Access & Functional Needs Guidance & Resource Book

Updated June 2022

OKLAHOMA
State Department
of Health

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1.0 Introduction

Natural disasters negatively impact everyone. Preparing for disasters and emergencies is important for all individuals, and is especially critical for those with access and functional needs (AFN) who may need specialized assistance during an emergency. To help reinforce the importance of pre-planning for AFN populations, the Oklahoma State Department of Health (OSDH) is providing this document to assist local entities during the planning process in their communities. This tool will help guide local planners in identifying the specialized resources needed to address the needs of these populations.

It should be understood that a person with access and functional needs is not automatically defined as a person with medical needs. Planning for access and functional needs (AFN) populations should be included within Emergency Support Function (ESF) #6 Mass Care, Housing and Human Services Annex of the State Emergency Operations Plan (EOP) or Annex F of the local EOP.

See the appendix A for important federal laws that guide the accessibility of emergency planning, response, and recovery for people with disabilities.

1.1 Principles of People with Disabilities Emergency Preparedness

The National Organization on Disabilities states that people with disabilities should have a support network before disaster strikes. Emergency managers, planners, and emergency volunteer workers understand that everyone should have an emergency plan. However, the emergency plans for communities must include people with all types of abilities and conditions. The following factors must be included in the community emergency planning for all people with disabilities.

A. People with disabilities must be included in preparedness planning for all emergencies and all plans must take people with disabilities into account.
B. People with all types of disabilities must be included: people who are Deaf, people who are hard-of-hearing (H-o-H), people who are blind, people who have mobility disabilities, people who have mental illness, people who have cognitive or intellectual disabilities, and people who have invisibility disabilities.
C. No plan will be complete unless it includes in its base material and emergency notification procedures facilities that communicate in alternate formats including languages, closed captioning, audio alters, and sign language interpreter services.
D. All speeches, directives, and meetings relevant to preparedness must make appropriate mention of the AFN of people with disabilities, senior

in age, people with cognitive or intellectual disabilities, people who speak English as a second language, and people who are transportation disadvantaged. The meetings should be held in accessible locations with all information pertaining to them available in accessible formats.

E. Universal design standards must be met. In evacuation from buildings and homes such standards often provide the best opportunity for escape.
F. To maintain the dignity and independence people with disabilities, people who are senior in age, and people who are considered transportation disadvantaged should take personal responsibility for their own personal emergency planning. However, the emergency community should provide education on emergency preparedness to the public
G. Each person with a disability, people who are senior in age, and people who are considered to be transportation disadvantaged should develop a plan for personal emergency preparedness that will maintain their safety and security to the greatest extent possible for up to a 72 hour - 144-hour period (three- six days) in any disaster.
H. Training people with disabilities to develop expertise in disaster/security/emergency management will save lives. It also increases the pool of experts on these important issues as they affect everyone in the community.

1.2 Access and Functional Needs Populations – Defined Historically

Numerous states have embraced the term “access and functional needs (AFN)” to include the following: people with disabilities, senior citizens, the Deaf community, children, non-English speaking populations, and people without transportation. These groups represent a large and complex variety of specific concerns and challenges for emergency responders and planners. However, the term is used to assist emergency managers and planners with guidelines for emergency planning and education for their state and county populations.

1.3 FEMA News Release

On January 11, 2021 Federal Emergency Management Agency (FEMA) defined Access and Functional Needs in their new release announcement as this: Simply put, people with access and functional needs includes individuals who need assistance due to any condition (temporary or permanent) that limits their ability to act. To have access and functional needs does not require that the individual have any kind of diagnosis or specific evaluation.

Although, terminology continues to evolve, Oklahoma State Department of Health (OSDH) will use the collective term “access and functional needs” to describe populations that need “functional support assistance” and “access” before, during, and after emergency situations. The term “access and functional needs (AFN)” is more descriptive of the “assistance requirement” by these individuals for independent living and during occurrences of natural, human-caused, or technological disasters. Many State and local governments are addressing their Emergency Operations Plans (EOPs) to specifically include the AFN populations. This change in focus facilitates a more effective “whole community” approach to emergency planning efforts. This concept is also consistent with language contained in the National Response Framework (NRF). The concept of Communication, Medical Care, Independence, Supervision, and Transportation (C-MIST) is defined as the different functions of whole community planning. C-MIST contains the following functions:

1.3.1 C-MIST

C-Mist functions assist in the care of access and functional needs (AFN) populations planning for disaster preparedness, response, and recovery.

Communication--- Individuals who speak sign language, who have LEP, or who have limited ability to speak, see, or hear. People with communication needs may have limited ability to hear announcements, see signs, understand messages, or verbalize their concerns.

Maintaining Health-- Individuals who require specific medications, supplies, services, durable medical equipment (DME), electricity for life maintaining equipment, breastfeeding and infant/child care, or nutrition, etc. Planning to maintain chronic health conditions, minimize preventable medical conditions, and avoid worsening of health status is important in the event of an emergency.

Independence- Individuals who function independently with assistance from mobility devices or assistive technology, vision and communication aids, services animals, etc. Independence is the outcome of ensuring that a person’s access and functional needs are addressed as long as they are not separated from their devices, assistive technology, service animals, etc.

Safety & Support- Individuals who become separated from caregivers may need additional personal care assistance; experience higher levels of distress and need support for anxiety, psychological, or behavioral health needs; or require a trauma-informed approach or support for personal safety.

Transportation --Individuals who lack access to personal transportation, are unable to drive due to decreased or impaired mobility that may come with age and/or disability, temporary conditions, injury, or legal restriction.

Emergencies can significantly reduce transportation options, inhibiting individuals from accessing services and staying connected.

1.3.2 At-Risk Individuals

At-risk individuals are people with access and functional needs that may interfere with their ability to access or receive medical care before, during, or after a disaster or emergency. Irrespective of specific diagnosis, status, or label, the terms “access and functional needs” are defined as follows:

- Access-based needs: All people must have access to certain resources, such as social services, accommodations, information, transportation, medications to maintain health, and so on.
- Function-based needs: Function-based needs refer to restrictions or limitations an individual may have that requires assistance before, during, and/or after a disaster or public health emergency.

The 2013 Pandemic and All-Hazards Preparedness Reauthorization Act defines at-risk individuals as children, older adults, pregnant women, and individuals who may need additional response assistance. Examples of these populations may include but are not limited to individuals with disabilities, individuals who live in institutional settings, individuals from diverse cultures, individuals who have limited English proficiency or are non-English speaking, individuals who are transportation disadvantaged, individuals experiencing housing insecurity, individuals who have chronic medical disorders, and individuals who have pharmacological dependency.

1.4 National Disabilities Statistics

The Centers for Disease Control and Prevention reports that 61 million adults in the United States live with a disability. These percentages demonstrate the importance of access and functional needs (AFN) planning in our nation. Please remember that these statistics can increase at any time in our nation. Having a disability can be temporary or permanent.

