least 36 inches wide, that connects each of the shelter activity areas with the food service and eating areas (it may narrow to 32 inches wide for up to 2 feet in length)? [ADA Standards § 4.3.2(3)]

Yes No

K2. Is there an accessible route that is at least 36 inches wide that connects accessible tables with serving, condiment, and dispenser areas? [ADA Standards § 5.3; 4.3.8]

Yes No

K3. In each eating area, if tables with fixed seats are provided, do at least 5% of each type of table with fixed seats have accessible locations with knee space at least 27 inches high, at least 19 inches deep, and at least 30 inches wide with a table top 28 to 34 inches above the floor? [ADA Standards § 5.1]

Yes No

K4. If built-in food, drink, condiment, and tableware dispensers are provided, are dispensers and operating controls mounted no higher than 54 inches above the floor if clear floor space is provided for a side approach? [ADA Standards § 5.5]

Yes No

K5. If the operating controls are set back 10 to 24 inches from the front edge of the counter or table are they no higher than 46 inches above the floor? [ADA Standards § 5.5]

Yes No

K6. If food service lines are provided, is an accessible route provided (at least 36 inches wide) and are the tray slides no higher than 34 inches above the floor? [ADA Standards § 5.5]

Yes No

Other Issues

L. Availability of Electrical Power

L1. Is there a backup source of electrical power for the facility?

Yes No

L2. Is there a refrigerator or other equipment, such as coolers with a good supply of ice, at the shelter?

Yes No

M. Health Units/Medical Care Areas

M1. Is there an accessible route, at least 36 inches wide, that connects each of the shelter activity areas with the health units and medical care areas (it may narrow to 32 inches wide for up to 2 feet in length)? [ADA Standards § 4.3.2(3)]

Yes No

Medical Shelter Facility Survey

N. Public Telephones

N1. If at least one public telephone or one bank of telephones is provided, does at least one of each type of telephone have the following?

Yes No

N1a. For a side approach (clear floor space is at least 30 inches long x 48 inches wide), is the coin slot no higher than 54 inches above the floor? [ADA Standards § 4.31.2]

Yes No

N1b. For a front approach (where clear floor space is at least 30 inches wide x 48 inches long), is the coin slot no higher than 48 inches above the floor? [ADA Standards § 4.31.2]

Yes No

N2. Does the phone have volume controls? [ADA Standards § 4.31.5]

Yes No

N3. If 3 or more phones are located in 1 bank serving the shelter, are a shelf and an electrical outlet provided at one telephone for use of a portable TTY? [ADA Standards § 4.31.9 (2)]

Yes No

N4. If four or more pay telephones are provided on the site, is there a TTY (text telephone) provided at the shelter?

Yes No

If yes, location _____

N5. Is there a sign at each pay phone or pay phone bank for the shelter directing people to the nearest TTY? [ADA Standards § 4.30.7 (3); 4.31.9(3)]

Yes No

Medical Shelter Facility Survey

NOTES:

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TAB L - Shelter Surveillance Summary Form, Situational Report and Instructions

Each shelter should fill out the form daily and fax it by 9:00 AM to your local health department at _____. If you do not have access to a fax machine, call your local health department at _____ with the information. Your local health department will forward this information to the state health department to monitor health status locally and statewide.

Directions:

1. If there is a medical emergency at your shelter, **IMMEDIATELY CALL 911.**
2. Please provide the number of people in your shelter. Make sure that you report the number of people in your shelter in the 24 hour reporting period. Please provide the number of people in your shelter that appear to be less than 7 years of age.
3. The number of persons who had a health complaint and counted in the Symptom/Condition sections of this report should be entered "**This report represents a total number of _____ ill persons**" on the form.
4. Please count the total number of people with each condition; one person may have multiple conditions. For example, a person who has been vomiting and has pink eye would be counted on each of those lines.
5. Please complete each section of the form. If there are no people complaining of a particular condition, please put in a zero for that line.
6. At the bottom of the page, please note if you have additional public health comments or concerns.
7. If you have any questions, please call your local health department for assistance.

***Note:** This form and the information reported back to the health department is only used to assess general health status. It is NOT used to request supplies, materials, staff, or transportation. Contact your local emergency management office.

Refer to the Forms and Reports on the following pages.



Shelter Surveillance Summary Form

Address for Local Health Department: _____ **Phone:** _____ **Fax Daily by 9:00 AM to:** _____

Reporting Person: Name: _____ **Title:** _____

Shelter/Reporting Facility/Address: _____

Shelter Phone #: _____ **Shelter Fax #:** _____

For the past 24 hour reporting period: Time/Date _____ **to** _____ **how many people were here?** _____
 (Taken at _____ AM PM)

Of these, how many appear less than 7 years of age? _____

This report represents a total number of _____ ill persons.

| Symptom/Condition Category | Total Number of Individuals with Complaint Within the Last 24 Hours |
|---|---|
| <i>Section 1. Infections and Disease Potential</i> | |
| Fever (temp > 100°F) or feverishness WITHOUT diarrhea, vomiting, sore throat, coughing | |
| Diarrhea | |
| Of those above with diarrhea, how many had fever? | |
| Vomiting | |
| Coughing, difficulty with breathing, sore throat (not chronic conditions, smoker's cough) without fever | |
| Fever (temp > 100°F) or feverishness AND either cough or sore throat or both | |
| Of those with respiratory symptoms above, how many had fever? | |
| Sores, boils, draining wounds, serious skin rash, blisters | |
| Of those with rash, how many had fever? | |
| Scabies, Lice, or other infestation or ringworm or fungal infections | |
| Jaundice (yellowing of the skin or eyes) | |
| Conjunctivitis (Pink Eye) | |
| Severe headache and stiff neck and fever | |
| <i>Section 2. Injury/Other</i> | |
| Self-Inflicted Injury | |
| Assault-related Injury | |
| Accidents | |
| Heat-related injury or dehydration (not due to diarrhea) | |

Total # of individuals referred to a medical facility for any medical concerns within the past 24 hours?: _____

Have any deaths occurred in your shelter within the past 24 hours? Yes No
If yes, number of deaths in past 24 hours: _____

Have any physical fights occurred among teen or adults within the past 24 hours? Yes No
If yes, the number of people involved: _____

Additional Public Health Comments or Concerns (use additional pages if more space is needed):



General Shelter Surveillance Situational Report

Name of Incident: _____
 Health Service Region _____
 Address: _____
 Phone: _____ Fax: _____

Date of Report: _____ (mm/dd/yyyy)

Total Number of Shelters in HSR: _____ Total Number of Individuals Housed in Shelters: _____

Total Number of Shelters Reporting _____

Summary of Current Public Health Events

For shelters that have reported an increased symptom/condition category with **public health significance** complete the table below.

Type of Events: Gastrointestinal Illness (GI), Respiratory Illness (*no fever*) (RI), Wound/Skin Infections (WI), Influenza-like Illness (ILI)*, rashes, other (specify)

Status of Event: **Preliminary:** new report, investigation pending
Active: currently investigating
Closed: investigation complete and interventions/recommendations provided
Ruled-out: investigation complete and determined not of public health significance

| Shelter Name | County | Type of Event | Status of Event | # Affected | Shelter Census |
|--------------|--------|---------------|-----------------|------------|----------------|
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COMMENTS:

Prepared by: _____ Title: _____

Shelter Surveillance Summary Form

Instructions for Local and Regional Health Departments

Public health surveillance in the evacuation shelters objectives:

- Monitor for infectious disease/injury so that trends may be recognized and interventions may be implemented
- Provide for local situational awareness on health status
- Create a daily statewide consolidated report by 10:00 am. The information is shared with state-level stakeholders including the State Operations Center.

The symptoms listed in this tool were selected to provide public health surveillance staff an indication of health status in a shelter and to monitor that status over a period of time. The language used in the tool was aimed at non-medical personnel at the shelter so that they can complete the tool and send it to the health department.

Steps to implement:

1. The local or regional health department that will be receiving the report will need to enter its name, address, reporting telephone number and fax number on the tool.
2. Surveillance staff should spend some time explaining the form's use, where, how and what time to report with one or more contacts at the shelter.
3. Public health staff should document the point of contact(s) for the shelter, telephone and fax numbers, address, capacity, and how the shelter will be reporting – fax or voice.
4. User instructions for filling out the form are part of the distribution document. However health department surveillance staff will need to review how to complete some data elements and other issues to ensure consistency:
 - The shelter census is usually taken at night when the highest numbers of people are in the facility. The time for taking a census can vary but is often between 10pm and 2am.
 - The reporting period will most often be for 24 hours. However, the reporting period may be less if the shelter is opening or closing in that 24 hour period.
 - Set up a 24 hour reporting period with shelter staff – for example 8:00am to 7:59am
 - Symptoms reported on the form are for people who have experienced them for the first time in that reporting period. Do not count those people with the same symptom reported on a previous day. If someone was missed from the previous the day, count them on the current report.
 - The lines at the bottom are for reporting other public health concerns not otherwise listed. If shelter staff suspects an outbreak of some kind, they should call the health department 24/7 reporting number.

Information flow:

One objective of this system is to have summary information and general situational awareness statewide available by 10am each day. These data assist local and state officials in making policy and resource allocation decisions.

The shelter should fax, or call in the data to their health department by 7:00am daily. The local health department receiving the data should have all the data summarized for their jurisdiction by 8:00am and provide the document to DSHS Regional Office at that time. Some shelters may not report on time for a variety of reasons. The local health department should not delay their report past 8:00am, just note the number of shelters reporting and show the total number expected in the report. In addition to the numerical summaries, include any brief explanations of possible outbreaks or public health significant issues occurring in the shelters.

Regional health departments will take the shelter reports received from the counties not served by a local health department and summarize as above. Then take the summaries from the local health departments to create a regional summary. This summary will be transmitted to the DSHS SMOC Operations for creating a statewide summary by 9:00am.

**TAB M - Suggested Supply Cache for Medical Shelters
(Shelter Set-Up Portion)**

| Items (Equipment/Supplies) | Quantity per 100 clients for 3 days |
|--|---|
| 2-way radios | 12 |
| AED with extra pads – 1 adult, 1 child | 1 |
| Alphabetical Files w/Flap | 2 |
| Antibacterial hand wash | 3 bottles (refill) & 18 small bottles for staff |
| Bag Valve Mask (BVM) – pediatric and adult | 2 each |
| Ball point pens | 1 box each of black and blue |
| Batteries | assorted sizes |
| Bedside commodes | 10 |
| Blood glucose monitor | 1 |
| Blood glucose strips | 2 boxes |
| Box to store/lock medications | 2 |
| BP Cuff Set - non-mercury (adult sizes and pediatric) | 3 |
| Bucket 2 gallon | 2 |
| Can opener | 1 |
| Clipboards | 15 |
| Cloth towels – small and large | 100 each |
| Cold Pak (Reusable) | 6 packs |
| Color Highlighters, Markers | 1 pack each |
| Cots, Blankets and Pillows | 118 each (includes staff) |
| Duct tape | 2 rolls |
| Extension cords | 10 |
| Flashlights | 10 |
| Forceps/tweezers | 2 |
| Garbage bags | 1 box |
| General first aid kit | 1 |
| Inter-office envelopes, letter size paper pads, manila envelopes | 20 each |
| Masking tape | 2 rolls |
| Message pads | 5 |
| Name Tags | 1 box |
| Paperclips small and large | 1 box large, 1 box small |
| Pharmaceutical counting tray and knife | 1 |
| Plug strips | 10 |
| Reference material (i.e. pocket PDR, etc.) | 2 |
| Rubber bands | 1 bag |
| Scissors | 4 |
| Sharpie regular and fine point marker | 10 each |
| Signs | 1 bag |
| Stethoscope | 10 |
| Storage containers-Assorted Sizes | 10 |
| Wash basins | 20 |
| Wheelchairs | 10 |
| Wrist Bands | 1 box of 100 |
| Ziploc bags | assorted sizes |
| 3 x 3 Gauze sponges 2 sterile per pack | 50 |
| 4x4 gauze sponges 2 sterile per pack | 100 |
| Alcohol based hand sanitizer | 5 |

