**COMPREHENSIVE EMERGENCY MANAGEMENT PLAN**

**for**

**Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Facility Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**County: \_\_\_\_\_\_\_\_\_\_\_\_**

**APD Region: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE PREPARED: \_\_\_\_**/**\_\_\_\_**/**\_\_\_\_\_\_\_\_**

**PREPARED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Reviewed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approved:**

**Review Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ County Review Required:**

# FACILITY OVERVIEW:

1. **Facility Information:**

|  |  |
| --- | --- |
|  | |
| **Facility Name:** |  |
| **Street Address:** |  |
| **City:** |  |
| **State:** |  |
| **Zip Code:** |  |
| **County:** |  |
|  | |
| **Main Phone #:** |  |
| **Email Address:** |  |
| **Fax #:** |  |
|  | |
| **Emergency Contact Name:** |  |
| **Emergency Contact Phone #:** |  |
|  | |
| **Type of Facility:** | Foster Home  Group Home  Residential Habilitation Center |
| **License #:** |  |
|  | |

1. **Owner Information:**

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

1. **Facility Operator:**

|  |  |
| --- | --- |
| **PRIMARY** | |
| **Name:** |  |
| **Street Address:** |  |
| **State:** |  |
| **Zip:** |  |
|  | |
| **Work Phone #:** |  |
| **Home/Cell Phone #:** |  |
| **Email:** |  |
| **ALTERNATE** | |
| **Name:** |  |
| **Street Address:** |  |
| **State:** |  |
| **Zip:** |  |
|  | |
| **Work Phone #:** |  |
| **Home/Cell Phone #:** |  |
| **Email:** |  |
|  | |

1. **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:** |  | | |
|  | | | |

1. **Organizational Chart:**
2. **Site-Specific Information:**

|  |  |
| --- | --- |
|  | |
| **Year Built:** |  |
| **Type of Construction:** |  |
| **Dates of Subsequent Construction:** |  |
| **Mitigation/**  **Fortification Projects:** |  |
|  | |
| **Number of Beds:** |  |
| **Maximum # of Residents:** |  |
| **Gender:** |  |
| **Age Range of Residents:** |  |
|  | |
| **Types of Residents Served:** |  |
|  | |

# HAZARD ANALYSIS:

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| --- | --- | --- |
| **POTENTIAL HAZARDS** | | |
| **Severe Weather/Wildfires** | **Hazardous Materials/Radiological Events** | **Other Hazards** |
| Severe Thunderstorms  Tornadoes  River or Inland Flooding  Coastal Flooding  Tropical Cyclones (tropical storms, hurricanes)  Excessive Heat  Excessive Cold  Tsunamis  Wildfires  Other: | Chemical Plant Spills  Nuclear Transport Spills  Fuel Spills  Nuclear Power Plant Emergencies  Other: | Epidemic/Pandemic or Public Health Emergency  Power Failure  Other: |
| **HURRICANE EVACUATION ZONE** | | |
|  | | |
| **FLOOD ZONE** | | |
|  | | |
| **PROXIMITY TO MAJOR TRANSPORTATION ARTERIES** | | |
| **TYPE** | **NAME** | **PROXIMITY** |
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| **NUCLEAR POWER PLANT ZONE** | | |
| **Located in**  **Planning Zone:** | **Turkey Point:**  **St. Lucie:**  **Crystal River:**  **Farley:** | **10-mile:**  **50-mile:** |

# CONCEPT OF OPERATIONS:

## 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** |
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| **EMERGENCY STAFFING PROCEDURES** | | | |
|  | | | |
| **EMERGENCY NEEDS AND SUPPLIES** | | |
| **Food and Water** | | |
| **Item** | **Amount Needed** | **Procurement & Storage** |
| Water (1 gal/person per day for 7 days) |  |  |
|  |  |  |
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|  |  |  |
| **Medications and Medication Administration** | | |
| **Item** | **Amount Needed** | **Procurement & Storage** |
| Medication Refills |  |  |
|  |  |  |
| Current Medication Administration Record Forms (MAR) for each resident |  |  |
|  |  |  |
| Blank MARs for each resident |  |  |
|  |  |  |
| **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 |  |  |
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| **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 covers, hand lotion, First Aid Kit |  |  |
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| **Sleeping Arrangements** | | |
| **Number of People** | **Space Needed (approx. 40 ft2 per person)** | |
|  |  | |
| **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:** |  | |
| **Generator Training Procedures:** |  | |
|  |  | |
|  |  | |
| **Transportation** | | |
| **Number of People Needing Transport** | **Modes of Transportation** | **Other Transportation Needs**  **(fuel, accessibility needs, GPS, etc.)** |
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## Notification of Potential Emergency Conditions:

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| **Emergency Notification Systems and Methods** | | |
| **Type** | **Position Responsible for Monitoring** | **Notification Source/Methods such as news, radio, weather radio, etc.** |
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|  |  |  |
| **24-Hour Contact Number** | | |
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| **Key Staff Notification and Reporting** | | |
| **Staff Member** | **Method of Notification** | **Time Frame for Reporting to Facility or Alternate Site** |
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| **Resident Notification** | | |
| **Method of Notification** | **Position Responsible for Notification** | **Precautionary Measures/Alternate Methods** |
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| **Family/Guardian/WSC Notifications** | | |
| **Method of Notification** | **Position Responsible for Notification** | **Precautionary Measures/Alternate Methods** |
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## Evacuation and Sheltering:

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| **Evacuation Triggers** | | | | | | |
|  | | | | | | |
| **Individual Responsible for Evacuation** | | | | | | |
| Name: |  | | | | | |
| Phone Number: |  | | | | | |
| Alternate Name: |  | | | | | |
| Alt. Phone Number: |  | | | | | |
| **Evacuation & Sheltering Options**  **(Based on Personal Disaster Plan)** | | | | | | |
| **Resident Name** | **Shelter Type** | **Address** | | **On-Site Contact #** | **Transport**  **Y/N** | **Accompanying Staff** |
|  |  |  | |  |  |  |
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|  |  |  | |  |  |  |
| **Equipment and Supplies** | | | | | | |
| **Type** | **Amount Needed** | **Method of Transportation** | | **Staff Responsible for Coordination and Tracking** | | |
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| **Client Transportation** | | | | | | |
| **Transportation Method** | **Provider** | **Capacity** | **Response Time** | **Contact Name** | **Contact Number** | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| **Notification & Tracking Procedures** | | | | | | |
| * Describe procedures for notification and tracking: procedures to include notification timeframes, person responsible for notifications and documentation of notifications. * 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:** |  |
|  | |

|  |  |
| --- | --- |
| **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:** |  |
|  | |

## Re-Entry and Reunification:

|  |  |
| --- | --- |
| **County Emergency Management Agency**  **(Contact to Determine Timing for Re-Entry to the Facility)** | |
| **Facility 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 Facility:** |  |
| **Resident Transportation Back to Facility** | |
| **Persons Responsible for Coordination:** |  |
| **Method(s) of Transport:** |  |
| **Transportation Capacity:** |  |
| **Family Notification** | |
| **Persons Responsible for Coordination:** |  |
| **Notification Method(s):** |  |
| **Notification Timeline:** |  |
| **APD/WSC/Guardian Notification** | |
| **Persons Responsible for Coordination:** |  |
| **Notification Method(s):** |  |
| **Notification Timeline:** |  |
|  |  |

## Host Sheltering (For Facilities Receiving Evacuating Residents and Staff):

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

|  |  |
| --- | --- |
| **CONTINGENCY FACILITY INFORMATION**  **(In the event Host Shelter must evacuate)**  **(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:** |  |
|  | |

# INFORMATION, TRAINING, AND EXERCISE

|  |  |  |  |
| --- | --- | --- | --- |
| **STAFF TRAINING REQUIREMENTS** | | | |
|  | | | |
| **TRAINING SCHEDULE** | | | |
| **Training Type** | **Frequency** | **Provider** | **Required Staff** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **EXERCISE SCHEDULE** | | | |
| **Scale** | **Frequency** | **Provider** | **Required Staff** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **CORRECTIVE ACTION PLAN** | | | |
|  | | | |