1.4.1 Percentage of adults with functional disability types:

- 13.7% of people with a disability have a mobility disability with serious difficulty walking or climbing stairs.
- 10.8% of people with a disability have a cognition disability with serious difficulty concentrating, remembering or making decisions.
- 6.8% of people with a disability have an independent living disability with difficulty doing errands alone.
- 5.9% of people with a disability are deaf or have serious difficulty hearing
- 4.6% of people with a disability have a vision disability with blindness or serious difficulty seeing even when wearing glasses.

- 3.6% of people with a disability have a self-care disability with difficulty dressing or bathing.

Disability is especially common in these groups: older adults, women and minorities.

- 2 in 5 adults age 65 years and older have a disability
- 1 in 4 women have a disability.
- 2 in 5 non-Hispanic American Indians/ Alaska Natives have a disability.

This information can be found at CDC website: https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html#:~:text=61%20million%20adults%20in%20the,Graphic%20of%20the%20United%20States.

1.5 Oklahoma Disabilities

The Centers for Disease Control and Prevention shared statistics of people with disabilities in our state. In Oklahoma 1,046,594 adults have a disability. This equals to 35% or 1 in 3 adults in Oklahoma. The website for this information is https://www.cdc.gov/ncbddd/disabilityandhealth/impacts/oklahoma.html It is paramount to include access and functional needs populations planning in every aspect of your all hazards plans.

The Centers for Disease Control and Prevention (CDC) states that Oklahoma has the following percentages in the various disability areas:

1.5.1 People with Disabilities in Oklahoma (2022) Statistics

Mobility	Cognition	Independence	Hearing	Vision	Self-Care
17%	15%	9%	10%	7%	5%

As mentioned in the National Disabilities area above; the numbers of people with disabilities can be temporary or permanent. At any time, a person might have a diagnosis that causes a permanent disability or a car accident that causes the same condition. A person might be born with a disability or develops one in a later stage of life (older/ seniors in age). You also have those that might have a temporary disability. This could occur due to a skiing accident or a surgery that leaves the person in a cast or brace for a short time. These mentioned factors validate the flow nature of access and functional needs planning. The emergency planner or emergency manager will never have the exact number of people with disabilities in their community. The exact number of people with disabilities will always be fluid. Planning should always be flexible for number and areas of people with access and functional needs populations in community all hazards planning.

1.5.2 Invisible Disabilities

The term invisible disabilities refer to symptoms such as debilitating pain, fatigue, dizziness, cognitive dysfunctions, brain injuries, learning differences and mental health disorders, as well as hearing and vision impairments. These are not always obvious to the onlooker, but can sometimes or always limit daily activities, range from mild challenges to severe limitations and vary from person to person.

Also, someone who has a visible or uses an assistive device such as a wheelchair, walker, or cane can also have invisible disabilities. For example, whether or not a person utilizes an assistive device, if they are debilitated by such symptoms as described below, they live with invisible disabilities.

Unfortunately, people often judge others by what they see and often conclude a person can or cannot do something by the way they look. This can be equally frustrating for those who may appear unable, but are perfectly capable, as well as those who appear able, but are not.

It is stated that about 10% of people with disabilities have invisible disabilities. https://www.umass.edu/studentlife/sites/default/files/documents/pdf/Invisible%20Disabilities%20List%20%26%20Information.pdf

1.6 Definition of Equity

The term "equity" means the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

The above definition is from Exec. Order No. 13985, January 20, 2021, Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.

https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive- order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.

The Oklahoma State Department of Health emergency preparedness plans adhere to the government's definition of equity. The state's emergency plans, preparedness and response to disasters will be demonstrated in a consistent and systematic fair, just and impartial treatment of all humans in our state.

1.7 Health Equity

Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.[12] Substantial disparities by social determinants are found for a number of health indicators, including infant mortality, life expectancy, health care access and utilization, health insurance, disability, mental health, preventive health services, and unintentional injuries.[1]

Health equity is included in the guidance due to the access and functional needs of populations that in the United States. Emergencies can cause disruptions to health care, care providers assistance and resources, medical equipment replacement, medicine replacements, and counseling. Emergencies should not "stop" medical care or resources from those that are in lower economic groups or people with access and functional needs (AFN).

1.7.1 Preparedness Considerations for Women who are Pregnant, Postpartum, and/or Lactating in Various Emergency Scenarios

Emergency plans should include protocols to address the needs of people who are pregnant, postpartum, and/or lactating during a variety of emergencies including infectious disease outbreaks, localized emergencies, natural and human-caused disasters requiring evacuation, and natural and human-caused disasters not requiring evacuation.

Emergency Scenario	Considerations for Infants and Young Children
Infectious Disease Outbreaks	• Communicate guidance to caregivers on any lasting effects of the outbreak that impact children, such as different strains of the disease, and prevention measures, such as getting vaccines.

[1] Health Resources and Services Administration Office of Health Equity (HRSA OHE). (2019-2020). *Health Equity Report 2019-2020*. https://www.hrsa.gov/sites/default/files/hrsa/health-equity/HRSA-health-equity-report.pdf

	• Communicate risks of known long-term effects of the infectious disease specific to infants and young children. Communication about individual circumstances and risks should occur one-on-one with providers. • Talk with caregivers and young children about changes in behavior in response to necessary measures to prevent the spread of disease (e.g., stay-at-home orders) and provide referrals to child mental health services as needed. • Return to a normal routine after stay-at-home orders have lifted and continue to provide children with opportunities to express themselves, such as through art or music.
Localized Emergencies	• Follow up with caregivers if an appointment was missed during the emergency, and respond appropriately to new needs that have arisen. • Maintain contact with local maternal child health (MCH) organizations should service outages persist, such as water and power, to ensure caregivers receive supplies to support infants and young children.
Natural and Human - Caused Disasters Requiring Evacuation	• Consider safety for young children returning to their homes. Children are more affected than adults by environmental contaminants, mold, and chemicals and should return after cleaning has occurred. Carbon monoxide from generators also poses a threat to health and safety. • Consider safety for young children going to temporary housing or relocating with familiar caregiving adults (e.g., parents or relatives) such as following child-safe guidelines with medications and household cleaning supplies. • Understand insurance policies and points of contact should health care take place out of network. • Ensure continuity of services for newborns and young children who temporarily relocate or relocate out of state, including newborn screenings. Communication among health care and social services providers across state lines is important for continuity of care and services.

	• Communicate information to children in a reaffirming way and give them space to ask questions, talk about their experiences, and help them identify emotions.
Natural and Human-Caused Disaster Not Requiring Evacuation	• Maintain contact with local, state, and federal maternal child health (MCH) organizations should service outages persist, such as water and power, to ensure caregivers receive supplies to support infants and young children is needed. • Recognize that even if a child experienced minimal effects of a natural disaster, such as heavy rain from a hurricane or smokey skies from a wildfire, they can still be impacted from the experience or from the experiences of family or friends.

1.7.2 Response Considerations for Infants and Young Children

According to the CDC, younger children are often more affected by emergencies than adults due to a variety of reasons. For example, infants and young children:

• Have thinner skin and breathe faster than adults do, making them more likely to take in harmful substances through the skin or airways.

• Have a higher chance of being harmed by very hot or cold temperatures.

• May be unable to follow directions or make decisions to keep them away from danger during an emergency.