| Items (Equipment/Supplies) | Quantity per 100 clients for 3 days |
|---|---|
| Alcohol Swabs | 3 boxes (100 each) |
| Applicators, Cotton tipped | 200 (box) |
| Arm sling | 1 |
| Band aids | 5-10 boxes assorted size |
| Bed Pans | 20 |
| Biohazard red bags large | 1 box |
| Biohazard red bags small | 1 box |
| Body lotion | 2 bottles |
| Bulb syringe | 2 |
| Chlorine bleach | 1 quart |
| Chux underpads | 150 |
| Cotton tip applicators | 1 box |
| CPR Face Mask – Pediatric | 3 each |
| CPR Face Mask – Adult | 3 each |
| Diapers - Adult | 50 |
| Diapers - Infant/Toddler | 50 |
| Dressing (abd pad) | 24 |
| Dressing paper for tables | 2 rolls |
| Elastic ace bandage | 10 |
| Elastic Band - 2 inch | 6 packages |
| Elastic Band - 6 inch | 6 packages |
| Eye pads | 12 |
| Face shields (disposable) | 12 |
| Facial tissue | 2 boxes |
| Feminine products | Assorted |
| First Aid Tape Roll (10 yd roll) | 10 |
| Gauze bandages | 5 - 10 boxes |
| General sponges | 12 |
| Germicidal wipes | 4 containers |
| Gloves -non latex large | 1 box (100 each) |
| Gloves -non latex medium | 1 box (100 each) |
| Gloves -non latex small | 1 box (100 each) |
| Goggles | 2 |
| Gowns | 3 |
| Hospital ID Bracelets | 75 yellow, 50 green, 20 light blue, 15 white, 25 dark blue, 10 red, 25 orange |
| In-line nebulizer | 10 |
| Irrigation kit | 2 |
| Lancing device | 25 |
| Medication cups/dosage spoons/syringes | 75/12/12 |
| Nasal Cannulas | 5 |
| Neck Brace | 1 |
| Obstetrical kit | 1 |
| Oxygen connectors | 5 |
| Oxygen mask -- disposable | 5 |
| Oxygen tanks (emergency use) with regulators and wrench | 5 |
| Salt substitute | 1 box |

| Items (Equipment/Supplies) | Quantity per 100 clients for 3 days |
|--|--|
| Sharps container | 1 gallon and 6 quart portable |
| Splint Board | 1 |
| Sterile Water – 500 ml (irrigation use only) | 4 bottles |
| Sugar | 1 bag |
| Surgical Masks | 1 box of 35 |
| Surgical Masks w/Shield (Latex-free) | 12 |
| Table salt | 1 box |
| Tape (1 inch paper) | 5 - 10 boxes |
| Tape (hypoallergenic 1 inch) | 1 box |
| Tape (silk 1 inch) | 1 box |
| Thermometer - non-mercury | 12 |
| Thermometer - non-mercury covers | 200 |
| Thermometer - Aural | 1 |
| Thermometer - Aural: Replacement Tips | 1 box |
| Tongue Depressors | 1 bag or box |
| Triangular Bandage | 10 |
| Urinals with covers | 20 |
| Urinary catheter bags | 10 |
| Urinary drainage bag | 2 |
| Vinegar | 1 bottle |

**Suggested Supply Cache for Medical Shelters
(OTC Medications and Supplies Portion)**

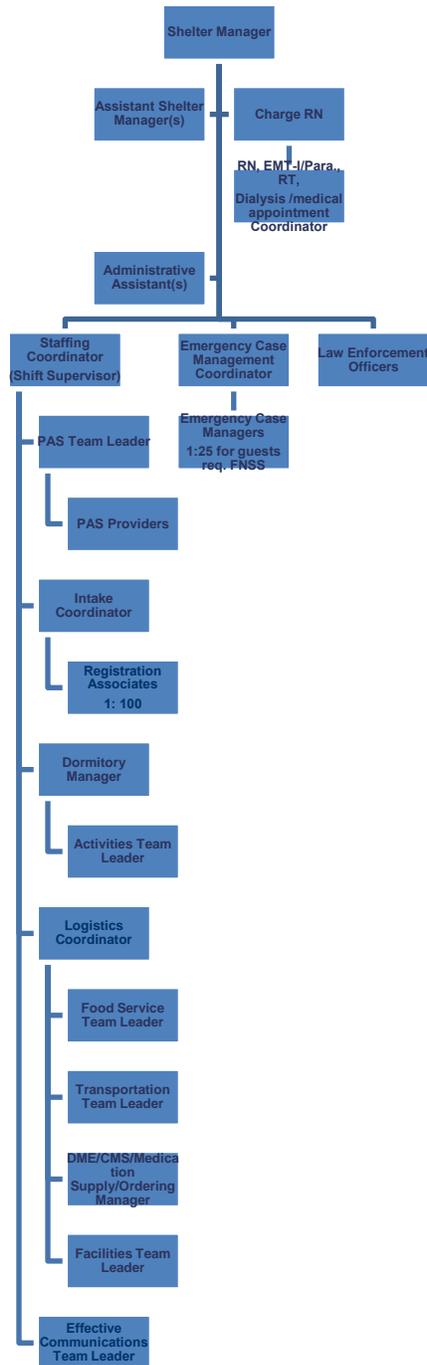
Items highlighted in **BOLD** are priority supplies

| Items (Equipment/Supplies) | Quantity per 100 clients for 3 days |
|---|--|
| Activated Charcoal/bottle | 2 |
| Alcohol - Isopropyl | 1 pint |
| Ammonia Inhalants | 2 boxes |
| Antacid-Low Sodium 24's/Box | 2 |
| Anti-septic Foam Alcohol | 2 bottles |
| Anti-septic Germicide Prep Sol (Iodine) | 8 bottles of 1 fl oz |
| Aspirin 5gr. Tablets 250 Tablets | 1 bottle |
| Benadryl Cream – antipruritic 1 ox. | 2 tubes |
| Benadryl/generic syrup 4oz | 2 |
| Betadine scrub | 1 bottle |
| Calamine Lotion (6 fluid oz) | 2 |
| Hydrocortisone 0.5% cream/tube | 2 |
| Hydrocortisone 1% cream/tube | 2 |
| Hydrogen Peroxide | 4 bottles |
| Ibuprophen 200ml Tablets 100 | 1 bottle |
| Instant Glucose/Tube | 2 |
| Insulin Regular, NPH & 70/30 10ml. | 10 vials of each |
| Insulin Syringes (small) | 25 |
| Ipecac Syrup 1oz | 2 |
| Kaopectate 12 oz | 2 |
| Loperamide 2mg tablets 24's | 4 |
| Loperamide Liquid 4oz Bottle | 2 |
| Maalox Antacid Suspension 12 oz. | 2 bottles |
| OTC Anti-Diarrheal Medicine e.g. bismuth subsalicylate | 2 boxes of 12 |
| Pedilyte – 12 oz bottles | 20 |
| Petroleum/Vaseline | 1 tube |
| Saline eye drops | 2 bottles |
| Triple Antibiotic Ointment (144 units) | 1 box |
| Tylenol - Adult Extra Strength – 500 mg. | 1 bottle of 250 pills |
| Tylenol - Children's Soft Chew – 160 mg. | 1 bottle of 60 pills |
| Zinc Ointment 1oz | 2 tubes |

Tab N – Recommended Shelter Staffing Profiles

Only those positions (shelter staff and medical) which are necessary for the operation should be filled. It may be appropriate to combine duties under a specific position when possible. (Staffing will depend on the scale and duration of the incident/operation/shelter)

Yellow indicates that these staff members will have to coordinate with one another.



The following chart is an example of Medical Staffing Ratios that may be needed in sheltering scenarios. Chart is based on per shift for a 24 hr. operation.

| Medical Staff | Medical Staffing Ratios |
|---|-------------------------|
| Staff for Health/ FNSS intake | 1:25 (Guests) |
| RNs (with a min. of 2 RNs at any time, 1 must be a Charge RN) | 1:10 (Guests) |
| EMT-I or Paramedic (with a min. of 1 at all times) | 5:250 (Guests) |
| Respiratory Therapist (if needed) | 1:250 (Guests) |
| Mental Health Staff (with a min. of 2 at all times) | 1:1 (Shelter) |
| Personal Assistant Services personnel (for intake) | 1:50 (Guests) |
| Personal Assistant Services (for individuals requiring PAS, a min. of 2 PAS at all times) | 1:1 (Guests) |
| Pharmacy Coordinator | 1:1 (Shelter) |
| Medical Director | 1:1 (Shelter System) |
| Primary Care Physician rounding daily (with a min. of 1 rounding daily) | 1:5 (Shelters) |
| Physician on call 24/7 | 1:1 (Shelter System) |
| Psychiatrist on call 24/7 | 1:1 (Shelter System) |
| Dentist on call 24/7 | 1:1 (Shelter System) |
| Medical appt. /Dialysis Coordinator | 2:1 (Shelter System) |
| Public health assessment team/infection control | 1:1 (Shelter System) |

Medical staffing ratios listed above are recommended based upon best practices. Medical shelter operational staffing may consist of all of the above or a subset of the above. Medical staffing could be configured into teams for rounds or assigned directly to a shelter. Medical staffing should be determined by evaluation of shelter population needs.

Shelter Staffing

Local jurisdictions have the responsibility for utilizing all local resources before requesting state assistance. Jurisdictions can find shelter staffing in a variety of locations to include:

- Local Jurisdiction Personnel
- Voluntary Agencies
- Service and Faith based organizations
- Citizen Emergency Response Teams (CERT)
- Students from area universities (consider working with the university to develop a method for students to obtain credits for working in a disaster shelter)
- Private Industry (local community businesses)
- Local nursing associations
- Private Industry
 - Medical staffing agencies
 - Home health agencies
- Public health department staff

Only those positions (shelter staff and medical) which are necessary for the operation should be filled. It may be appropriate to combine duties under a specific position when possible. (Staffing will depend on the scale and duration of the incident/operation/shelter)

Shelter Manager - Responsible for overall operation of the shelter, ensuring guests/clients are registered, cared for and have mass care needs met. Responsible for ensuring that FNSS are in place to support individuals with disabilities, functional and access needs. Responsible for coordinating with the medical staff ensuring that staffing levels are appropriate and that all medical/FNSS resource requests are met. Responsible for communication up the chain of command, this may be within the Incident Command System (ICS) or Emergency Operation Center (EOC) structure.

Assistant Shelter Manager- Assumes all responsibilities/duties of the Shelter Manager in his/her absence. Assists the Shelter Manager with all responsibilities/duties at the direction of the Shelter Manager.

Administrative Assistant- Supports the Shelter Manager and assists where needed, especially with documentation and resource tracking.

Staffing Coordinator (Shift Supervisor)- Responsible for ensuring that appropriate staffing levels are in place to support shelter operation. Coordinator oversees all staffing levels subordinate to them on the organization chart and ensures that Personal Assistance Services (PAS), Intake, Logistics and Dormitory Management needs are all being met. The coordinator also is responsible for ensuring that coordination amongst positions is occurring where/when necessary.

PAS Team Leader- Serve as the lead for PAS providers and will communicate directly with the staffing coordinator to ensure that needs are being met. PAS Team Leader will serve as the single point of contact for all PAS providers within a shelter. Team Leader will coordinate all PAS staffing needs with the Staffing Coordinator to ensure appropriate FNSS staffing levels are met. PAS Team Leader may need to communicate directly with medical staff to ensure that the medical needs of the individuals for whom they are caring for are met. Additionally, medical staff may have to communicate directly with a PAS provider to ensure that the PAS provider understands all the needs of the guest/client.

