

Planning For Emergencies

PLANNING FOR EMERGENCIES

Connecticut Community Care, Inc. Self-Directed Support Services

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Getting Started

Many people don't really plan for emergencies. The reality, however, is you will most likely have an experience either yourself or with someone else you know at some point in your life. Being prepared ahead of time will help you during an actual emergency.

There are different kinds of emergencies that can occur. The most common type of emergency that people think of is a personal health or fire emergency where you need to call 911. An emergency may also involve a number of people, such as a disaster. This could be a hurricane, floods or blizzards more common in New England. This tip sheet will give you information you need to plan for a variety of emergencies.



In partnership with



Money Follows the Person Demonstration
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What Do I Need to Do?

When we think about emergencies, we generally don't think about how quickly someone responding to your situation may need to assess the situation and work with you to help you through the emergency. If you become familiar with the people responding to emergencies in your community, and let them know your needs before an emergency, this will help them respond to your needs as much as possible. You can do this through a variety of ways:

- Complete an Emergency 911 Form** that is sent to dispatch when 911 is called from your home alerting them of your type of disability;
- Contact your local police or fire department** to ask them how additional information about your specific disability needs can be entered into their 911 system;

What Do I Need to Do? Continued

- ☑ **Ask the town or city you live in if they have an emergency registry** for people with disabilities or older adults with specific needs;
- ☑ **Put the letters ICE in your cell phone followed by a phone number** to represent who you want to be your emergency contact;
- ☑ **Complete a File of Life** and place on your refrigerator, as well as carry another form with you at all times;
- ☑ **Complete a Disability Specific Disaster Preparedness Inventory Form** and put this information with your File of Life;
- ☑ **Develop an Evacuation Kit** for you, your personal care assistant (optional), and your pets/service animal with items needed for the first 72 hours;
- ☑ **Have medication in your Evacuation Kit** for as long as possible – usually at least a week (talk to your doctor about this if needed);
- ☑ **Have a Personal Emergency Plan** in place and practice with the people who provide support to you (personal care assistant, family, friend and/or neighbor). Your plan should include the following:
 - Know your plan at home, work and in the community;
 - Evaluate your functional capabilities and limitations in various emergencies that may occur;
 - What support networks are available to you? Who can you contact? What support can they provide?;
 - Practice and review with support networks on a regular basis – supports change over time and it's important you are prepared;
 - Tell support networks your needs and how to use equipment if they are not familiar already.

**Plan, Plan, Plan
Before an
Emergency Occurs**



How to Alert 9-1-1 to Your Special Needs

You should complete this form if you want your police department, fire department, ambulance, or other emergency response agencies to know about medical conditions or disabilities when you call 9-1-1 in an emergency.

When you call 9-1-1 from a wireline phone, Connecticut's 9-1-1 emergency telephone service displays your name, address, and telephone number at your local 9-1-1 answering point. (A wireline phone is a phone that has a wire from a telephone pole to your home.) Filling out this form will alert the 9-1-1 operator that you or someone else living in your household has a medical condition or disability. This information helps the 9-1-1 operator to provide appropriate emergency help.

If you want the 9-1-1 operator and emergency response staff, (that is the police department, fire department, or emergency medical staff) to know that you or someone else living in your household has a medical condition or disability, fill out this form. This information will be displayed at the 9-1-1 answering point *only* when you call 9-1-1.

This service is *not* available for cell or internet phones.

The information that you provide will be put into the 9-1-1 system and will stay there until you request that it be changed or removed or your account is closed. It is your responsibility to notify us when there is a change in the condition described on this form. When there is a change, send us an updated form.

When filling out this form, be sure to:

1. Provide your name, address, and telephone number.
2. Check the box or boxes which apply.
3. Sign and date the form,

Mail this form to SBC at this address:

AT&T
Enhanced 9-1-1 DMS Group
310 Orange St., 2nd Floor
New Haven, CT 06510

How to Alert 9-1-1 to Your Special Needs

Telephone Number (include area code) _____

Name _____

Address _____

Town/City _____

Check all the boxes that apply.

- B Blind** – Someone at this location is blind or visually impaired.
- COG Cognitive Impairment** – Someone at this location has a cognitive impairment.
- H/D Hard of Hearing / Deaf** – Someone at this location is hard of hearing or deaf.
- LSS Life Support System** - Someone residing at this location is physically linked to equipment required to sustain his or her life.
- MI Mobility Impaired** - Someone residing at this location is bedridden, uses a wheelchair, or has a mobility impairment.
- PI Psychiatric Impairment** – Someone at this location has a psychiatric impairment.
- SI Speech Impairment** – Someone at this location has a speech impairment.
- TDD Telecommunications Device for the Deaf** – Someone at this location may be using a TDD/TTY.

- Please **remove** any existing indicators presently being displayed.
- Please **change** existing indicators to the ones above.

By completing this form, I understand that I am responsible to notify AT&T of any changes with regard to the above information. I further agree that I will indemnify, defend, and hold harmless AT&T, the State of Connecticut, the Public Safety Answering Point, and my municipality from and against any and all claims, suits, and proceedings resulting from or arising out of the provision of this information.

I understand that this information will remain as part of my 9-1-1 record until such time as I notify AT&T to either change or delete it.