• Use energy more quickly than adult bodies, and they need food and water more often.

• Are more likely to put their hands in their mouths, and spend more time outdoors and on the ground, making them more likely to encounter dangers in the environment.

• May not be able to explain how they are feeling, which can make it harder to identify a medical problem and treat them quickly.

• Have more contact with others, and they have less developed immune systems to fight off infections. This means they are more likely to catch an illness that can spread from person to person.

• Some children have special health care needs (e.g., physical, intellectual and developmental disabilities, chronic medical conditions). These can increase a child's chance of getting sick or highly distressed during an emergency, especially if the child is separated from a parent or caregiver Health care, public health, and social services providers who care for and support infants

and young children should activate emergency plans to protect the health and safety of infants and young children during emergencies.

For example, providers may need to procure and use or provide appropriate equipment and supplies for treating infants and young children, such as child-size masks and needles, transportation equipment (e.g., infant carriers, car seats), and other necessary supplies (e.g., diapers, wipes, bottles, disposable cups).

Mental Health Considerations for Infants and Young Children in Emergencies It is important for all individuals who will be caring for and supporting infants and young children during an emergency to understand that children may react differently during emergency situations than adults and mental health needs may present differently depending on the child's age and development. Changes in behavior, fussiness, and anger can be signs of stress, anxiety, or depression in infants and young children. Children react, in part, on what they see from the adults around them. When parents and caregivers deal with an emergency calmly and confidently, they can provide the best support for children. Take the time to calm a child during an emergency, when possible, which will help them follow instructions from teachers, caregivers, or first responders. For example, consider employing psychological first aid, an early intervention that promotes an environment of safety, calm, connectedness, self-efficacy, empowerment, and hope. National Child Traumatic Stress Network (NCTSN) Common reactions to distress for children include:

• Infants to 2-year-olds: Infants may cry more and/or want to be held and cuddled more than usual

• 3 to 5-year-olds: Preschool and kindergarten children may return to behaviors they have outgrown, such as toileting accidents, bed-wetting, or being frightened about being separated from their parents/caregivers. They may also have tantrums or a hard time sleeping.

1.7.3 Local Emergency Stockpile Supply List

Infants (0-12 months)	Young Children (1-5 Years)
Car Seats Ready to Feed Formula Diapers Wipes	Car seats Diapers Wipes Pull ups Disposable cups

Bottles, nipples, and disposable cups Clothing Infant feeding, cleaning supplies (tub, clean water, dish soap, brush) Safety approved cribs, and fitted sheets to support safe sleeping	Child-size equipment such as masks Child friendly nutritious snacks, water, and milk Clothing Sensory kits Stress relief activities, such as coloring books, colored pencils, toys, and books Child-size first aid equipment such as backboards, splints, and bandages, and wheelchairs.

1.7.4 Resource Guide for Access and Functional Needs of Children & Youth

The American Academy of Pediatrics has established that children have unique physical and emotional needs when a disaster strike. In addition to being placed at an increased risk of physical harm, children respond to illness, injury, and treatment differently than adults do. They also rely on stable routines in their daily lives, and when a disaster occurs, the drastic changes to their known world not only endanger their safety, but also greatly frighten them. To ensure the physical security and emotional stability of children in disasters, communities must modify their emergency planning efforts to include children's unique needs during disasters.

Children have unique needs that must be addressed in emergency preparedness, mitigation, response and recovery operations. Examples of needs specific to children are the following:

a. Children require different dosages of medications and different forms of medical and mental health interventions than those used to treat adults.
b. Different approach to mental health evaluation and treatment is necessary to accommodate children's specific mental health needs.
c. Decontamination of children is more time and resource intensive than decontamination of adults.
d. Children's developmental and cognitive levels may impede their ability to escape danger, evacuate, and self-identify. Young children may not be able to communicate enough information to be identified and reunited with parents, guardians, or caregivers.

e. Communication formats such as the following: non-verbal, American Sign Language (ASL), usage of communication devices, and foreign languages will be utilized throughout their stay in the shelter.
f. Professional language interpreters will be provided by the shelter staffing for functional needs and care of the children in the shelter.
    i. ASL interpreters certified by the Oklahoma state Quality Assurance Screening Test (QAST) Levels IV and V will be used in the shelters.
    ii. QAST certification Level V will be used in all medical examinations both (mental and physical).
    iii. ASL interpreters will be used for the parent and/or child as requested and needed by either individual.
g. Children may experience increased psychological effects as they may have difficulty comprehending disasters within the context of normal every day events. This may leave children unable to cope long after disasters and result in later consequences including depression, lack of focus and poor school performance.
h. Critically sick or injured children may have specialized transportation needs.
i. Children with mobility disabilities may also require specialized transportation care to and from the shelter.
j. Children's safety in a disaster and their individual recovery is dependent on the preparedness, response and recovery capabilities and resources of a network of institutions, including schools, childcare providers and other congregate care settings.

Note: The Oklahoma State Department of Health, Emergency Preparedness and Response Services have developed an extensive resource guide dedicated to children and youth in disaster planning. Contact Emergency Preparedness & Response Services for the location of this guidance to assist in your emergency planning.

1.7.5 Child Reunification in Disaster

Child reunification is defined as the process of assisting displaced disaster survivors, including children, involuntarily reestablishing contact with family and friends after a period of separation. State and local law enforcement agencies have a large roll in this process in uniting families after separation. Local child welfare agencies such as the Department of Social Services, Department of Human Services, Department of Children and Family Services, and other emergency agencies such as the American Red Cross can assist in child or children reunification during and after a disaster. State and local agencies roles mentioned above can assist in the following areas:

- Support the safety and needs of children separated from parents or legal guardians and parents or legal guardians seeking missing children during a disaster.
- Coordinate with the appropriate agencies and organizations for culturally and linguistically appropriate temporary care and shelter of unaccompanied children.
- Coordinate with law enforcement and the judicial system to ascertain the legal responsibilities of various agencies to accomplish the following:
    i. Provide temporary and, if necessary long-term care of the minor.
    ii. Implement standardized guidance to verify the identity and custody rights of adults seeking the release of the child.
    iii. Safely release or assist in the release of a child or children to a verified parent or legal guardian.
    iv. Work within the judicial system to ensure that proper legal procedures are followed and keep the safety of the child in mind at all times.
- Support human services role and functions, including reunification, in disaster response and recovery operations in accordance with defined roles and emergency preparedness plans.
- Develop consensus among agencies and organizations responsible for the management (e.g., processes, procedures, credentialing, and training) of needs of children and families, including those with disabilities and other access and functional needs.
- Provide guidance and assistance to local child welfare agencies and childcare centers with their emergency preparedness planning and reunification activities.
- Plan for the potential need for emergency foster care in a mass casualty event in which many children are left orphaned.
- Support the development of all-hazards emergency preparedness planning inclusive to children with disabilities and other access and functional needs to address lockdown procedures in daycares and summer camps, evacuation, sheltering-in-place, relocation, and reunification of children with their parents or legal guardians.
- Reinforce the need for family contact information and authorization for emergency transportation and medical care before a disaster happens.

