

COMPREHENSIVE EMERGENCY MANAGEMENT PLAN

For Adult Day Training Programs

Facility Name: _____

Facility Address: _____

County: _____

APD Region: _____

DATE PREPARED: ____/____/____

PREPARED BY: _____

----- APD Office Use Only -----

Reviewed By: _____

Approved:

Review Date: ____/____/____

County Review Required:

I. FACILITY OVERVIEW:

A. Facility Information (site specific):

Facility Name:	
Street Address:	
City:	
State:	
Zip Code:	
County:	
Main Phone #:	
Email Address:	
Fax #:	
Emergency Contact Name:	
Emergency Contact Phone #:	
Participant Capacity:	
License # (Renewals only):	

B. Governing Authority Information:

Owner Name:	
Street Address:	
City:	
State:	
Zip:	
Work Phone #:	
Home/Cell Phone #:	
Email:	

C. Program Director Information:

PRIMARY	
Name:	Title:
Street Address:	City:
State:	Zip:

Work Phone #:	Home/Cell Phone #:
Email:	
ALTERNATE/BACK-UP	
Name:	Title:
Street Address:	City:
State:	Zip:
Work Phone #:	Home/Cell Phone #:
Email:	

D. Emergency Person in Charge:

PRIMARY	
Name:	Title:
Street Address:	City:
State:	Zip:
Work Phone #:	Home/Cell Phone #:
Email:	
ALTERNATE	
Name:	Title:
Street Address:	City:
State:	Zip:
Work Phone #:	Home/Cell Phone #:
Email:	
ALTERNATE	
Name:	Title:
Street Address:	City:
State:	Zip:
Work Phone #:	Home/Cell Phone #:
Email:	

E. Organizational Chart:

Identify chain of command and hierarchy of authority as it pertains to emergency response.

F. Site-Specific Information:

Year Built:		Type of Construction:
Dates of Subsequent Construction:		
Mitigation/ Fortification Projects:		
Number of bathrooms:		
Licensed Participant Capacity:		
Current # of Participants:		
Age Range of Participants:		
Characteristics of Participants Served:		

II. HAZARD ANALYSIS:

POTENTIAL HAZARDS		
Severe Weather/Wildfires	Hazardous Materials/Radiological Events	Other Hazards
<input type="checkbox"/> Severe Thunderstorms <input type="checkbox"/> Tornadoes <input type="checkbox"/> River or Inland Flooding <input type="checkbox"/> Coastal Flooding <input type="checkbox"/> Tropical Cyclones (tropical storms, hurricanes) <input type="checkbox"/> Excessive Heat <input type="checkbox"/> Excessive Cold <input type="checkbox"/> Tsunamis <input type="checkbox"/> Wildfires <input type="checkbox"/> Other:	<input type="checkbox"/> Chemical Plant Spills <input type="checkbox"/> Nuclear Transport Spills <input type="checkbox"/> Fuel Spills <input type="checkbox"/> Nuclear Power Plant Emergencies <input type="checkbox"/> Other:	<input type="checkbox"/> Epidemic/Pandemic or Public Health Emergency <input type="checkbox"/> Power Failure <input type="checkbox"/> Other:

HURRICANE EVACUATION ZONE

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FLOOD ZONE

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PROXIMITY TO MAJOR TRANSPORTATION ARTERIES

TYPE	NAME	PROXIMITY

NUCLEAR POWER PLANT ZONE

Located in Planning Zone: <input type="checkbox"/>	Turkey Point: <input type="checkbox"/> St. Lucie: <input type="checkbox"/> Crystal River: <input type="checkbox"/> Farley: <input type="checkbox"/>	10-mile: <input type="checkbox"/> 50-mile: <input type="checkbox"/>
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III. CONCEPT OF OPERATIONS:

A. Direction, Control, and Continuity of Operations:

Operational Support Roles & Chain of Command (Attach Standard Operating Procedures)		
Position Title	Name & Phone Number	Successor Name & Phone Number

EMERGENCY STAFFING PROCEDURES

B. Emergency Needs and Supplies:

Food and Water		
Item	Amount Needed	Procurement & Storage
Water = 1 gal/person per day for 3 days (If ADT is serving as an emergency shelter.)		
72 hours' worth of essential supplies (If serving as a shelter)		
Medications and Medication Administration		
Item	Amount Needed	Procurement & Storage
Current Medication Administration Record Forms (MAR) for each participant		
Blank MARs for each participant		
Public Health Emergency Supplies		
Cleaning Items	Amount Needed	Procurement & Storage
Examples: Paper towels, plastic trash bags and liners and hand soaps		
Sanitation Items	Amount Needed	Procurement & Storage
Examples: Disinfectant supplies such as, alcohol-based hand sanitizer, rubbing alcohol, disinfectant wipes and sprays, hydrogen peroxide		

PPE (Personal Protection Equipment) Items	Amount Needed	Procurement & Storage
Surgical/procedural masks, disposable gloves (in appropriate sizes for staff), safety glasses, isolation gowns, etc.		
General Health Items	Amount Needed	Procurement & Storage
Thermometers and thermometer cover, hand lotion, First Aid Kit		

Transportation		
Number of People Needing Transport	Modes of Transportation	Other Transportation Needs (fuel, accessibility needs, GPS, etc.)