PAS providers- Provide formal and informal services that enable children and adults to maintain their usual level of independence in a general population shelter. This includes assistance with activities of daily living such as:

- Grooming
- Eating
- Bathing
- Toileting
- Dressing and undressing
- Walking / transferring
- Maintaining health and safety
- Taking medications
- Communicating
- Accessing programs and services

Intake Coordinator- Ensures that intake of all guests/clients occurs and that the process is accessible.

Registration Assistants- Conducts the intake process and documents accordingly.

Staff for Health/FNSS Intake- Responsible for conducting a health/FNSS intake for individuals who indicate they will require FNSS and/or access to medical services. (It is recommended that a Licensed Vocational Nurse conduct the intake in order to effectively articulate to shelter staff the full scope of each individual's needs and to maintain situational awareness.)

Dormitory Manager- Ensures smooth operation of the shelter. Responsible for ensuring that proper and accessible signage is hung in appropriate locations within the shelter, ensures that schedules are posted, and provides all necessary information to guests/clients. This information has to be communicated in accessible formats. Lastly, the Dorm Manager is responsible for answering questions and responding to needs requests.

Activities Director- Responsible for ensuring activities are made available to all guests/clients. This includes ensuring that all activities offered are accessible. This is generally a position that is filled during extended events in order to establish services such as school pick up or mail services.

Logistics Coordinator- Oversees all logistics staff and ensures the needs of guests/clients are met. Logistics Coordinator may have to make requests to the Staffing Coordinator, Shelter Manager, or directly to EOC/ICP depending on the operational plans specified by the Incident Commander.

Food Service Team Leader- Ensures that meals, snacks and beverages are served. Responsible for cleanliness, coordinating with sanitarians that inspect shelters, and ensuring a clean and healthy environment. Food Team Leader also ensures that dietary concerns are met, including low sodium, low fat, low sugar, pureed foods etc. are available. Also, Food Service Team Leader is responsible for communicating allergies and ensuring that the food providers are aware of all allergy and diet concerns.

Transportation Team Leader- Responsible for ensuring that transportation resources are available to shelter guests/clients, this also includes *accessible* transportation. Transportation is necessary for such things as dialysis and/or medical appointments.

Durable Medical Equipment (DME)/Consumable Medical Supplies (CMS)/Medication Ordering /Supply- Responsible for supporting the shelter logistically with necessary Durable Medical Equipment, Consumable Medical Supplies and coordinating medication pick up/delivery. This may include ordering directly, communicating the need to the Staffing Coordinator, or the ICP/EOC depending on the operation plans specified by the Incident Commander.

Facilities Team Leader- Responsible for ensuring that the facility is ADA compliant, that the shelter set up is ADA compliant and ensuring that all areas within the shelter are accessible. In addition the Facility Team Leader oversees any electricians, plumbers, custodial staff or other technicians that are necessary to ensure operation of the shelter.

Effective Communications Team Leader- Responsible for ensuring that services are in place or brought in to ensure effective communication is available to all individuals within the shelter. Effective Communications Team Leader is also responsible for making sure that all signage, information and activities are delivered utilizing effective communication.

Emergency Case Management Coordinator- Serves as the single point of contact to the Shelter Manager communicating case management/services needs, information and updates. Additionally, serves at the single point of contact for all emergency cases. Helps to ensure consistency of services and to ensure that all needs are met and access to all services needed are available and communicated to guests/clients.

Emergency Case Managers- Works with guests/clients to ensure that access to services are communicated and that guests/clients understand how to access services when they return to their homes/leave the shelter. This can include things like connecting guests with pharmacy services, meal services, DME providers, accessible housing etc.

Law Enforcement Officer- Provide onsite law enforcement

Medical Staffing

If you have medical staff operating within the shelter, they must operate under the authority of a medical director, who is overseeing the city or county shelter operation program. Typically, this medical director's role is assumed by the local health authority and it may or may not be delegated to another party. The delegation should be appropriately documented.

Local jurisdictions are responsible for exhausting all local resources before requesting state assistance. Jurisdictions can find medical staffing in a variety of locations to include:

- Area hospitals
- Nursing students from area universities (consider working with the university to develop a method for students to obtain credits for working in a disaster shelter)
- Medical reserve corps
- County Medical societies
- Local nursing associations
- Private Industry
 - Medical staffing agencies
 - Home health agencies
- Public health department staff
 - Local health authority may provide or delegate the responsibility to provide Standing Delegation Orders for medical staff in a shelter.

The State will support local jurisdictions after confirming that all available local resources have been utilized. The State will prioritize the allocation of medical staff to jurisdictions based on the first principal of the NIMS resource allocation prioritization - Life Safety.

Registered Nurse (RN) for individuals not requiring FNSS- Responsible for providing overall medical supervision/services for the general population.

RN for individuals requiring FNSS- Responsible for providing/coordinating medical services for individuals requiring FNSS. This may include such things as ensuring prescriptions are filled, medication administration, minor wound care, glucose monitoring etc.

Emergency Medical Technician (EMT) or Paramedic- Responsible for providing services within the shelter to the entire population as needs arise. EMT-I or Paramedic will assist RN's

when necessary. Paramedics will help to evaluate/assess individuals with acute onset of signs and symptoms and help determine if 911 transportation is necessary.

Respiratory Therapist- Responsible for providing O₂ oversight and monitoring.

Mental Health Staff- Responsible for delivering mental health services to all guests/clients. Provides psychological first-aid, assesses guests' psychological state, refers guests to local resources for ongoing psychiatric or psychological treatment if necessary, and mediates in the event of a guest's disruptive behavior.

Primary Care Physician- Provides overall medical oversight and direction to all medical staff. Evaluates guests/clients for medical needs, prescription needs and treatment needs. Treats guests needing medical care and makes referrals as needed.

Public Health Assessment Team- Local or regional health departments are responsible to ensure issues of infection control, food safety, and sanitation are properly addressed in a shelter. Health department may engage the assistance of other partners to complete the duties of public health in a congregate setting such as a shelter

Physician, Psychiatrist, Dentist, Vet on call- To be available for phone consultations, make referrals if necessary. Available to respond to a shelter for emergencies.

Medical Appointment/Dialysis Coordinator- Works with medical staff and shelter staff to schedule medical appointments and dialysis appointments. Communicates these schedules with the Shelter Manager to ensure that transportation and food service are arranged for these appointments.



MEDICAL CLINIC EVALUATION FORM



| | | | | | | | | | |
|--|---|---|---|-------------------|------------------------------------|-------------|------------------|---------------------------------|-------------|
| INCIDENT NAME | | LOCATION (Shelter, City/Town) | | | DATE (MM/DD/YYYY) | | | | |
| | | | | | | | | | |
| NAME LAST, FIRST MI | | DATE OF BIRTH (MM/DD/YYYY) | GENDER (Circle) M / F | | ID TAG # (If Applicable) | | | | |
| | | | | | | | | | |
| CHIEF COMPLAINT / DURATION | | | | | CODE STATUS /ADV DIR | | | | |
| | | | | | | | | | |
| | | | | | ALLERGIES | | | | |
| CIRCLE POSITIVES: TOXIC SUBSTANCE EXPOSURE, TRAUMA, RASH, SWELLING, BLEEDING, DIZZINESS, CHILLS, PAIN, FEVER, NAUSEA, VOMITING, DIARRHEA, SORE THROAT, COUGH, CONGESTION, HEADACHE, FATIGUE, WEAKNESS | | | | | | | | | |
| PATIENT CONSENTS TO TREATMENT? Y / N | | PATIENT'S PRIMARY LANGUAGE ENGLISH / SPANISH / OTHER _____ | | | SPECIAL DIET | | | | |
| | | | | | | | | | |
| MEDICAL/ SURGICAL HISTORY | | | | | | | | | |
| PRIMARY CARE PHYSICIAN | | NAME: | | | PHONE: | | | | |
| | | | | | | | | | |
| CIRCLE POSITIVES: DIABETES, HYPERTENSION, THYROID, ARTHRITIS, COPD, HIV, CANCER, CHEMO, ASTHMA, PREMATUREITY, DEMENTIA, MIGRAINES, CHRONIC PAIN, ANXIETY, DEPRESSION, DISABLED, RENAL FAILURE, DIALYSIS, DENTAL PROBLEMS, CHOLESTEROL, MI, CVA, CABG, AMPUTATION, BACK SURGERY, HERNIA, APPY, CHOLECYSTX, HYSTX | | | | | | | | | |
| CURRENT MEDICATIONS (PRESCRIPTIONS CONFIRMED? Y / N) | | | | | | | | | |
| MEDICATION | | DOSE | FREQUENCY | MEDICATION | | DOSE | FREQUENCY | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| SOCIAL HISTORY (Alcohol/Drug Abuse, Tobacco, STD) | | | | | | | | | |
| TOBACCO | YEARS SMOKED | PACKS / DAY | PASSIVE EXP. YRS | ALCOHOL | AMOUNT | FREQ | IV DRUGS | DRUG | FREQ |
| Y / N | | | | Y / N | | | Y / N | | |
| REVIEW OF SYSTEMS | REMARKS AND/OR CONSTITUTIONAL, IMMUNOLOGICAL, MUSCULOSKELETAL, OR INFECTIOUS ISSUES? | | | | | | | See Body Diagram On Back | |
| NEURO | | | | | | | | | |
| CARDIO | | | | | | | | | |
| RESP | | | | | | | | | |
| GI | | | | | | | | | |
| GU | | | | | | | | | |
| DERM | | | | | | | | | |
| PSYCH | | | | | | | | | |
| INFECTION SCREENING (IF YES TO ANY, CIRCLE SYMPTOM) | | | | | | | | Answer | |
| BODY TEMPERATURE LESS THAN 36 C OR 97 F OR GREATER THAN 38 C OR 100 F ? | | | | | | | | Y / N | |
| NEW SKIN RASH, INFESTATION, OR WOUND INFECTION ? | | | | | | | | Y / N | |
| RAPID ONSET OF CHILLS, MYALGIAS, SORE THROAT, COUGH, OR DYSPNEA ? | | | | | | | | Y / N | |
| HEMOPTYSIS, NIGHT SWEATS, OR UNEXPLAINED WEIGHT LOSS ? | | | | | | | | Y / N | |
| SEVERE HEADACHE OR ACUTE CHANGE IN NEUROLOGICAL STATUS ? | | | | | | | | Y / N | |
| NAUSEA, VOMITING, DIARRHEA, HEMATOCHEDIA, JAUNDICE, OR ABDOMINAL PAIN ? | | | | | | | | Y / N | |

Tab P - Public Health Shelter Checklist

This document could be used by Health Service Regions to evaluate a new shelter building or a pop-up shelter. The Public Health Shelter Checklist helps assure the necessities for shelter operation are available.