For more detailed information on access and functional needs of children and youth in emergency review the Access and Functional Needs of Children and Youth in Disaster Guidance. Contact Emergency Preparedness & Response services for the link to this document.

1.8 Definition of Human Trafficking

In the United States, the Trafficking Victims Protection Act of 2000 (TVPA), as amended by the Justice for Victims of Trafficking Act of 2015 (JVTA), defines sex trafficking as “recruiting, harboring, transporting, providing, obtaining, patronizing, or soliciting of an individual through the means of force, fraud, or coercion for the purpose of commercial sex”. However, it is not necessary to demonstrate force, fraud, or coercion in sex trafficking cases involving children under the age of 18.

1.8.1 Sex Trafficking

Sex trafficking is a form of modern-day slavery in which individuals perform commercial sex through the use of force, fraud, or coercion. Minors under the age of 18 engaging in commercial sex are considered to be victims of human trafficking, regardless of the use of force, fraud, or coercion.

Sex traffickers frequently target victims and then use violence, threats, lies, false promises, debt bondage, or other forms of control and manipulation to keep victims involved in the sex industry for their own profit.

Sex trafficking exists within diverse and unique sets of venues and businesses including fake massage businesses, escort services, residential brothels, in public on city streets and in truck stops, strip clubs, hostess clubs, hotels and motels, and elsewhere.

1.8.2 Definition of Commercial Sex Act

The term “commercial sex act” is defined as “any sex act on account of which anything of value is given to or received by any person” (*22 U.S.C. 7102*).

Sex trafficking may be distinguished from other forms of commercial sex by applying the Action + Means + Purpose Model. Human trafficking occurs when a trafficker takes any one of the enumerated actions, and then employs the means of force, fraud, or coercion for the purpose of compelling the victim to provide commercial sex acts. At a minimum, one element from each column must be present to establish a potential situation of sex trafficking. The presence of force, fraud, or coercion indicates that the victim has not consented of his or her own free will. In addition, minors under the age of 18 engaging in commercial sex are considered victims of human trafficking regardless of the use of force, fraud, or coercion.

1.8.3 Demand for Sex Trafficking: What You Need to Know

Sex trafficking is a market-driven criminal industry that is based on the principles of supply and demand. Therefore, people who purchase commercial sex increase the demand for commercial sex and likewise provide a profit incentive for traffickers, who seek to maximize profits by exploiting trafficking victims. Therefore, buyers of commercial sex need to

recognize their involvement in driving demand. By not buying sex and not participating in the commercial sex industry, community members can reduce the demand for sex trafficking.

For currant statistics on Human Trafficking visit https://polarisproject.org/2020-us-national-human-trafficking-hotline-statistics/

1.8.4 What is slavery?

Slavery: being forced to work without pay, under the threat of violence, and being unable to walk away.

1.8.5 Where do slaves work?

Slaves work in-farm fields, factories, mines, construction sites, logging camps, restaurants, hotels, retail stores, brothels and private homes- anywhere slave owners can feed their greed.

1.8.6 Are you supporting slavery?

Many everyday products are made by slaves, or with slavery-tainted parts or raw materials –such as cars, computers, chocolate, cell phones and clothing.

1.8.7 Who can end slavery?

Everyone can help put an end to slavery: governments, businesses, investors, international organizations, faith communities, schools, consumers, and you.

1.8.8 What words are used for slavery?

Slave holders use many terms to avoid the word “slavery” such as debt bondage, bonded labor, attached labor, forced labor, indentured servitude and human trafficking.

1.8.9 Assessments Questions on Human Trafficking

A. Are you in control of your identification/personal documents? If not, who is?
B. Were you recruited for one job and are doing another?
C. Has someone asked you to engage in sexual activity in exchange for anything?
D. Have you been asked to do something for pay that you did not want to do, or felt uncomfortable with?
E. Are you in control of your own money? Do you have to turn over the money you make?
F. Do you have deb you cannot pay off?
G. Are you paid for your work? Are you paid enough? Do you only earn tips?
H. Can you leave if you want?

I. Has anyone threatened to harm you/your family if you leave your job?

Look for signs of physical, psychological, or sexual abuse that may also indicate human trafficking.

1.8.10 Human Trafficking

Sex trafficking is defined as: sex act is induced by force, fraud, or coercion, or in which the person induced to perform such as has not attained 18 years of age; or

The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

1.8.11 Human Smuggling

Human Smuggling is defined as the importation of people into the United States involving deliberate evasion of immigration laws. This offense includes bringing illegal aliens into the United States as well as the unlawful transportation and harboring of aliens already in the United States.

The terms are not interchangeable terms.

- Smuggling is transportation-based
- Trafficking is exploitation-based

1.8.12 Blue Campaign

- Serves as the unified voice for DHS's efforts to combat human trafficking.
- Educates the public through awareness resources including public service announcements, posters, brochures, and infographics.
- Partners with state, local, and tribal governments, federal agencies, and non-governmental and private organizations to provide training and resources on recognizing and reporting suspected human trafficking.
- Use social media to communicate with stakeholders and the general public about DHS efforts, how to recognize and report human trafficking, and how to get involved.
- For more Information visit: www.dhs.gov/bluecampaign

1.8.13 How to Get Involved

As an individual or organization there are many actions you can take to help raise awareness of human trafficking and work to combat this heinous crime. Visit www.dhs.gov/bluecampaign

- Educate yourself by viewing free educational awareness products and videos at www.dhs.gov/bluecampaign

- Learn more about how to recognize and report suspected human trafficking.
- Download and share free resources in your community and online at www.dhs.gov/bluecampaign

1.8.14 Trafficking Indicators

- Is the victim in possession of identification and travel documents; if not, who has control of the documents?
- Was the victim coached on what to say to law enforcement and immigration officials?
- Was the victim recruited for one purpose and forced to engage in some other job?
- Is the victim's salary being garnished to pay off a smuggling fee? (Paying off a smuggling fee alone is not considered trafficking.)
- Was the victim forced to perform sexual acts?
- Does the victim have freedom of movements?
- Has the victim or family been threatened with harm if the victim attempts to escape?
- Has the victim been threatened with deportation or law enforcement action?
- Has the victim been harmed or deprived of food, water, sleep, medical care, or other life necessities?
- Can the victim freely contact friends or family?
- Is the victim a juvenile engaged in commercial sex?
- Is the victim allowed to socialize or attend religious services?

Report Suspicious Activity: 1-866-DHS-2-ICE (1-866-347-2423)

www.dhs.gov/bluecampaign

1.8.15 Indicators of Human Trafficking

Recognizing human trafficking is the first step in combating the heinous crime. Learning the indicators and reporting tips helps law enforcement identify victims and connect them with the care and services they need. The indicators listed below may help you recognize human trafficking, but any one indicator is not necessarily proof of human trafficking.

A. Physical:

Does the person…

- Show signs of physical and/or sexual abuse, physical restraint, confinement, or torture?
- Appear to be deprived of food, water, sleep, medical care, or other necessities?
- Lack personal possessions?