Emergency Power Sources	
Type of Emergency Power Source (if not a generator)	Description of Power Capacity and Duration

Generator Information		
Generator Type	Fuel Type	Fuel Capacity & Burn Rate
Generator Capacity: (What specific components of the facility will the generator be able to power)		
Person Responsible for Ensuring Fuel Supply:		
Fuel Storage Capacity & Storage Location:		
Fuel Source(s):		
Generator Testing frequency and person responsible:		

Family/Guardian/WSC Notifications		
Method of Notification	Position Responsible for Notification	Precautionary Measures/Alternate Methods

D. Evacuation and Sheltering:

Evacuation Triggers		
Individual Responsible for Evacuation		
Name:		Phone Number:
Alternate Name:		Alt. Phone Number:

Evacuation & Sheltering Options (Based on Personal Disaster Plan)					
Participant Name	Shelter Type	Address	On-Site Contact #	Transport Y/N	Accompanying Staff

Equipment and Supplies			
Type	Amount Needed	Method of Transportation	Staff Responsible for Coordination and Tracking

Client Transportation					
Transportation Method	Provider	Capacity	Response Time	Contact Name	Contact Number

Notification & Tracking Procedures
<ul style="list-style-type: none"> Describe procedures for notification: procedures to include notification timeframes, person responsible for notifications and documentation of notifications. Describe procedures for tracking the location of each program participant. APD Regional Office, WSCs, Families/Guardians all need to be notified.

PRIMARY HOST FACILITY INFORMATION (ATTACH AGREEMENT(S))	
Facility Name:	
Street Address:	City:
State:	Zip Code:
County:	
Contact Name:	Contact #:
Alt. Name:	Alt. #:
Pre-Staged Equipment and Supplies:	
Available Staff to Assist:	
Number of Available Beds/Spaces:	
Primary Evacuation Route:	
Alternate Evacuation Route:	
Directions from Evacuating Facility:	
Estimated Evacuation Time:	
Staff to Accompany Evacuated Participants	

ALTERNATE HOST FACILITY INFORMATION (ATTACH AGREEMENT(S))	
Facility Name:	
Street Address:	City:
State:	Zip Code:
County:	
Contact Name:	Contact #:
Alt. Name:	Alt. #:
Pre-Staged Equipment and Supplies:	
Available Staff to Assist:	
Number of Available Beds/Spaces:	
Primary Evacuation Route:	
Alternate Evacuation Route:	
Directions from Evacuating Facility:	
Estimated Evacuation Time:	
Staff to Accompany Evacuated Participants	

E. Re-Entry and Reunification:

County Emergency Management Agency (Contact to Determine Timing for Re-Entry to the Program)	
Program Staff Required to Contact County EM:	
County Name:	
Street Address:	
City:	
State:	
Zip Code:	
Emergency Management Contact Name:	
Contact #:	
Alt. Name:	

Alt. #:	
Persons Responsible for Inspecting the Program:	
Family Notification	
Persons Responsible for Coordination:	
Notification Method(s):	
Notification Timeline:	
APD/WSC/Guardian Notification	
Persons Responsible for Coordination:	
Notification Method(s):	
Notification Timeline:	

F. Host Sheltering (For Programs Receiving Evacuating Participants and Staff):

Name of Evacuating Facility:		
Street Address:		City:
State:		Zip Code:
County:		
Contact Name:		Contact #:
Alt. Name:		Alt. #:
Number of People Received:		
Check-In Procedures:		
Log of Additional Persons Sheltered:		
Pre-Staged Equipment and Supplies:		
Available Staff to Assist:		
Number of Available Participant Beds/Spaces: (attach floorplan)		
Number of Available Staff & Family Beds/Spaces: (attach floorplan)		
Will Evacuated Participants Exceed Licensed Capacity?		
APD Contact #: (must contact w/in 48 hours if capacity is exceeded)		

CONTINGENCY PROGRAM INFORMATION
(In the event Host Shelter must evacuate)
(ATTACH AGREEMENT(S))

Facility Name:		
Street Address:		
City:		
State:		
Zip Code:		
County:		
Contact Name:		
Contact Name:		Contact #:
Alt. Name:		Alt. #:
Pre-Staged Equipment and Supplies:		
Available Staff to Assist:		
Number of Available Beds/Spaces:		
Primary Evacuation Route:		
Alternate Evacuation Route:		
Directions from Evacuating Facility:		

IV. INFORMATION, TRAINING, AND EXERCISE:

STAFF TRAINING REQUIREMENTS			
TRAINING SCHEDULE			
Training Type	Frequency	Provider	Required Staff
EXERCISE SCHEDULE			
Scale	Frequency	Provider	Required Staff

EMERGENCY MANAGEMENT PLAN STORAGE LOCATION

CORRECTIVE ACTION PLAN