Shelter: _____
 Physical Address: _____
 Shelter Manager: _____
 Manager Contact: _____
 (Primary contact #) (Secondary contact #)
 Shelter Census: _____

| |
|------------------------|
| Assistance Team: _____ |
| Date/Time: _____ |
| City/County: _____ |

SHELTER LIAISON TEAM CHECKLIST

| | |
|---|--|
| 1. Have you established a system for identifying illness in your shelter? | |
| 2. Do you have all the appropriate contact information for medical services? | |
| 3. Do you have hygiene supplies on hand? EX: toilet paper, paper towels, soap, clean running water, hand sanitizer | |
| 4. Do you have a check in/check out process for shelter residents? | |
| 5. Do you have a social services resource directory or contact information for social services? | |
| 6. Do you have a process for obtaining meals? | |
| 7. Are you familiar with the process for obtaining supplies needed for the shelter? | |
| 8. Does the shelter have adequate staffing, including management back-up? Security staff? | |
| 9. Does the shelter have access to 24 hour volunteer medical staff? | |
| 10. Do you have a staff member trained in CPR on each shift? | |
| 11. Do you have a process for keeping common use areas clean? | |
| 12. Do you have a system for identifying and transporting residents that need to be moved to a medical needs shelter? | |
| 13. Are there any problems with the physical building that interfere with sheltering? | |

| | |
|--|--|
| 14. Is the Emergency Evacuation Plan posted? AND are exit signs clearly marked? | |
| 15. Are fire extinguishers and smoke alarms available and operable? | |
| 16. Are off limit areas (janitor, storage, office) locked and secured? | |
| 17. Are there any problems with sewage and water? Is sewage or water public or on-site? | |
| 18. Any problems with pests/rodents? | |
| 19. Is trash being adequately managed? | |
| 20. Are electric breaker boxes accessible? | |
| 21. Are passenger drop-off areas accessible to those using mobility aids, such as wheel chairs? | |
| 22. Does the facility have ADA accessible parking spaces to include accessible route to facility? | |
| 23. Are there protruding wall mounted or overhead objects along the accessible route that can be hazards for those who are blind or have low vision? | |
| 24. Is there at least one entrance to the facility that is accessible for those with mobility aids? | |
| 25. Are hallways, corridors and interior routes to services and activity areas at least 36" wide? | |
| 26. ADA compliant restrooms? Is there an area within the toilet room where a person using a wheelchair can turn around? | |

Comments (List # and comment): _____

Issues for DSHS Follow-up

| Order # | Issue to Resolve | Forwarded to ROC |
|----------------|-------------------------|-------------------------|
| | | |
| | | |
| | | |
| | | |

Tab Q - Medical/Functional Needs Discharge & Repopulation Assessment

The form is used to document the pre-discharge assessment which determines if the evacuee destination (point of origin) is safe for habitation and has the necessary support for the evacuees needs.

| | | |
|---|---|--|
| Name of Evacuee: | | DOB: |
| Current Location: <input type="checkbox"/> Shelter <input type="checkbox"/> Nursing Home <input type="checkbox"/> Hospital <input type="checkbox"/> Hotel <input type="checkbox"/> Other | Address (include county, city & state): | Shelter Name & Phone: |
| Destination availability confirmed? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you need state transportation assistance to get to destination? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you need Personal Assistant Services (attendant) care to get to destination? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any chronic/acute health care conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, describe health care condition: | |
| Were you receiving any of the following services/support in your home prior to evacuation or will you need any of the following when you return? | | |
| Care/Item | Services Needed | Name and location of pre-hurricane services |
| <input type="checkbox"/> Home Health | | |
| <input type="checkbox"/> Hospice Care | | |
| <input type="checkbox"/> Durable Medical Equipment | | |
| <input type="checkbox"/> Other Support Services | | |
| <input type="checkbox"/> Oxygen | | |
| <input type="checkbox"/> Dialysis | | |
| <input type="checkbox"/> Physical Therapy | | |
| <input type="checkbox"/> Other | | |
| <input type="checkbox"/> Psychiatric/Psychological | <input type="checkbox"/> Medical patient | <input type="checkbox"/> Physical/Durable medical equipment |
| INFRASTRUCTURE VERIFICATION: 1. Does the location have power? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Does the location have potable water? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Is medical infrastructure for minimal services (911, EMS, Meals on Wheels, etc.) Restored? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Has receiving DDC been notified? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Is there a habitable structure? <input type="checkbox"/> Yes <input type="checkbox"/> No | TYPE OF TRANSPORTATION NEEDED: <input type="checkbox"/> Wheelchair accessible <input type="checkbox"/> Ambulance <input type="checkbox"/> Bus <input type="checkbox"/> Plane <input type="checkbox"/> None <input type="checkbox"/> Other: | Is wheelchair: <input type="checkbox"/> Powered <input type="checkbox"/> Oversized <input type="checkbox"/> Manual Able to fold up: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Needs immediate follow up for medical care? <input type="checkbox"/> Yes <input type="checkbox"/> No | Needs immediate case management? <input type="checkbox"/> Yes <input type="checkbox"/> No | Flu shot given? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Return Location <input type="checkbox"/> Home <input type="checkbox"/> Assisted Living <input type="checkbox"/> Other <input type="checkbox"/> Need Shelter | Address (include county, city & state): | Contact and Phone: |
| Do you use oxygen? <input type="checkbox"/> Yes <input type="checkbox"/> No | AMOUNT (flow) _____ | Do you have enough oxygen to return home? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have a pet in shelter? <input type="checkbox"/> Yes <input type="checkbox"/> No | Type | Name |
| COMMENTS: | | |
| Name of Assessor/Data Collector: | | Date of Assessment: |

Tab R - Medical/Functional Needs Client Transportation Request Form

This form is used to coordinate medical evacuee transportation needs in and around the local shelter.
This form is not a request for state transportation assistance.

Name of Shelter Guest: (Last Name, First Name):

Name:

Phone:

Residence Address (street, county, state):

DOB / Age:

Gender: Male / Female

Current Location

- Shelter
- Hospital
- Nursing Home
- Other

Current Location Name:

Address, City, County, Phone

Does shelter guest have any chronic/acute healthcare conditions?

Yes No

If yes, describe current health care condition:

(diabetes, COPD, dialysis needed, morbidly obese, etc)

Need Transportation To

- Hospital
- Doctor's Office
- Physical Therapy
- Dialysis Center
- Shelter
- Home
- Other (facility name)

Name/Physical Address:

City/County

Accompanying Attendant/Caregiver:

Name:

Phone:

Accompanied by Service Animal? Yes No

If yes, please list type & name:

Type of Transportation Needed

Are you requesting state transportation resources? Yes No

Type of transportation needed: Bus Ambulance Bariatric capable Ambulance

Wheelchair/Para-transit vehicle

Is wheelchair: Powered

Oversized

Manual

Able to fold up: Yes No

If oxygen is needed: AMOUNT (flow) ____ Do you have enough oxygen to return to the shelter? Yes No

Date/Time Transportation Needed:

Special Instructions/Notes (include durable medical equipment to be returned with evacuee):

Requestor/ Contact Number:

Tab S - Support Capabilities and Jurisdictional Checklist for Re-Entry of Evacuated Persons with Disabilities and Medical Needs

Persons with disabilities run the gamut in the types and levels of ability and capability to function and fulfill routine daily activities needed to meet and maintain personal and physical needs. The fastest growing age group in the United States is 85 years of age and older (Texas Emergency Management On-Line, 2011). Along with 50 – 60 percent of the United States population living within 50 miles of coastal regions, and with coastal regions prone to hurricane and other related disasters, it is imperative that persons with disabilities requiring evacuation have a means to do so. Those having to evacuate from a hurricane will at some point have to repatriate to their pre-hurricane residence. Since persons with disabilities often require functional and access support services to accommodate needs, it is imperative that the jurisdiction evaluates readiness and capability to receive those with disabilities who have been evacuated.

If persons with disabilities required assistive or supportive components prior to the evacuation, they will require the same support and/or services upon repatriation. Evacuees cannot be repatriated unless they can adequately access and obtain the needed functional support services required before the evacuation.

There are several conditions and situations which qualify a person to meet the definition of 'persons with disabilities', each having different levels of disability and ability to meet and maintain daily activities making it challenging to get a true assessment of the population which will need assistance and support prior to evacuation. Once people are evacuated, it does become a little clearer what the needs are for persons with disabilities in host community shelters being repatriated to the pre-storm residence/location.

Prior to repatriating those with disabilities to a significantly impacted area following a disaster, key components need to be evaluated and assessed for capability to support and ensure persons with disabilities access, support and services to meet and maintain daily activity demands. The following are fundamental core services from a jurisdiction's infrastructure which need to be functional and available to support the gamut of needs of persons with disabilities. There are other major components that need to be assessed which need to be functional, accessible, and available for this population prior to repatriation (see following checklist for specifics).

Jurisdictional Checklist

Support Capabilities for Re-Entry of Evacuated Persons with Disabilities and Medical Needs

Water & Waste Water Systems

Water services need to be operational to support water supply demands, which often become greater following a major hurricane impact. Equally important, waste water systems need to be operational.

- Potable (drinking) water, sanitation, cleaning, toilets, hand washing (hygiene), bathing, showering, washing clothes, etc. are available
- Water supplies available to support medical equipment
- Fire protection water supply restored
- Healthcare facilities have needed supply to open and provide care/treatment (hospitals, nursing homes, home health, assisted living care centers, clinics, dialysis centers, etc.)
- Water available to support residents, businesses, clinics, medical supply business, etc.
- Able to provide for critical support to businesses who provide food, supplies, equipment, fuel, utilities, pharmacies, out-patient treatment centers, therapy, batteries, drinks, other if no water supply
- Electrical generation power plants restored with needed water supply
- Sanitation, lift stations, and sewer plants operational to reduce risk and threat of disease outbreak
- To wash and clean equipment
- Support emergency responders needs

Fire Service

Fire Service capabilities should be assessed and evaluated prior to repatriation of community residents, to identify if capable to provide defined level of service to protect life, property, and provide assistance as requested after a disaster.

The ability to provide appropriate response and firefighting capabilities is predicated on numerous key factors – which need to be considered following a disaster and repatriating the community.

- Restored capability of personnel/staffing to support firefighting/rescue apparatus 24/7 (multiple operations required to man apparatus to provide basic services)
- Capable of providing, supporting, and sustaining levels (safety standards) of apparatus/equipment maintenance for extended operational periods
- Fire apparatus and equipment deemed safe to respond and provide services to community (e.g. apparatus, ambulances, medical equipment, harnesses, lifting equipment, oxygen regulators, cardiac monitors, etc.)
- Restored and capable to provide structural firefighting for jurisdiction
- Rescue and technical capabilities restored to ensure community has level of protection
- Fire protection's jurisdiction Healthcare institutions and facilities cannot be protected

- Technical services such as hazardous materials, high-angle and confined space rescue capabilities reestablished
- Capability to provide adequate fire protection to healthcare infrastructure (e.g. hospitals, nursing homes, home health care residents, assisted living centers, dialysis centers, physician clinics, etc.)
- Fire service resources available and adequate to provide assistance as needed for lifting, transferring, and/or transporting community population having unique needs (e.g. bariatric, obese, lifting, psychiatric, etc.)
- Fire departments providing full EMS emergency services (911) reestablished and support resources available – to include mutual-aid resources

Law Enforcement

Law enforcement must be reestablished before allowing repatriation of evacuated population:

- Law Enforcement security reestablished
- Security risks are higher for persons with disabilities. Are security measures in place?
- Traffic management and flow established
- Coordinated road blocks and designated routes for EMS and transportation assets repatriating evacuees established
- Security at POD (Points of Distribution) locations
- Security needed for local businesses to reopen who provide fuel and other supplies such as medications, groceries, etc.
- Security for healthcare institutions
- Escort for critical resources
- Check-points established and point of control re-entry protocol for evacuees returning
- Coordination and communication with City/County departments and EOC/OEM to enhance coordination at local, regional, and state levels
- Process for monitoring and validating responders/volunteers assisting in regional disaster
- Resources to rapidly intervene if criminal activity occurs post-disaster

Power

- Major power grids restored
- Restored power for lighting, heating, cooling, refrigeration, security, alarms, medical alert, media, etc.
- Power for medical equipment
- Operate AC/Heating system
- Street lights, signal lights, intersection signs to safely navigate roadways
- 911 emergency centers restored
- Power restored to clinics, treatment centers, dialysis, etc.
- Electronic for equipment dependent on batteries for charging
- Electronic driven pharmacies requiring electronic scripts/orders restored
- Electronic transfer of funds restored
- Electronically controlled fuel pumps restored
- Power grid and residential supply stabilized
- Transportation dependent on power restored

Hospitals & Healthcare Systems

Since hospitals and other healthcare facilities are critical to support many of the medical and personal needs of persons with disabilities, the following need to be restored:

- Hospitals need to be restored and able to provide needed services
- Care takers and support staff established to provide care/treatment needed
- Staff able to report to support healthcare
- Specialized technicians able to report
- Dialysis centers open and operational
- Electronic systems functioning such as pharmacies, medical records network systems (ITT), CT scans, computer registration, lab diagnostics, and vendors back on-line and supports supply/equipment/specialty needs
- Physicians and nursing staff able to reach hospital/clinic/treatment/radiological/ultra sound unit and provide adequate level of service
- Specialized clinics and treatment/therapy restored
- Specialized care restored
- Medications sensitive to temperatures can be supported and maintained in homes, hospitals, clinics, pharmacies, etc.
- Hospitals open, evaluated and able to handle surge of increased vulnerable populations returning following disaster

Emergency Medical Services

- Established EMS services available to respond and support persons with disabilities (persons with disabilities often have a higher need for EMS and hospital services due to chronic illnesses).
- Ambulances available for transportation for dialysis or other treatments
- Ability to coordinate and manage mutual-aid ambulances needed to meet demands of post-disaster impact
- Local EMS services established to effectively manage increased volume of atypical transport and turn-around times to receive medical care/treatment in situations where healthcare infrastructure is impacted and fragmented.
- Establish an EMS mutual-aid management team to assist with coordination of resources, to minimize delays, due to operators which may not be familiar with the area
- Household communication systems (911) restored for contacting Fire, Police, Sheriff, EMS, Physician, etc.
- Specialized care/treatment restored in close proximity to avoid traveling long distances to receive care/treatment
- EMS resources staged and available to avoid extended delays in receiving care
- Functioning EMS communication with 911, hospitals, nursing facilities, etc.