B. Social:

Does the person…

- Work excessively long and/or unusual hours?
- Show sudden or dramatic changes in behavior?
- Act fearful, anxious, depressed, submissive, tense, or nervous/paranoid?
- Defer too another person to speak for him or her?
- Appear to be coached on what to say?
- Appear disconnected from family, friends, community organizations, or place of worship?
- Not have the ability to freely leave where they live?

1.8.16 What Disaster Responders Need to Know

As a disaster responder and/or a healthcare provider, the likelihood that you will come in contact with a human trafficking victim is very high! Remember that anyone can be trafficked- men and boys, women and girls.

1.8.17 Disasters Increase the Risks of Human Trafficking

A. Beginning of Disasters
   - Disruption and chaos make it easy to exploit disaster survivors
   - Perpetrators of trafficking may pose as responders offering survivors help with housing, food, or water

B. During Disasters
   - Disaster survivors may engage in survival strategies that make vulnerable to be taken advantage of
   - Children may be separated, sometimes permanently, from their parents

C. After Disasters
   - Rebuilding and cleanup create new markets for cheap or free labor
   - Disaster survivors may lose their main source of income and look for new types of work, including commercial sex

1.8.18 Recognize the Signs of Human Trafficking

A. Sex Trafficking

- Reports providing sex in exchange for basic necessities (food, water, housing)
- Unexplainable injuries
- Reports being forced to engage in commercial sex
- Aged <18 and involved in commercial sex
- Reports unusually high number of sex partners

B. Labor Trafficking

- Reports performing work duties in exchange for basic necessities (food, water, housing), rather than money
- Unable to freely choose where they live
- Identification documents are held by employer

1.8.19 Labor Trafficking

Labor Trafficking is the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purposes of subjection to involuntary servitude, peonage, debt bondage, or slavery, (*22 USC § 7102*). The federal government has three different categories of labor trafficking.

1. Involuntary Servitude
2. Debt Bondage
3. Coercion

1.8.20 Involuntary Servitude

A condition of servitude induced by means of any scheme, plan, or pattern intended to cause a person to believe that, if the person did not enter into or continue in such condition, that person or another person would suffer serious harm or physical restraint; or the abuse or threatened abuse of the legal process *(22 U.S.C. 7102 (6))*.

1.8.21 Debt Bondage

The status or condition of a debtor arising from a pledge by the debtor of his or her personal services or of those of a person under his or her control as a security for debt, if the value of those services as reasonably assessed is not applied toward the liquidation of the debt or the length and nature of those services are not respectively limited and defined *(22 U.S.C. 7102 (5)*).

1.8.22 Coercion

(A) threats of serious harm to or physical restraint against any person;
(B) any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or
(C) the abuse or threatened abuse of the legal process (*22 U.S.C. 7102 (3)*).

If you think someone may be a victim of human trafficking, call or encourage them to call the National Human Trafficking Hotline: (888) 373-788 to receive help, resources, and information. https://humantraffickinghotline.org/

1.9 Authorities

The United States has numerous regulations and laws designed to prohibit discrimination and ensure adequate access to services for individuals with access and functional needs. This guidance is based upon responsibilities and requirements outlined in Title II of the Americans with Disabilities Act (ADA).

State and local governments must comply with Title II of the Americans with Disabilities Act in the emergency- and disaster-related programs, services, and activities they provide.[2] This requirement applies to programs, services, and activities provided directly by state and local governments as well as those provided through third parties, such as the American Red Cross (ARC), private nonprofit organizations, and religious entities.[3] Under Title II of the Americans with Disabilities Act (ADA), emergency programs, services, activities, and facilities must be accessible to people with disabilities[4] and generally may not use eligibility criteria that screen out or tend to screen out people with disabilities.[5] The ADA also requires making reasonable modifications to policies, practices, and procedures when necessary to avoid discrimination against a person with a disability[6] and taking the steps necessary to ensure effective communication with people with disabilities.[7]

1.10 Situations

1. Some individuals with access and functional needs (AFN) will identify the need for assistance during emergency situations; others will not.
2. Local planners have access to their jurisdictions' demographic and ethnographic profiles. Emergency planners and emergency managers can develop these demographics from Social Vulnerability Index (SVI) at https://www.atsdr.cdc.gov/placeandhealth/svi/index.html
3. Major needs of individuals with AFN may include, but are not limited to, preparation, notification, evacuation and transportation, sheltering, first

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[2] 42 U.S.C § 12132; see generally, 28 C.F.R. §§ 35.130, 35.149

[3] 28 C.F.R. § 35.130 (b) (1).

[4] 28 C.F.R. § 35.149 - 35.151.

[5] 28 C.F.R. § 35.130 (b) (8).

[6] 28 C.F.R. § 35.130 (b) (7).

[7] 28 C.F.R. § 35.160 - 35.164.

aid and medical services, temporary lodging and housing, transition back to the community, clean-up, and other emergency- and disaster-related programs, services, and activities.

4. Some people who have AFN may utilize service animals. Accommodations for these animals should be considered when developing evacuation and sheltering plans. Note: Service animals are not considered pets. These animals perform specific functions to assist their owner in activities of daily living. Additionally, in order to be permitted into a shelter with their owner, the service animal cannot pose a direct threat to other animals or individuals residing in the shelter and must have had prior training to remain calm in public situations.

1.11 Planning Assumptions

1. Local resources are limited. The intent of Title II, the American with Disabilities Act (ADA) will be followed to ensure that emergency management programs, services, and activities will be accessible to and usable by individuals with access and functional needs without causing undue financial or administrative hardship on State or local governments providing the emergency and disaster-related response and recovery operations and services.[8] Responsibilities and requirements outlined in Title II, ADA will be prioritized and instituted in order to provide for immediate, lifesaving needs during response operations to the return and transition into the community during recovery operations.
2. Persons with access and functional needs are included in the local planning process and in training drills with emergency managers, first responders, voluntary agencies, and disability agents.
3. Community resources such as certified interpreters, health care personnel, and housing managers will provide assistance to members of the community and emergency response personnel.
4. Collaboration and partnerships with access and functional needs (AFN) stakeholders, community base and faith-based organizations, (CBO, FBO), and non-governmental organizations (NGOs) provide community resource capacity for preparedness, response, recovery, and mitigation.

[8] 28 C.F.R. §§ 35.130(b) (7), 35.150 (a) (3), 35.164.

5. Mutual-aid agreements and memorandums of agreement/understanding (MOA/MOU) with neighboring jurisdictions and partner agencies provide additional emergency capacity resources.
6. Some members of the community may have to be evacuated without or may be separated from the durable medical supplies and specialized equipment they need such as wheelchairs, walkers, and telephones. Every reasonable effort should be made by emergency planners to ensure these durable medical supplies are made available or are rejoined with the community member.
7. Frequent public education programs with an emphasis on personal preparedness and local jurisdiction self-identifying registries should be available in accessible formats and languages so that they reach most, if not all, people in a community.
8. Emergency human services are vital for the long-term recovery of a community and are as important as the repairs to its physical infrastructure.
9. A sustained long-term commitment to providing human services is needed to restore all residents to a state of mental, physical, and social well-being.

