EVACUATION DISASTER PLAN-AGENCY/INDIVIDUAL FOSTER CARE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADULT AND AGING SERVICES
SFN 823 (10-2024)

Clear Fields

Agency/Individual Foster Care Name	Email Address	Telephone Number	Cell Phone Number
Address	City	State	ZIP Code

This document contains my relocation plan in the event that I am required to leave the above address due to a natural disaster or catastrophic vent.

If I need to evacuate the facility, I would relocate to:

FIRST CHOICE WITHIN THE SAME COMMUNITY

Name	Email Address	Telephone Number	Cell Phone Number
Address	City	State	ZIP Code

SECOND CHOICE WITHIN THE SAME COMMUNITY

Name	Email Address	Telephone Number	Cell Phone Number
Address	City	State	ZIP Code

FIRST CHOICE OUT OF REGION

Name	Email Address	Telephone Number	Cell Phone Number
Address	City	State	ZIP Code

SECOND CHOICE OUT OF REGION

Name	Email Address	Telephone Number	Cell Phone Number
Address	City	State	ZIP Code

Contact information for the person with whom I will be in touch in case of an emergency whom the agency/individual foster care can contact if necessary (family member/friend living outside of the immediate area)

Name	Email Address	Telephone Number	Cell Phone Number
Address	City	State	ZIP Code

* I understand that there are critical items I am urged to take with me when we evacuate. These may include agency/ individual foster care contact information (agency/individual foster care emergency contact number) and the resident's information (prescriptions, recent medical reports, physician's name, contact information and immunization history).
* I understand that in the event I must evacuate the facility, I am required to report my location to the resident's family, legal representative, guardian, Human Service Zone, Human Service Center, licensor, or the North Dakota Department of Health and Human Services. To contact the North Dakota Department of Health and Human Services, call 1-855-462-5465 (toll free), 701-328-4601, or email location to carechoice@nd.gov.
* I understand that if any of the information included in this plan changes, I am to update the family, legal representative, guardian, Human Service Zone, Human Service Center, licensor, or the North Dakota Department of Health and Human Services within 14 days of the change.

Signature	Printed Name