Public Works Components

- Roadways accessible and safe
- Street signs and street lights over highways/roadways secured and safe
- Dangerous debris cleared from roadways
- Water systems operational and stabilized
- Sanitation pump stations operating normal
- Bridges, highways and roadways open and accessible to connect critical facilities (e.g. fire stations, hospitals, emergency rooms, trauma centers, etc.)
- Damaged, hazardous or debris covered roadways, highways, bridges, overpasses, secured/blocked to avoid access by vehicles/responders
- Communications and coordination established with key City departments (Fire, Police, Public Works, Health, Office or Emergency Management, Emergency Operations Center, etc)
- Established coordination and communication with TXDOT (Texas Department of Transportation)
- Ensure network and communication infrastructure is re-established between County/Regional stakeholders

Communication (Interoperability)

- Communication capability reestablished telephone/cell/radio
- News media capable of updating and communicating critical information to community households.
- Joint Information Center (JIC) established to ensure accurate post-event messages communicated to community and responders
- City/County departments have established communications to coordinate reception point and staging areas, PODs, repatriation routes
- Communication via WebEOC established for EMS to account for, and track return and movement of persons with disabilities (important to ensure follow up post return)
- Established communication with EOC, City/County departments or Department Operations Centers (DOCs) and regional stakeholders to affect the return of evacuees in a coordinated effort

Public Health Component

Certain components of Public Health need to be active to support health components such as environmental preparation, monitoring, and capturing of epidemiological information.

- Ensure safe environment
- Facilities, which had been closed for the incident, are safe to reopen
- Identify and intervene appropriately to respond to disease outbreak
- Ability to rapidly communicate messages to responders and community regarding crucial health protective messages and /or instructions
- Services established which provide for the needs of the community to include persons with disabilities (e.g. mental health, adult protective services, child protective services, case management, psychiatry support, mass prophylaxis, SNS (Strategic National Stockpile), POD for medications, etc.) post-disaster event.
- Coordination with regional public health providers

Establish Repatriation Management Team

When the decision is made to implement the repatriation of evacuees the established Repatriation Management Team provides inter-jurisdictional communication through the following:

- Real-time tracking and posting activity through WebEOC to coordinate and manage return of evacuees
- Medical records management to ensure continuity of care and continuum of care
- Logistical position assigned to track and support planning and operational components between shelter(s) and reception centers at local level
- Transportation focus to monitor and ensure resources reach their intended destination with persons being repatriated
- Plan for multiple operational periods to ensure management and coordination continuity
- Establish routine and consistent repatriation management team briefings
- Liaison evaluates and communicates bi-directional critical information needed to adequately prepare for receiving repatriated populations.
- Conduct shelter briefings with assigned liaison and EOC/OEM.

Liaison Established

Establishing a repatriation liaison will allow for better evaluation of local capability to receive evacuees from shelters in other jurisdictions.

- Liaison established locally at the EOC
- Liaison established at each shelter to communicate evacuee information
- Collect data and information on sheltered persons with disabilities or functional and access needs
- Reports local and regional capabilities to EOC
- Determines estimated time lines for reestablishing needed capabilities
- Evaluate types of services and support persons with disabilities may/will need (e.g. blind, deaf, language, durable medical equipment, bariatric, assistive devices, dialysis, oxygen, chronic illnesses, ostomy, catheters, colostomy, medications, therapy, consults, mental counseling, etc.).
- Ensure appropriate resources are matched for transporting persons with disabilities (e.g. ambulance-critical/basic/specialized, bus, van, air-transport, vehicle, etc.)
- Consistent briefings to OEM

Transportation Established

Establishing adequate transportation is in place prior to allowing evacuees to repatriate is imperative - especially for those dependent on public transportation for accessing care and treatment, or for picking up medications, supplies, and medical equipment, etc.

- Survey actual or potential transportation resources ahead of time to determine capacity
- Make arrangements and coordinate transportation component ahead of time
- Attempt to coordinate additional stops to routes to include sites where evacuees can access basic goods such as groceries, supplies, hospital clinics, pharmacy, etc.
- Add additional stops to include disaster recovery centers or locations where services are being provided
- Make reasonable modifications to existing fleet vehicles which will make transporting persons with disabilities effective
- Survey high traffic areas and add ramps and other adjuncts to increase ease of access and egress
- Remove and/or modify seats in non-traditional vehicles to make them usable for transporting people with disabilities

Medical Needs (Non-Medical Criteria)

An individual with disabilities may require medical support or services yet not meet or require advanced care from healthcare professionals. It is critical that needed support is provided before repatriating to a City/County or region:

- Assign a person with medical experience to differentiate those needing medical support/services and true “medical” attention
- Ability and capability to provide assistance for those requiring ostomy and indwelling catheter management care
- Support services and facilities for those that activities of daily living are restricted by immobility
- Have respiratory condition requiring special equipment to monitor or deliver constant or periodic oxygen via a mask or ventilator
- Persons requiring dialysis must receive dialysis on a set pattern – therefore dialysis centers have to be operational and accessible for the person
- Durable medical equipment must be supported and replaced if needed

Medical Population (Require Professional Care)

Populations categorized as “medical needs” typically have greater care acuity healthcare problems requiring specialized care, equipment, transportation, and services to receive and sustain care. Care provided for “medical” populations are mostly institutionalized (e.g. hospitalized, nursing home, rehabilitation unit, Alzheimer facility, etc.) and require specialized care provided by healthcare professionals such as physicians, nurses, respiratory therapists, physical therapists, critical care providers, etc. to provide appropriate care.

If medical populations have been evacuated and are preparing to repatriate, local and regional jurisdictions must have the ability to provide specialized support and services required to provide and sustain care.

Below are examples of medical situations that local and regional medical/healthcare infrastructure must evaluate and be capable of managing before repatriating:

- Medical infrastructure capable of providing multiples levels of care for those hospitalized and requiring care/treatment provided by licensed healthcare professionals (e.g. physicians, nurses, technicians, critical specialized care, etc.)
- Capable of providing transportation, healthcare facility, and services to patients who require high level oxygen flow rates (> 4 liters)
- Vendors are operational and capable of supplying consumable medical supplies, durable medical equipment, and services to support medical population.
- Appropriate facility and specialized professional care to monitor and care for patients requiring hemodynamic monitoring (e.g. BP, ART, CVP, etc.)
- Facility and specialized professional care capable of assessing, evaluating and providing care for patients requiring continuous intravenous (IV) medication drip (e.g. cardiac, blood pressure, heart rate, cardiac rhythm management, etc.)
- Local infrastructure capable of accepting and providing care for patients repatriating having orthopedic injuries that require specialized appliances or other acute medical conditions (e.g., cervical traction, unstable pelvic fracture, active labor, etc.) prohibiting patient from traveling via alternative method such as taxi, vehicle, bus, airport passenger van, etc.
 - Capable of receiving aircraft service to return patient to medical facility
 - Specialized transportation available and staffed to handle medical population
 - Support services to provide supplies and equipment to support care needs
 - Specialized healthcare professionals available and adequate to provide care to the entire medical population
- Mental health professionals available to support institutionalized patients
- Capable of providing services such as high level invasive procedures which have inherent risk or may require an emergency procedure
- Receiving medications affecting heart rate and blood pressure
- Local healthcare infrastructure having the ability to provide support, care, and treatment for those with altered mental status attributed to stroke, TIA, trauma, etc. (e.g. Rehab, Therapy, CT, MRI, etc)
- Obtunded and unable to protect airway (regardless of reason), can be supported and maintained after returning to local/region
- Adequate and appropriate transportation capable of transporting/transferring medical patients to hospital and to medical procedures for care and treatment required (e.g. may require air transport or critical care ambulances with advanced medics/nursing/physician staff)

Tab T - Effective Communications

Tips for Interacting with People with Disabilities, Functional and Access Needs During a Disaster

The following guidance is not meant to be an exhaustive list but a general guide for first responders. *As a reminder always ask the person how you can best be of assistance.*

Live Broadcast Briefings by Emergency Managers to the Public

Place the sign language interpreter **within the camera frame so that the interpreter can be seen** as the emergency manager speaks about the current disaster. If any information is presented in a visual manner, describe the chart for listeners who are blind. For example, instead of saying, *“all the counties in red should evacuate.”* Instead say *“all the counties in red should evacuate, those counties are, Travis, Williamson, Bell and McLennan.”*

General tips for communicating with [people with disabilities](#):

[Mobile TIPS for First Responders](#)

- Etiquette considered appropriate when interacting with people with disabilities is based primarily on respect and courtesy.
- When introduced to a person with a disability, it is appropriate to offer to shake hands. People with limited hand use or who wear an artificial limb can usually shake hands. (Shaking hands with the left hand is an acceptable greeting).
- If you offer assistance, wait until the offer is accepted, then listen to or ask for instructions.
- Treat adults as adults. Address people who have disabilities by their first names only when extending the same familiarity to all others.
- Relax. Do not be embarrassed if you happen to use common expressions such as "See you later," or "Did you hear about that?" that seem to relate to a person's disability.
- Do not be afraid to ask questions when you are unsure of what to do.

Effective Television Broadcast

We recommend local emergency management professionals visit with their local television stations and disability/functional stakeholder groups in non-disaster times to discuss the stations requirements under the [Federal Communications Commission to make emergency broadcasts accessible to people with disabilities.](#)
<http://www.fcc.gov/cgb/consumerfacts/emergencies.html>

Transcription into Braille Companies

- Braille Texas <http://www.brailletexas.org/>
- Three Bridges Interpreting Services in Braille <http://www.3bridgesaustin.com/>
- National Federation of the Blind Transcription Resource List: <https://nfb.org/braille-transcription-resource-list>
- American Council for the Blind: Transcriber Services <http://www.acb.org/resources/transcribers.html>

The Texas Department of Assistive and Rehabilitative Services (DARS) Resource Specialists

This program outreaches statewide to provide specialized services to individuals who are deaf or hard of hearing, as well as assisting agencies and other service providers to serve these consumers. The program, which operates through contracts with local/regional service providers, offers services in each of the 11 Health and Human Services regions of the state. Regionally-based specialists assist consumers in getting the services they need from state and local government, service organizations, employers and private entities while advocating within the communities to remove communication barriers to render more access to the targeted groups. The program also addresses attitudinal and cultural barriers affecting the populations which may hinder successful service delivery; provides information and referral services; and may provide training geared toward the consumers acquiring a better understanding of the laws which support and protect them. Resource Specialists are a preparedness resource to assist in discovering local needs and resources to support such needs.