2.0 Preparedness

2.1 Planning Networks

Effective planning involves engaging disability navigators, disability organizations, community and faith-based organizations, non-governmental organizations, and other private sector groups that assist or provide services to individuals with access and functional needs. No single person or agency can provide all of the expertise needed for comprehensive planning. A multi-agency approach is needed at all stages of the planning process including the initial assessment of plan purpose, situational needs and assumptions, and the development of a draft concept of operations. Members of this planning network should assess how their efforts can be coordinated to ensure an integrated response.

Focus should be on improving the understanding of agency-based assets, capabilities, and limitations as well as identifying opportunities for improvement and cooperation. This includes the development of mutual-aid agreements and memorandums of understanding and agreements (MOU/MOA) regarding sharing of resources during emergency events.

The Oklahoma State Department of Health (OSDH) hosts a statewide team of subject matter experts on access and functional needs (AFN) populations planning for all hazard's disaster preparedness. This team seeks to educate, as well as identify gaps and possible resources for the AFN populations in Oklahoma. These resources will assist in the emergency planning and care for people with AFN before, during, and after disaster occurrences. For more information on this task force, contact the Emergency Preparedness & Response Service (EPRS) at the Oklahoma State Department of Health (OSDH).

2.2 Assessments and Geographic Information System (GIS)

2.2.1 What is GIS?

GIS, or geographic information systems, are computer-based tools used to store, visualize, analyze, and interpret geographic data. Geographic data (also called spatial, or geospatial data) identifies the geographic location of features.

These data include anything that can be associated with a location on the globe, or more simply anything that can be mapped. For example, roads, country boundaries, and address are all types of spatial data. At the CDC, we use GIS to help answer questions about how location impacts disease and disability.

2.2.2 Pieces of GIS

People: People use GIS to answer specific data-related questions. People collect data, develop procedures, identify research questions and define analysis tasks to run in GIS. In public health, people use GIS to explore a variety of topics. For example, researchers at CDC have used GIS to identify how to target polio immunization campaigns in geographically isolated locations.

2.2.3 Data

There are two main GIS types: vector data and raster data.

– Vector data includes spatial features (points, lines, and polygons) and attributes about that data (descriptive information).

– Raster data are stored electronic images (e.g., pictures taken as an aerial photograph or satellite images).

-Analysis is the process of using spatial data to answer questions. There are many different analysis techniques.

-Hardware: GIS software is run on computers. Memory and computing power are important because spatial data includes many attributes making it very large.

Software: Geographic Information Systems require specialized software. The most commonly used GIS software at CDC/ATSDR include ArcGIS and QGIS. These types of programs can be used in conjunction with other types of software such as databases, statistical packages, or programming languages to increase functionality.

2.2.4 HIPAA

The Health Insurance Portability and Accountability Act's (HIPAA's) Privacy Rule will assist planners in understanding their ability to obtain data from

agencies and private groups serving access and functional needs populations. The Privacy Rule controls the use and disclosure of protected health information held by “covered entities” (healthcare providers who conduct certain transactions electronically, healthcare clearinghouses, and health plans). The Privacy Rule permits covered entities to disclose information for public health and certain other purposes. Transportation and social service providers are not likely to be subject to the Privacy Rule and may be permitted to disclose the number of individuals they serve.

2.2.5 Geographic Information System (GIS) and Access and Functional Needs

After defining the access and functional needs (AFN) populations within the community, demographic and registry information can be entered into a database management program. This database maps communities, facilities, and households where persons with access and functional needs reside relative to response assets and hazard scenarios. Some fire departments and emergency managers use mapping neighbors in evacuation planning. Geographic dispersion can go a long way towards strengthening relationships with State and local organizations and can play key roles in preparedness, response, and recovery. The best method for locating access and functional needs populations should include Geographical Information Systems (GIS) technology, such as the U.S. Census, combined with community collaborations and networking. GIS databases have been used extensively for many years to help institutions, business, and federal, State, and local governments collect and analyze information to make better solutions.

2.3 Community Outreach Information Network (COIN)

People are more likely to receive information and act on it when the message comes from a trusted source they view as credible. Some examples of trusted sources or non-traditional leaders in your community may be the local faith-based leaders, local community-based organizations, parent-teacher association (PTA) president, and respected school teachers and school leaders. Spokespersons in government (local, state, or federal) authority are not always perceived as the credible, trusted sources we hope they will be in delivering information to the general public and might even be less credible for the access and functional needs populations you are trying to reach.

This lack of credibility underscores why it is so important to build your network, or community outreach information network (COIN), of trusted spokespersons with who you’re access and functional needs (AFN) populations and your minority populations will identify and trust. These individuals might not serve in an official capacity, or be known to public health and emergency providers yet, but they can serve as a channel of

information and become a cadre of leaders in emergencies. The same qualities that make them leaders in their communities often make them willing to serve as a liaison between health professionals and access and functional needs (AFN) populations before and during an emergency.

A community outreach information network (COIN) might also include members of the media, especially those who have closer connections to access and functional needs (AFN) populations, such as the local ethnic media outlets and websites that serve and connect the deaf communities. These media outlets can be a very powerful voice and provide a close connection to the populations they serve. Another trusted source might be the director of a multicultural community center or a community health worker (CHW). In addition to having the confidence of the people the center serves, this person might also have a good network already in place to reach community members through an e-mail listserv, telephone tree, mailing list, or simple word of mouth.

Include trusted sources in meetings and planning sessions with other community organizations and service providers. Add them to your database, capturing their contact information and how they prefer to be reached. As you build your network of trusted sources, map their locations in your community so you can begin to get a visual representation of the network you are developing.

Eventually you will be able to integrate this information in such a way that you can develop digital maps showing the locations of trusted sources, spokespersons and community resources coordinated with the populations that they serve. Later on, this graphic representation of your network and the populations that they serve will help you identify gaps in coverage for AFN populations in your community.

Engaging community members in activities to locate AFN populations requires collaboration, contribution, and commitment. Engaging the community members and leaders in this process will ensure the development of long-term relationships built on respect, credibility. Within this process a shared concern that people in AFN populations are included in health, education, and emergency planning, response, and recovery planning.

The process of identifying trusted leaders in your community is an ongoing process. Emergency managers and emergency planners will want to continuously identify who is missing from the community outreach information network (COIN). The COIN members may be a good resource in directing you to such non-traditional leaders.

2.4 Education, Training, and Exercises

Emergency plans and procedures are only useful when accompanied by comprehensive training and exercise programs. These programs are meant

to strengthen the overall effectiveness of plans by “testing” all or some components of the process. They also identify strengths, weaknesses, and solutions to improve existing procedures and protocols. From past experiences it is clear, if included, individuals with access and functional needs can:

a. Assist emergency planners in developing plans that take into consideration access and functional needs (AFN) issues within their community.
b. Identify weaknesses and gaps in plans that require further development.
c. Help develop solutions and resources within the community that can support the emergency management system.
d. Articulate emergency needs within their communities.
e. Encourage overall greater collaboration, coordination, and communication before, during, and after disasters.
f. Provide opportunities to build awareness about AFN and emergency preparedness issues.