 X
Signature _____

Date

American Medical Alarms sponsors the Vial of Life Program.

Please cut out the two Vial of Life pictures below. Fill out the Vial of Life form and put it behind one cut out in a plastic bag and tape the bag to the front of your refrigerator. Then put the second cut out in a bag and tape it on the outside of your front door. Be sure to amend the information on your Vial of Life form as your medications and or medical information changes. You can print new forms anytime you need them by visiting our website:

www.americanmedicalalarms.com



Thank you!

American Medical Alarms

VIAL OF LIFE

DATE COMPLETED: _____

EMERGENCY MEDICAL INFORMATION - FOR RESCUE SQUAD

Sponsored by American Medical Alarms, Inc. - Phone Toll Free (800) 542-0438

FIRST NAME			INITIAL	LAST NAME			SOCIAL SECURITY NUMBER			
STREET			CITY		STATE	ZIP	TELEPHONE			
DATE OF BIRTH		MALE/FEMALE	HEIGHT	WEIGHT	HAIR COLOR	EYE COLOR		BLOOD TYPE	RELIGION	
IF PACEMAKER, MODEL #			DEFIBRILATOR, MODEL #			HEARING AID	DEAF		DENTURES	UNABLE TO SPEAK
VISION		GLASSES	CONTACTS		BLIND	ARTIFICIAL EYE		UPPER LOWER	NATIVE LANGUAGE IF NOT ENGLISH	
					L	R	L	R		
IDENTIFYING MARKS:										
CIRCLE CONDITIONS YOU HAVE BEEN TREATED FOR IN THE PAST										
AIDS		BLOOD PRESSURE		EPILEPSY		HEART CONDITION		TUBERCULOSIS		
ANEMIA		CANCER		GLAUCOMA		JAUNDICE		OTHER:		
ARTHRITIS		DIABETES		HAY FEVER		SINUS				
ASTHMA		INSULIN Y / N		HEPATITIS		STROKE				
CURRENTLY BEING TREATED FOR?										
CURRENT MEDICATIONS/DOSAGE/FREQUENCY/LOCATED					CURRENT MEDICATIONS/DOSAGE/FREQUENCY/LOCATED					
NAME OF DOCTOR			TELEPHONE NUMBER		NAME OF DOCTOR			TELEPHONE NUMBER		
NAME OF DOCTOR			TELEPHONE NUMBER		NAME OF DOCTOR			TELEPHONE NUMBER		
ALLERGIES TO MEDICATIONS										
LAST HOSPITALIZATION										
HOSPITAL		LOCATION			YEAR		PATIENT #			
LIVING WILL			ORGAN DONOR							
REFER TO:					REFER TO:					
MEDICAL COVERAGE										
BLUE CROSS # _____			BLUE SHIELD # _____			MEDICARE # _____				
MEDICAID # _____			OTHER _____			POLICY # _____				
IN CASE OF EMERGENCY - NOTIFY					RELATIONSHIP					
STREET ADDRESS			APT	CITY	STATE	ZIP	PHONE			

PLACE ON FRONT OF REFRIGERATOR AND UPDATE AS NEEDED

Disability Specific Disaster Preparedness Inventory

This inventory is designed to be used with the free vial of life program form located at www.VialofLife.com Please complete that form first, then answer these questions and put both in a highly visible location such as a refrigerator or front door, so that it may be used in the event of an emergency.

What is your primary diagnosis?

For example: Cerebral Palsy, Muscular Dystrophy

Do you have any secondary diagnose(s) that emergency personnel need to be aware of such as epilepsy?

Yes No

If yes, please explain:

Do you utilize Personal Assistance?

Yes No

In the event that you do, please enter the following information:

Activity (Dressing, Bathing etc.)	Time Normally Started
1.)	
2.)	
3.)	
Is there any adaptive equipment or technique you use in order to avoid getting hurt?	

Do you have a disability specific doctor or hospital?

Yes No

If yes, Doctor:

Hospital:

Do you have anyone in your life that helps you make choices?

Yes No

If yes, what is this person's name, address and telephone number? Is this person your Personal Care Assistant, parent or other relative? Please enter this information below:

Name	Address	Phone Number	Who is this Person?

Disaster Preparedness Inventory (Continued)

Do you require an accessible shelter? Yes No

Do you require Assistive technology and/or Medical Equipment?

Yes No

If yes, please indicate what you use, where it is in your home, and if it requires electricity.

Name of Equipment	Location in Home	Electricity needed?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Once you get to a shelter, will you need a sign language interpreter or other aide to help you communicate?

Yes No If yes, please list:

Do you have a Service Animal? *(Do not include pets here as they may be unable to come with you)*

Yes Please write their name and species, i.e. Dog, Cat, Bird, Monkey.

No

Is there any medication that you currently take that would be life-threatening to you if you did not have access to it temporarily?

Name of Medication	Purpose	Dosage	Frequency

If you were unable to return home, would you express a desire to return to a community or institutional setting? Community Institution

What features do you currently have in your home or apartment that you would need wherever you lived after the disaster? (Check all that apply)

Sure hands or Equivalent Grab Bars Ramp

Environmental Control Unit Other (Please Specify):

Is there anything else that you would need in the shelter or after the disaster that is not covered here?

Yes (If yes, please specify):

No