Deafness Resource Specialists (DRS) have the knowledge-base and communication ability to work with persons who are deaf, hard of hearing and late-deafened in the areas of advocacy, self-empowerment and sensitivity training, as well as with Federal and State mandates on equal access to services, including education and employment. In many instances, Resource Specialists work as liaisons between consumers and service providers on appropriate service provision. Deafness Resource Specialists can assist local emergency management preparedness effort by locating local deafness stakeholder groups and local vendors/ agencies that provide resources to communicate with and support the local deaf community.

Hearing Loss Resource Specialists (HLRS) typically focus their services on sensitivity training, communication strategies and assistive technology for the workplace, home and beyond for more independence and self-sufficiency. Specialists help locate resources when working with people who are hard of hearing or who have an acquired loss of hearing. Hearing Loss Resource Specialists can assist local emergency management preparedness effort by locating local hearing loss stakeholder groups and local vendors/ agencies that can provide resources to communicate with and support individuals with hearing loss.

Contact information is as linked: <http://www.dars.state.tx.us/dhhs/providers/specialists.asp>

Deafblind Specialists functionally evaluate the overall situation of a person who is deafblind including: educational needs/ support/ resources, existing support systems, support/ training needs in relation to independent living and employment. Specialists help locate resources and make recommendations to agencies and organizations that are involved or requested to serve individuals. Deafblind Specialists can assist local emergency management preparedness effort by locating local hearing loss stakeholder groups and local vendors/ agencies that can provide resources to communicate with and support the individuals who are deafblind.

Contact information is as linked: <http://www.dars.state.tx.us/dbs/deafblind.shtml>

Deafblind Specialist for Austin, Tyler, Waco Central/Northeast areas: 512-377-0573

Deafblind Specialist for El Paso, Harlingen, San Antonio West/ Southwest areas: 512-377-0572

Deafblind Specialist for Corpus, Houston Gulf Coast/ Southeast areas: 512-377-0575

Deafblind Specialist for Dallas/ FW, Lubbock, Amarillo Panhandle/ Northwest: 214-378-2645

Statewide Division for Blind Services at 1-800-628-5115. To contact the Deafblind Services Unit directly email us at deafblindservices@dars.state.tx.us or call (512) 377-0566 (Voice/TTY) and (512) 410-1524 (VP).

Seniors

- Some people may respond more slowly to a crisis and may not fully understand the extent of the emergency. Repeat questions and answers if necessary. Be patient! Taking time to listen carefully or to explain again may take less time than dealing with a confused person who may be less willing to cooperate.
- Reassure the person that they will receive medical assistance without fear of being placed in a nursing home.
- Older people may fear being removed from their homes be sympathetic and understanding and explain that this is temporary.
- Before moving a person, assess their ability to see and hear; adapt rescue techniques for sensory impairments.
- Persons with a hearing loss may appear disoriented and confused when all that is really wrong is that they cannot hear you. Determine if the person has a hearing aid. If they do, is it available and working? If it isn't, can you get a new battery to make it work?
- If the person has a vision loss, identify yourself and explain why you are there. Let the person hold your arm and then guide them to safety.
- If possible, gather all medications before evacuating. Ask the person what medications they are taking and where their medications are stored. Most people keep all their medications in one location in their homes.
- If the person has dementia, turn off emergency lights and sirens if possible. Identify yourself and explain why you are there. Speak slowly, using short words in a calming voice. Ask yes or no questions: repeat them if necessary. Maintain eye contact.

People who use a Service Dog

- Traditionally, the term service dog is referred to dogs that assist people who are blind; however there are many types of service dogs trained to assist people with a disability. (2010: New Guidance for Service Animals) More recently, service dogs have been trained to assist returning soldiers with Post Traumatic Stress Disorder (PTSD) and children with autism. (http://www.ada.gov/regqs2010/factsheets/title2_factsheet.html)
- Remember a service dog is not a pet. Service dogs are allowed to go anywhere a person could go, including food preparation and medical areas.
- Do not touch or give the dog food or treats without the permission of the owner.
- When a dog is wearing its harness, it is considered working and on duty. In the event you are asked to take the dog while assisting the individual, hold the leash and not the harness.
- Plan to evacuate the dog with the owner. Do not separate them!

- Service Dogs are not required to be registered and there is no proof that the dog is a service dog. If the person tells you it is a service dog, treat it as such. However, if the dog presents a direct threat to the individual or others, you do have the leeway to remove it from the site. *Remember though, that in disasters, animals are also nervous and anxious; take all considerations into your decision before removing a service animal from its owner. (For example, if a person steps on a dog's tail while on a crowded bus with lots of people in panic, and the dog reacts to it, that may be considered a normal reaction)*
- A person is not required to give you proof of a disability that requires a service dog. If you have doubts, wait until you arrive at your destination and address the issue with the supervisors in charge.
- A service dog must be in a harness or on a leash, but need not be muzzled.

People who have Mobility Impairments

- Always ask the person how you can help before attempting any assistance. Every person and every disability is unique. Even though it may be important to evacuate the location where the person is, respect their independence to the safest extent possible. Don't make assumptions about the persons' abilities.
- Ask if they have limitations or problems that may affect their safety.
- Some people may need assistance getting out of bed or out of a chair, but CAN then proceed without assistance. Ask!
- Under new guidance a Segway Personal Transport is recognized to be a mobility device for some individuals.

Here are some other questions you may find helpful.

- Are you able to stand or walk without the help of a mobility device like a cane, walker or a wheelchair?
- You might have to [stand] [walk] for quite awhile on your own. Will this be ok? Please be sure and tell someone if you think you need assistance.
- Do you have full use of your arms?
- Avoid the fireman's carry. Use the one or two person carry techniques.

People who use Crutches, Canes or Other Mobility Devices

- A person using a mobility device may be able to negotiate stairs independently. One hand is used to grasp the handrail while the other hand is used for the crutch or cane.
- Do not interfere with the persons' movement unless asked to do so, or the nature of the emergency is such that absolute speed is the primary concern. If this is the case, tell the person what you'll need to do and why. Offer assistance if needed.
- If the stairs are crowded, assist by helping to create space for the individual to traverse.

Evacuating People who use a Wheelchair

- If the conversation will take more than a few minutes, sit down to speak at eye level.
- People who use a wheelchair are familiar with special techniques to transfer from one chair to another. Depending on their upper body strength, they may be able to do much of the work themselves.

- Ask before you assume you need to help, or what that help should be.

Carrying Techniques for People using a Non-Motorized Wheelchair

The In-chair carry is the most desirable technique if possible.

One-person assist:

- Grasp the pushing grips, if available.
- Stand one step above and behind the wheelchair.
- Tilt the wheelchair backward until a balance (fulcrum) is achieved.
- Keep your center of gravity low.
- Descend frontward.
- Let the back wheels gradually lower to the next step.

Two-person assist:

- Positioning of second rescuer:
- Stand in front of the wheelchair.
- Face the wheelchair.
- Stand one, two, or three steps down (depending on the height of the other rescuer).
- Grasp the frame of the wheelchair.
- Push into the wheelchair.
- Descend the stairs backward.

Carrying Techniques for People using a Motorized Wheelchair

- Motorized wheelchairs may weigh more than 100 pounds unoccupied, and may occupy a larger footprint. Lifting a motorized wheelchair and user up or down stairs requires two to four people.
- Certain circumstances may dictate transporting the individual without their wheelchair.
- People in motorized wheelchairs probably know their equipment much better than you do! Before lifting, ask about heavy chair parts that can be temporarily detached, how you should position yourselves, where you should grab hold, and what, if any, angle to tip the chair backward.
- Turn the wheelchair power off before lifting it.
- Most people who use motorized wheelchairs have limited arm and hand motion. Ask if they have any special requirements for being transported down the stairs.

People who have a Mental Illness

You may not be able to tell if a person has a mental illness until you have begun the evacuation procedure.

- In an emergency, the person may become confused. Speak slowly and in a normal speaking tone.
- Ask their name and address them by name throughout the emergency response.
- If the person becomes agitated, help them find a quiet corner away from the confusion.
- Keep your communication simple, clear and brief.
- If they are confused, don't give multiple commands ask or state one thing at a time.
- Be empathetic show that you have heard them and care about what they have told you.
- Be reassuring.

- If the person is delusional, don't argue with the individual or try to talk the individual out of it. Just let the individual know you are there to help them.
- Ask if there is any medication they should take with them.
- Try to avoid interrupting a person who might be disoriented or rambling just let him/her know that you both have to evacuate the area quickly.
- Don't talk down to the person, yell or shout which can escalate delusional behavior.
- Have a forward leaning body position which shows interest and concern. Use open palms and avoid balling your hand into a fist.

People who are Blind or Visually Impaired

- There is a difference between visual impairment and blindness. Some people who are legally blind have some sight, while others are totally blind.
- Announce your presence, speak out, and then enter the area.
- Speak naturally and directly to the individual.
- Do not shout.
- Don't be afraid to use words like see, look, or blind.
- State the nature of the emergency and offer them your arm. As you walk, advise the individual of any obstacles.
- Offer assistance but let the person explain what help is needed.
- Do not grab or attempt to guide a person without first asking..
- Let the person grasp your arm or shoulder lightly for guidance.
- A person may choose to walk slightly behind you to gauge your body's reactions to obstacles.
- Be sure to mention stairs, doorways, narrow passages, ramps, etc.
- When guiding someone to a seat, place the person's hand on the back of the chair.
- If leading several individuals with visual impairments, ask them to guide the person behind them.
- Remember that you'll need to communicate any written information orally.
- When you have reached safety, orient the person to the location and ask if any further assistance is needed.
- If the person has a service animal, don't pet it unless the person says it is ok to do so. Service animals must be evacuated with the person.
- Refer to the section on 'People who use a Service Animal.'

People who are Deaf or Hard of Hearing

There is a difference between people who are hard of hearing and those who are deaf. People who are hearing impaired vary in the extent of hearing loss they experience. **The effects of hearing loss vary per individual depending on the level of severity and time of onset.** Some people are completely deaf and rely on **various forms of** visual communication, while others can hear almost normally with hearing aids. Hearing aids do not guarantee that the person can hear and understand speech. They increase volume, not clarity

- Establish eye contact with the individual, this is important for communication and to facilitate lip reading.
- Talk directly to the person who is deaf, not the interpreter.

- Use facial expressions and hand gestures as visual cues.
- Check to see if you have been understood and repeat if necessary.
- Offer pencil and paper. Write slowly and let the individual read as you write.
- Written communication may be especially important if you are unable to understand the person's speech or if the person doesn't understand you.
- Do not allow others to interrupt you while conveying information.
- Be patient as the person may have difficulty understanding the urgency of messages.
- Provide the person with a flashlight to signal their location in the event they are separated from the rescue team. This will also facilitate lip-reading or signing in the dark. Darkness can make communication almost impossible for those who rely on visual communication techniques.
- While written communication should work for many people, others may not understand English well enough to understand written instructions. Keep instructions simple, in the present tense and use basic vocabulary.

Effective communication onsite and on scene:

Written communication will work for many people, others may not understand English well enough to understand written instructions. Keep instructions simple, in the present tense and use basic vocabulary. Print in clear format. Not all individuals will be able to read English.

Work with your local population and consider the tools techniques below:

High Tech Communication tools:

- Utilize hand held mobile devices to text back and forth.
- Deliver general announcements via text blast or email.
- Share a computer to facilitate written communication. (Utilize large font for citizens who have visual impairments)
- Establish video remote interpreting (VRI) services which may be used to provide effective communication. VRI is an interpreting service that uses video conference technology over dedicated lines or wireless technology offering a high-speed, wide-bandwidth video connection that delivers high-quality video images. To ensure that VRI is effective, performance standards have been established for VRI and requires training for users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the VRI system. Video signing services are relatively new; not all consumers have acquired the ability to use it as well as others and some may have never experienced the service. Although, the best practice routinely is for on-site qualified interpreters, in times of disasters the whole community is involved in rearranging their lives and remote interpreter services may be the best (and sometimes only) option for acquiring qualified interpreter services. For new users, it may take some time for them to become accustomed to seeing a small version of a real live interpreter by their side. Work with them and explain due to the circumstances, VRI is allowing you the ability to more easily communicate with them about their needs.
- Utilize accessibility tools that individuals may bring with them for communication.