Emergency management agencies and other response agencies should partner with access and functional needs organizations and advocacy groups to identify how to address these issues in planning, training, and exercise. It should be a matter of protocol to include such agencies and programs in these endeavors.

2.4.1 Education

Public education on personal and family preparedness is one component of effective response. Encouraging individuals with access and functional needs (AFN) to take responsibility for their own safety and security will benefit emergency managers and responders. Everyone should have preparedness, evacuation, and sheltering plans. A general rule of thumb is to plan to be self-sufficient for at least three – six days. Individuals with AFN needs should be encouraged to prepare these plans that include provisions for support networks, evacuation (if needed), adaptive equipment, service animals, pets, effective communication, rendezvous components, accessible transportation, medications, food, water, sanitation, and other individual go-kit needs. An emergency support network can consist of friends, relatives, neighbors, or aides who know where the person resides, what assistance he or she needs, and who will join the person to assist them in seeking shelter or when sheltering-in-place. If a person’s plan depends on assistance from others, it is essential that all persons fully understand and commit to their role, and that these individuals establish backup plans as a safeguard against unforeseen contingencies.

2.4.2 Emergency Preparedness Educational Videos: American Sign Language, English, Spanish and Highlighted Text

The Oklahoma State Department of Health, Emergency Preparedness and Response Services have developed educational videos in American Sign Language (ASL) to assist the Deaf communities in education and disaster planning. English (audio), and Spanish (audio) and highlighted text to assist people who have visual disabilities, people that speak Spanish as their primary language, people who have cognitive or intellectual disabilities, and people who have low literacy. The videos can be accessed on the Oklahoma State Department of Health YouTube website at http://www.youtube.com/user/HealthyOklahoma.

2.4.3 Training

People with access and access and functional needs should be involved in all different aspects of emergency management training as developers, trainers, and participants. In the emergency management spectrum, there are several types of training that should be inclusive and incorporate access and functional needs issues. These include the following:

a. First responder training (fire, law enforcement, Emergency Medical Services (EMS).
b. Community-based training and education (community disaster preparedness and outreach).
c. Volunteer training Oklahoma Medical Reserve Corps (OK-MRC), Oklahoma Volunteer Organizations Active in Disasters (OK-VOADs), American Red Cross (ARC).
d. Emergency management agency training on specific hazard annexes/plans (tornado, flood, evacuation, sheltering, pandemic flu, Hazmat, terrorism, etc.).
e. Cross-training within state and local agencies, and non-profit organizations for these trainings.

2.4.4 Functional Assessment Support Team

The Functional Assessment Support Team (FAST) is a group of Subject Matter Experts (SME's) that train on Access and Functional Needs (AFN) populations for emergency planning. This group of Subject Matter Experts (SME's) focus on integration and disability awareness education through lecture and hands on training for first responders, disaster volunteers, and emergency planners.

2.4.5 Cultural and Linguistic Competency in Disaster Preparedness and Response

The racial and ethnic diversity of the United States population is increasing, necessitating an inclusive and integrated approach to disaster preparedness, response, and recovery activities. This approach ensures that culturally and

linguistically diverse populations are not overlooked or misunderstood, and receive appropriate services as needed. The "Whole Community Approach" to emergency planning includes people with disabilities, the Deaf communities, people who are senior in age, children and youth, people that speak English as a second language, and people who have low English literacy in our communities.

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards), issued by the Department of Health and Human Services, Office of Minority Health (OMH), offer individuals working in the areas of emergency management, public health, and other health-related organizations a framework for developing and implementing culturally and linguistically competent policies, programs, and services. Cultural competency is defined as "the ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, sexual orientations, and faiths or religions in a manner that recognizes, affirms, and values the worth of individuals, families, tribes, and communities, and protects and preserves the dignity of each.[1]

Developing cultural and linguistic competency allows public health officials and emergency managers to better meet the needs of diverse populations and to improve the quality of services and health outcomes during and after a disaster. To be effective, however, cultural and linguistic competency must be included in all phases of a disaster or public health emergency – preparedness, response, and recovery.

2.5.6 Five Elements of Cultural Competency within Disaster Preparedness

1. Awareness and Acceptance of Difference: Responders and survivors are often different in their racial, ethnic and/or language characteristics. By improving communication skills as well as becoming self-aware of potential biases and stereotypes, however, public health officials and emergency managers can provide quality care to diverse populations in a culturally competent manner.

Example: Not all cultures react to pain in the same way. While the experience of pain is universal, the way of perceiving, expressing, and controlling pain is one of these learned behaviors, that when manifested, is culture-specific.[2] An example of cultural competency is a public health official's and an emergency manager's self-awareness of expectations associated with how an individual expresses pain or stress.

2. Awareness of One's Own Cultural Values: Examining personal prejudices and cultural stereotypes by performing an individual self-assessment can help public health officials and emergency managers

become aware of their own cultural values and biases.

Example: The Valuing Diversity and Self-Assessment questionnaire is a widely used self-assessment that allows individuals to identify their own strengths and weaknesses when working with or treating populations with backgrounds different than their own. For example, immigrant and refugee populations may speak a language other than English, have different cultural norms, come from a different socioeconomic background, and have a different style of dress. Recognizing and respecting cultural differences and understanding your own biases and beliefs are critical to effectively serving or assisting culturally diverse populations during or after an emergency.

3. Understanding and managing the "Dynamics of Difference": This refers to the various way's cultures express and interpret information. Taking an individual's medical history is a systematic way to collect both medical and cultural information. This information promotes cultural understanding and improves the quality of services provided to the individual.

   Example: The RESPOND tool succinctly defines the key components of taking the medical history of culturally and linguistically diverse populations.

R – Build rapport
E – Explain your purpose
S – Identify services & elaborate
P – Encourage individuals to be proactive
O – Offer assistance for individuals to identify their needs
N – Negotiate what is normal to help identify needs
D – Determine next steps

4. Development of Cultural Knowledge: Cultivating a working knowledge of different health and illness related beliefs, customs, and treatments of cultural groups in your local area can better equip public health officials and emergency managers with the information necessary to provide timely and appropriate services.

Example: Research illustrates that racial and ethnic minorities are disproportionately vulnerable to, and impacted by, disasters. Minority communities also recover more slowly after disasters because they are more likely to experience cultural barriers and receive inaccurate or incomplete information as a result of cultural differences or language barriers.

5. Ability to Adapt Activities to Fit Different Cultural Contexts: This concept refers to the ability to adapt and as appropriate, to modify, the services offered to fit the cultural context of the patients and

communities you are serving.

Example: Increasingly, the role of disaster personnel includes involvement with interpreters during the triadic interview. A triadic interview is a process in which people with limited English proficiency can communicate their needs in the language of their choice and the interpreter relays this information to the disaster personnel. This process fosters mutual understanding and builds trust between the survivor and the responder.

2.4.7 Proper Translation and Interpretation in Communication During Disasters

To ensure proper translation is occurring, ensure you have a translator that is educated to the level that is conducive to your needs. Having medical personnel that is bilingual is essential to accurate medical translation. The same situation will occur with mental health counseling. Having a bilingual mental health counselor is important for the accurate translation of their questions and guidance for mental health care.