Low Tech Communication tools:

- Utilize pen and paper to clearly and legibly print information
- White boards with large font to carry through the shelter area with announcement information.
- Print general instructions in large font and in Braille.

- Record announcements or information on tapes or other data and provide access to mediums to listen to the materials.
- Utilize American Red Cross “Visual Language Translator for Emergency Assistance” booklet, “Language Identification Chart”, “Basic Emergency Sign Language Poster” Braille communication book and pictogram tools

Provide for an onsite American Sign Language Interpreter:

Although various technological methods are available for communicating with persons who are deaf, the circumstances of an emergency can incapacitate these methods or reduce their effectiveness. In adverse situations, sign language interpreters can be a very effective communication link with deaf persons and those who may depend on lip reading. Effective communication can best be assessed by asking the individual which communication methods work for them.

Texas ASL Interpreter providers (<http://www.dars.state.tx.us/dhhs/list.shtml>)

Coordinate with local stakeholder groups to identify accessible communication support needs and capabilities in your community. Consider developing a local CERT Team which includes members who are deaf to help with planning and communications in shelters during a disaster.

Understanding American Sign Language

American Sign Language (ASL) uses visually transmitted sign patterns to convey meaning while simultaneously combining hand shapes, body orientation and movement of the hands, arms or facial expressions to fluidly express a speaker's thoughts. In terms of sentence structure, people who use ASL and have been deaf from birth, use topic-comment syntax, while hearing people who speak English use subject-object-verb. Speakers of sign language communicate through concepts and words in non-English sentences.

While it is possible to interpret sign language into a spoken language such as English (and vice versa), such an interpretation often is not a direct translation. American Sign Language (ASL) is a complex visual-spatial language that is used by the community who is deaf in the United States. It is a linguistically complete, natural language. It is the native language of many men and women who are deaf, as well as some hearing children born into families of parents who are deaf. Sign languages across time are developed specific to their communities and are not universal. For example, ASL is completely different from British Sign Language even though both countries speak English.

One example of conceptual framework for sign language would be, if an employee in a grocery store asks his supervisor for the day before Thanksgiving off...he would say, "*Do you mind if I have the day before Thanksgiving off?*" Translated into sign language would be, "*Wednesday, day before thanksgiving, don't-mind, off.*" Another example would be if a person in a shelter was asked, "*How often do you need to take your medication?*" in sign language it would conceptually translate to, "*Medicine pills-taking how many times day?*"

People who are Deafblind

People with combined hearing and vision loss. Individuals may be deafblind, deaf with low vision, or hard of hearing with any kind of vision loss.

- Let the deafblind person know you are there by simple touch on the shoulder or arm.
- Avoid bright/ glaring and loud environments.
- Identify yourself

- Communicate directly with the person, even when using an interpreter.
- Do not assume the deafblind person knows where they are or what is going on. Share as much information as possible.
- Always tell the person when you are leaving, even if it is for a brief period of time. Leave them as comfortable and safe as possible. It is good to offer them a chair, table, or wall for an anchor.
- When guiding a person who is deafblind never place him/her ahead of you. Allow the person to hold your arm above the elbow. It is rarely necessary to “help” the deafblind person sit down or climb stairs; placing their hand on a chair or banister will give them the information they need.
- If emergency situation happens and you must notify a deafblind person quickly, draw "X" on deafblind person's back with your finger and lead them by the arm. "X on the back" is a universal deafblind sign for an emergency. (If their back is not available, draw X in their palm.) Note: This is used in the culturally deafblind community. Persons who may have vision and hearing loss but not of that community will not understand this cue. You may, however, establish this as a quick emergency cue with them.

Communication:

People who are deafblind sometimes have usable speech, vision and/or hearing. Determine if the individual can effectively communicate via speech, American Sign Language (ASL), finger spelling, writing with a dark pen, computer/ assistive device communication or print-on-palm. If a citizen who is deafblind indicates that they are in need of Sign Language assistance for effective communication, attempt to determine which sign language modes used by people who are deafblind provide for their needs: (taken from [Deafblind Interpreting Guidelines](#) , e-Michigan Deaf and Hard of Hearing). Note that not all ASL interpreters are capable of providing this specialized service. Coordinate with Interpreter providers to ensure that Interpreters with the appropriate skills are requested:

Visual Frame (Box Signing) Signs are made within a more confined space or “box,” the size of which is individual to the client; interpreters’ distance from client also depends upon the client’s individual preference. Using this technique allows a client with a limited visual field to see the signs and the interpreter’s facial expressions and mouth movements simultaneously.

Close Vision Same as above, but with interpreter directly in front of client, within very close proximity. This is used when the client(s) have reduced visual acuity, as well as a peripheral field loss.

Tracking Client holds wrist(s) of interpreter to keep signs within the client’s field of vision and to gain information from interpreter’s movements. This technique is meant to reduce the client’s visual fatigue by helping them to keep track of where the interpreter’s hands are in space.

Tactile Signing In this technique the client places her/his hands over the hands of the interpreter, in order to read signs through touch and movement. Tactile signing can be taxing for interpreters, and may require more frequent interpreter switches or breaks. The interpreter should supply both auditory and visual information to the client. It is important to determine a seating arrangement that is comfortable to both the client and the interpreter. Tactile signing is used by client’s who have very limited vision and by those who are blind.

Tactile Finger spelling (DeafBlind Alphabet). The two-hand manual alphabet (i.e. the one used in British Sign Language) is adapted to fingerspell letters onto the palm of the client's hand. Most people who are deafblind in the United States use the standard American Manual Alphabet, however, interpreters may encounter clients who know and prefer the DeafBlind alphabet.

Short-cut Signs Key signs that can be signed onto palm of client's hand are used as a supplement to tactile finger spelling; generally used in English word order.

The sign language alphabet can be used to spell a word visually or tactually. To "fingerspell" to an individual who is unable to see your letters, you can sign the letters into the palm of the person's hand.

In an Emergency If an emergency situation happens and you must notify a deafblind person quickly, draw "X" on deafblind person's back with your finger and lead them by the arm. "X on the back" is a universal deafblind sign for an emergency. (If their back is not available, draw X in their palm.) *Note:* This is used in the culturally deafblind community. Persons who may have vision and hearing loss but not of that community will not understand this cue. You may, however, establish this as a quick emergency cue with them.

People who have a Cognitive or Intellectual Disability

- Some people may be distracted with a lot of activity and noise around them.
- Be prepared to repeat what you say, orally or in writing.
- Offer assistance and instructions and allow extra time for decision making.
- Be patient, flexible and supportive. Take time to understand the individual and make sure the individual understands you.

Say:

- My name is _____. I am here to help you, not hurt you.
- I am a _____ (name your job).
- I am here because (explain the situation).
- I look different than my picture on my badge because _____ (for example, if you are wearing protective equipment).

Show:

- Your picture identification badge (as you say the above).
- That you are calm and competent.

Give:

- Extra time for the person to process what you are saying and to respond.
- Respect for the dignity of the person as an equal and as an adult (example: speak directly to the person).
- An arm to the person to hold as they walk. If needed, offer your elbow for balance.
- If possible, quiet time to rest (as possible, to lower stress/fatigue).

Use:

- Short sentences.
- Simple, concrete words.
- Accurate, honest information.

- Pictures and objects to illustrate your words. Point to your ID picture as you say who you are, point to any protective equipment as you speak about it.

Predict:

- What will happen (simply and concretely)?
- When events will happen (tie to common events in addition to numbers and time, for example, “By lunch time ___By the time the sun goes down___.”)
- How long this will last when things will return to normal (if you know).
- When the person can contact/rejoin loved ones (for example: calls to family, re-uniting pets).

Ask for/Look for:

- An identification bracelet with special health information.
- Essential durable equipment and supplies (for example: wheelchair, walker, oxygen, batteries, communication devices [head pointers, alphabet boards, speech synthesizers, etc.]).
- Medication.
- Mobility aids (for example, assistance or service animal).
- Special health instructions (for example: allergies).
- Special communication information (for example, is the person using sign language)?
- Contact information.
- Signs of stress and/or confusion (for example, the person might say [s] he is stressed, look confused, withdraw, start rubbing their hands together).
- Conditions that people might misinterpret (for example, someone might mistake a person with [Cerebral Palsy](#) or low blood sugar for a person with diabetes for drunkenness).

Repeat:

- Reassurances (for example, you may feel afraid. That’s ok. We’re safe now.)
- Encouragement (for example, Thanks for moving fast. You are doing great. Other people can look at you and know what to do).
- Frequent updates on what’s happening and what will happen next. Refer to what you predicted will happen, for example: “Just like I said before, we’re getting into my car now. We’ll go to now.”

Reduce:

- Distractions. For example: lower volume of radio, use flashing lights on vehicle only when necessary.

Explain:

- Any written material (including signs) in everyday words.
- Public address system announcements in simple words.

Share:

- The information you’ve learned about the person with other workers who’ll be assisting the person.

People who have a Speech Impairment

- If you do not understand something the individual says, do not pretend that you do. Ask the individual to repeat what he or she said and then repeat it back.
- Be patient. Take as much time as necessary.
- Try to ask questions that require only short answers or a nod of the head.
- Concentrate on what the individual is saying.
- Do not speak for the individual or attempt to finish her or his sentences.

People who have Autism

- The person with autism may or may not be able to communicate with words. The individual should be approached gently and spoken to softly as high levels of sensory input may cause agitation.
- Understand that a person with autism may become stressed when their regular routine is disrupted.
- Unless absolutely necessary, don't touch someone with autism without the person's permission. Many people with autism are very sensitive to touch and simple touch can be painful.
- Understand that rocking, repetitive motion, and repeating words or phrases can be comforting to a person with autism during an emergency.
- Avoid loud noises, bright lights, and high levels of activity whenever possible.
- Don't assume that a person does not understand if they are not using words.

Source References:

U.S. Health and Human Services Office on Disability "[Dealing with Disabilities: Tips for First Responders](http://www.hhs.gov/od/tips.html)" (<http://www.hhs.gov/od/tips.html>)

University of Texas Center on Disability Studies, [Tips for First Responders and Texas Resources](http://tcds.edb.utexas.edu/documents/Tips2010.pdf), <http://tcds.edb.utexas.edu/documents/Tips2010.pdf>

The National Organization on Disability's Emergency Preparedness Initiative: Functional Needs of People with Disabilities, "[A Guide for Emergency s, Planners and Responders](http://www.nod.org/assets/downloads/Guide-Emergency-Planners.html)," 2009
<http://www.nod.org/assets/downloads/Guide-Emergency-Planners.html>

Tab U - Oxygen Support (O2)

The purpose of this section is to provide local jurisdictions with scalable recommendations for meeting the Oxygen (O2) needs of displaced populations with functional needs in a disaster/emergency.

Key stakeholders from local agencies, businesses, disability organizations, community-based organizations, and faith-based organizations that serve functional needs populations within the jurisdiction should be identified and included in emergency planning committees. The resources and capabilities of each entity should be assessed and integrated into short- and long-term plans in order to ensure that management of functional needs starts at the local level before escalating to State and federal levels of government.

Most cities and counties have local resources for access to medical oxygen. It is recommended that local jurisdictions establish working relationships and/or contingency contracts with local suppliers for their oxygen needs. Below is a link to all Prescription Gas Distributors, sorted by county:

<http://www.dshs.state.tx.us/commprep/response/ToolsInfo.aspx>

For further information or assistance with State of Texas Comptroller contracts, contact the CPA Contract Management Team at **(512) 463-3034** or e-mail at tpass_cmo@cpa.state.tx.us if available or contact the CPA Procurement Customer Service staff at **(512) 463-3034** or e-mail procurement_info@cpa.state.tx.us if available.

Available State of Texas, Comptroller Contracts for Durable Medical Equipment (DME):

- Contract: **430-M1-GASES: HOSPITAL, LABORATORY and WELDING and EQUIPMENT**
Contractor contact information:
Link: <http://www.window.state.tx.us/procurement/contracts/gci/430-M1.php>

DSHS Managed Contracts During Disaster and Emergency Operations in Support of Oxygen Resupply Procedures:

The Department of State Health Services (DSHS) has a contingency contract in place to support Oxygen Re-Supply Operations during Disaster and/or Emergency Evacuation Operations. This contract will support the following areas:

- **Ambulance Staging** – Deliver full oxygen cylinders (25_{CF}, 110_{CF}, and 251_{CF}) to ambulance staging locations in, **San Antonio, Houston, Corpus Christi, or McAllen depending on the disaster location**, to be used as oxygen cylinder exchanges on deployed ambulances.
- **TxMF Refuel Points** - Deliver DSHS owned inventory to selected fuel points along evacuation routes and pick-up empty cylinders at request of DSHS. In the event that current stock is exhausted, provide additional full cylinders to fulfill demand.
- **Shelter Areas** - Deliver full oxygen cylinders (25_{CF}, 110_{CF}, and 251_{CF}) to shelters, refill cylinders as needed and remove cylinders when shelter is closed.

Activation of Contract:

When local resources are exhausted, jurisdictions may submit a request for O2 support through the established channels of assistance.

Tab V - Kidney Dialysis

The purpose of this section is to provide local jurisdictions with recommendations/considerations to accommodate and assist individuals with functional and medical dialysis needs in a disaster/emergency.

1. Planning

A. General

- Include provisions for individuals with kidney failure in all plans, and involve End Stage Renal Disease (ESRD) networks and dialysis facilities in all planning efforts.
- Establish clear contacts in each response area and make contact information known to ESRD networks and dialysis facilities on an annual basis.
- Provide alternate sites for treatment if dialysis clinic operations are impacted by the disaster. Work with the End Stage Renal Disease Network organization 972-503-3215 (www.esrdnetwork.org), dialysis providers, and state agencies in establishing appropriate locations.
- Provide security assistance to protect dialysis facility staff, emergency generators, and fuel used to run the dialysis equipment.
- Allow dialysis facilities to provide dialysis to all their patients if at all possible prior to mandatory evacuation. This is critical to the safety of the patients.

B. ESRD Patients

- Persons with kidney failure have both a critical medical need as well as a functional need. Persons with kidney failure require either medications to prevent rejection of a transplanted kidney or regular dialysis treatments to clean their blood in addition to medications (most likely for diabetes or high blood pressure) in order to remain alive.
- Encourage early evacuation of individuals with kidney failure if they are on dialysis, with appropriate family members (where possible). Since medical services are needed on a frequent basis, the individual should be triaged, provided urgent care if indicated, and evacuated to a location where services can be provided frequently in a safe environment.
- Recognize that individuals with kidney failure have unique medical needs and will need to limit fluid intake and use caution in consuming foods high in salt and potassium (such as Meals Ready to Eat (MREs)) particularly during periods of limited access to dialysis; as example, public service announcements may need to be edited to recognize these restrictions.

C. Dialysis Facilities

- List dialysis facilities as high priority locations for restoration of all services such as power; water, and phone services.
- Designate dialysis facility as high priority for emergency services such as generators; fuel; and tanker water.
- Give priority to dialysis personnel for limited supplies such as gasoline and housing.
- Facilitate delivery of needed supplies to dialysis clinics that will be handling evacuees as well as prioritize delivery of supplies to dialysis clinics that will continue to serve patients in areas that have been impacted by the disaster if safely possible.

- Allow patients and staff with appropriate identification to cross roadblocks and travel during curfews in order to get to and from dialysis clinics.

2. Shelters

- Many kidney dialysis patients will come to a shelter with a purple wrist band and a purple fanny pack that includes their medications and kidney dialysis physician orders.
- Dialysis patients may be sheltered in either a general shelter or a medical shelter based upon their functional need and other underlying medical condition.
- Ask shelters
 - to consider that arrangements for transportation to dialysis must be made
 - to consider transferring these individuals to another shelter nearer a dialysis facility
- Designate a few shelters as the “go to” locations for dialysis patients to make transportation to dialysis treatment easier. These go to shelters should be close to large dialysis centers (if possible). These shelters can also be used for others. NOTE: Individuals needing dialysis treatment cannot be forced into a particular shelter. It should only be suggested that they go to the shelter closest to the dialysis center.
- Routinely screen for people who require dialysis or have a transplant when individuals seek shelter in disasters. Add: “Do you require dialysis?” and “Do you have a transplanted organ?” to all screening tools.

3. Resources

- Contact The Texas Emergency ESRD Coalition Hotline at 1-866-407-3773 to receive assistance with scheduling dialysis services for patients.
- End Stage Renal Disease Network: www.esrdnetwork.org; 972/503-3215; fax: 972/503-3219
- Department of State Health Services: www.dshs.state.tx.us/comprep/RandP/
 - Procedures For Shelter In Need of Dialysis In Texas
 - Dialysis In-Take Form
 - Dialysis and Transplant Patient Triage Form – Texas ESRD Emergency Coalition (TEEC)
 - Recommendations for Renal Diet in Shelters

Tab W – Sample MOU for Facility Use

MEMORANDUM OF UNDERSTANDING Facility Use Agreement – Medical Shelter Site or Similar

This Memorandum of Understanding – Facility Use Agreement is entered into between _____, a political subdivision of the State of Texas, (“Jurisdiction”) and _____, (“Facility”) for the purpose of providing shelter in the event of a Declaration of Disaster, effective _____ (the “EFFECTIVE DATE”) and will continue for one (1) year from the EFFECTIVE DATE.

Jurisdiction has identified the need for the provision of a temporary site that can be utilized to support the Jurisdiction in the event of a local disaster or emergency. The facility may be used as a(n):

- Medical Shelter: intended to provide temporary care and housing for individuals with medical conditions requiring skilled care
- Alternate Care Site: a facility staffed and equipped to provide the necessary and appropriate medical services to citizens when surge capacities and resources of local hospitals have been overextended or become inaccessible.
- General Population Shelter: intended to provide temporary mass care and housing for citizens displaced during a disaster
- Point of Distribution (POD): a site configured to dispense equipment, supplies, or service to appropriate groups of citizens
- Reception Point or Center: a site staffed and equipped to receive and appropriately route equipment, supplies, and citizens
- Emergency facility deemed necessary and appropriate by the Jurisdiction.

I. Purpose

In the event of a Declaration of Disaster that would require the placement and care of its citizens, Jurisdiction, functioning under local authority, intends to establish a safe and comfortable location in which to place persons and provide for their care. Facility intends to cooperate with Jurisdiction to provide a location for the care of the citizens in the event of an emergency

II. Party Agreement

A. Activation

- i) In the event of an emergency and upon notice given by Jurisdiction of the need to move citizens to a Medical Shelter, the Facility agrees to use its best efforts to make its premises and facilities ready and available to serve as a Medical Shelter.
- ii) Facility agrees to provide such rooms and facilities as may be reasonably necessary under the circumstances to house and care for these citizens.
- iii) Representatives from Jurisdiction and the Facility will conduct a joint inspection of the Facility prior to opening as a Medical Shelter. Any existing damage and the condition of the Facility will be documented. There will also be a joint inspection

upon closing the Facility documenting any damages created by the operation as a Medical Shelter.

- iv) It is the intent of Jurisdiction to maintain the property at the highest standards consistent with the comfort and convenient care of the displaced citizens. Jurisdiction will conduct its operations in a manner so as not to present a safety threat or unduly interfere with the operations of the Medical Shelter or the use of the site by its staff.
- v) Jurisdiction will make no permanent changes to the premises without the consent of Facility.

B. Equipment, Supplies and Staffing

- i) Jurisdiction will coordinate the availability of cots, blankets, and any other materials and supplies necessary for the care of the citizens.
- ii) Jurisdiction will coordinate the management and staffing necessary to operate the site and care for the citizens routed to/through the Medical Shelter.
- iii) Jurisdiction (unless otherwise agreed) will provide normal or daily-type maintenance services and materials, including such things as janitorial services, waste management, and laundry services for the premises during use as a shelter.
- iv) Facility agrees that all shelter staff will work under the supervision of Jurisdiction in providing for the well-being of the citizens assigned to the shelter.
- v) Jurisdiction is responsible for ensuring the safety and well-being of the displaced persons and will provide all necessary security for the premises.
- vi) Jurisdiction will coordinate food service for feeding the citizens and volunteers within the Medical Shelter.

C. Reimbursement

- i) Jurisdiction will reimburse Facility for any expenses incurred by Facility over and above its normal operating expenses caused by the provision of care for the citizens. (Define these terms based on attached fact sheet)
- ii) Jurisdiction will be responsible for any damage to the premises caused by its operations, excluding normal wear and tear.
- iii) Facility will submit a request for reimbursement within 30 days of Jurisdiction vacating the Facility. All costs for which Facility seeks reimbursement must be documented and must show that they are attributable to the use of the premises as a Medical Shelter.

III. Compliance and Indemnification

- i) Jurisdiction will comply with all statutes, ordinances, rules and regulations during its occupation of and operations in the facilities while on the premises.

- ii) Jurisdiction will indemnify and hold harmless Facility for any claim or cause of action that may arise in any manner as the result of any act or omission of any of its employees, officers, directors or staff. Facility will indemnify and hold harmless Jurisdiction for any claim or cause of action that may arise in any manner as the result of any act or omission of any of its employees, officers, members or staff. Nothing in this section shall limit any right to contribution or other allocation of fault between the parties as determined by a court of competent Jurisdiction and as permitted by applicable law.

IV. Term

The term of this understanding shall commence on the EFFECTIVE date and continue for one (1) year. At the end of one year, the agreement shall automatically renew for an additional year. At the anniversary of the EFFECTIVE DATE, this understanding may be extended or modified, as the parties agree. Either party may terminate this understanding by giving 10 days written notice unless the Facility is actively in use as a Medical Shelter, in which case Facility will continue to provide Medical Shelter services as provided herein until the end of the emergency incident. In any instance, this understanding shall not extend beyond two (2) years without written consent from both Jurisdiction and Facility.

Signatures of Authorized Representatives

Agreed this _____ day of _____, 2011

Facility Name

Jurisdiction X

By: _____

By: _____

Its: _____

Its: _____

And

By: _____

Its: _____

Facility Address:

Address:

Facility Phone Number:

POC Phone Number:

Jurisdictional Considerations for Modification **of** **Memorandum of Understanding**

Due to the multiple and varied conditions and situations found among each locale, including but not limited to established relationships, previously developed agreements, and/or local administrative functions, Jurisdictions may deem it necessary and appropriate to modify verbiage in the general Memorandum of Understanding initially provided by BCFS for use in the Alternate Care Site Initiative. Modifications and changes should be considered on a facility-to-facility basis.

Specific items each municipality may consider adding some/all of the following key points and their associated reimbursement processes, if applicable:

- Emergency facility deemed necessary as requested by the State, with concurrence by the involved jurisdiction for a State-involved event
- Lease Fee or Loss of Revenue
(In the event the State asks you to operate the shelter and/or in a federally declared event, the State of Texas will reimburse for either the Loss of Revenue directly related to using a facility as a shelter (MEDICAL SHELTER) or a Lease Fee, but will not reimburse for both)
- Janitorial services provided by the Facility
- Staff services provided by the Facility
- Maintenance services provided by the Facility
- Laundry services provided by the Facility
- Waste management service provided by the Facility
- Utility costs above and beyond normal operating costs that are the direct result of the use of the Facility
- Other costs/fees incurred above and beyond normal operating costs/fees that are the direct result of the use of the Facility
- Damages that are a direct result of using the Facility
- Use of a Facility kitchen or food service
- Use of any supplies or equipment (including vehicles) the Facility may own, lease, or be contractually obligated to use
- Use of Facility security (if applicable)
- Use of any other services and/or equipment mandatorily associated with or contractually obligated to the Facility