The same situation occurs with American Sign Language (ASL) interpretation. Having proper certification in ASL interpretation will ensure accurate translation is occurring for both medical and mental health care needs in people who are Deaf or Hard-of-Hearing (H-o-H).

2.5 Federal Recognized Nations and Tribes in Oklahoma

In Oklahoma we have, 38 Federal Recognized Nations and Tribes. All 38 Nations and Tribes have a unique culture, customs, and languages. Oklahomans respond to and prepare for a variety of natural and human made disasters. Cultural competency is essential for the exchange of emergency plans and practices for each individual Tribe, Nation, and non-Tribal partner. Partnerships with respect for customs, language, and culture enhances emergency planning for everyone. Each Tribe and Nation develops his or her own emergency preparedness and response plans. Partnerships with county and state health departments provides networking within the state for responses that are greater than their immediate resources. Oklahoma State Department of Health collaborates with the Inter-Tribal Health Board for guidance in cultural competency in emergency preparedness activities across the state of Oklahoma.

2.6 Exercises

Exercises and drills are used to test the effectiveness of plans. The Department of Homeland Security (DHS) Homeland Security Exercise and Evaluation Program (HSEEP) list seven types of exercises. They include seminars, workshops, tabletop exercises, games, drills, functional exercises,

and full-scale exercises. This variety provides options to best suit the need. DHS-funded exercises are required to follow HSEEP guidelines. Also supporting HSEEP are the Target Capabilities and the Exercise Evaluation Guides. Those responsible for integrating access and functional needs into exercise programs should be familiar with this material.

After an exercise or drill, an after-action report (AAR) should be developed to capture the following: exercise successes, needed improvements, and points of failure, as well as to determine steps for corrective actions. By partnering with access and functional needs organizations and advocacy groups, workable solutions to identified gaps should be easily addressed.

3.0 Response

3.1 Crisis and Risk Communications

The primary goal of emergency messages is to motivate people to take a desired action before and during a crisis. This is easier said than done. It requires an understanding of how to reach the targeted populations in ways that grab their attention and change how they think so they will take action. This is a major challenge for individuals with access and functional needs (AFN). The National Organization on Disability (NOD) identifies three types of disabilities of concern for emergencies and disasters: sensory, mobility, and cognitive. The following definitions are from NOD's Emergency Preparedness Initiative:

Sensory:	Persons with hearing or visual limitations, including low vision, total blindness and hard-of-hearing (H-o-H). Note: a person who is Deaf is not considered to have a disability.
Mobility:	Persons who have limited or no mobility of their legs or arms. They generally use wheelchairs, scooters, walkers, canes, and other devices as aids for movement.
Cognitive:	The terms "Intellectual" and "cognitive" most commonly include conditions that may affect a person's ability to listen, think, speak, read, write, do math, or follow instructions.

Understanding risk communications starts with examining the many places and points where vulnerability intersects and then targeting those points with good science and effective practices. Risk communication principles and practices are universal. Every community's risk communication should have the objective of equity in outreach so that no one is left unprotected. Outreach and networking with access and functional needs population groups can enhance experience in training, identify how best to alert and notify, and help identify and meet unexpected resource needs during an emergency.

3.1.1 Messages

Messages delivered during an emergency should provide information about transportation, evacuation, and sheltering locations. Message content should include the following: incident facts, health risk concerns, pre-incident and post-incident preparedness recommendations, and locations to access

assistance in a format or language that a broad spectrum of the community can understand. The base content of these messages should be composed and translated into other languages in advance (with opportunity for collaboration and input from all interested stakeholders), leaving placeholders to insert the specifics of each emergency situation and the protective actions recommended.

Composing warning messages, directions, announcements, offers of assistance, and other public information accessible to people with disabilities requires awareness of different needs, and familiarity with the capabilities and limitations of various communications technologies. There are many communication methods that can be used such as, phone, radio, television, bill inserts, word-of-mouth, typed reports, different languages, audio amplifier devices, certified American Sign Language (ASL) interpreters QAST Level III-IV signing messages in ASL, social and community networks. For people to act, they must understand the message, believe the messenger is credible and trustworthy, and have the capacity to respond. It is essential to utilize multiple redundant channels and alternative formats in alerting populations to an emergency. Yet, for cultural and linguistic minorities, readying the optimal communication media is a time-intensive task that must be accomplished at the local level prior to an emergency.

3.1.2 People-First Language

Emergency planners, first responders, and emergency managers should use people-first language while communicating with the public in any disaster or emergency situation. People-first language emphasizes the person, not the disability. By placing the person first, the disability is no longer the primary, defining characteristic of an individual but one of several aspects of the whole person.[9] Using appropriate terms can reduce barriers instead of creating barriers in any public situation. The chart below contains examples of people-first language:

Say:	Instead Of:
People with disabilities.	The handicapped or disabled.

[9] The North Carolina Office of Disability and Health with Woodward Communications. (2002) Removing Barriers- Tips and Strategies to Promote Accessible Communication.

Paul has a cognitive disability (diagnosis).	He's mentally retarded.
Bob has a physical disability (diagnosis).	He's a quadriplegic/crippled.
Sara has a learning disability.	She's learning disabled.

Note: A few communities prefer not to be recognized as having a disability, and as such, People-First Language would not apply to them. One such example is the Deaf community. They do not recognize deafness as a disability rather they see it as their way of life. They prefer to be recognized as the Deaf community and not a community with a hearing disability.

3.1.3 Communications Without Barriers

Oklahoma is a very diverse state. We have 13 federally recognized Native American (Tribes or Nations). Oklahoma populations consist of people who identify as being the following: African American/Black, Asian, Native American, Native Hawaiian/Pacific Islander, Hispanic, Asian, African, Arabic, White, Russian, and many more. The native languages are as diverse as their identified ethnic group. Language barriers can occur when trying to communicate during a disaster. These barriers can disrupt medical care, childcare, legal custody of children, housing assistance, and basic transportation.

3.1.4 Language Line Solutions Services

This is one area of planning that must take highest priority of networking and community planning. This level of community planning will reduce the barriers that can occur with communication. The Oklahoma State Department of Health has a contract services call Language Line Solutions. This service provides is provided 24 hours a day/7 day a week. Video services (tablet, laptop, or smart phone) are provided by the top 20 languages requested and this does include American Sign Language.

Language Line Solutions provide interpretation services in approximately 240 languages (audio only). Telephone interpretation and document translations are services also provided in the Oklahoma State Department of Health (OSDH) contract. The language interpretation can be used on a laptop, tablet, or cell phone. The laptop or tablet must have cellular capabilities to utilize these services. The approved OSDH employee must have the agency's account number and "special code" to activate the Language Line Insight Video Interpreting or Audio Services. The Oklahoma State Department of Health/ Office of Communications will be able to guide the OSDH employee in the account and "code" process.

3.2 Transportation

Populations that will require transportation assistance during emergency response and recovery include:

a. Individuals who do not have access to a vehicle but can independently arrive at a pick-up point.
b. Individuals who do not have access to a private vehicle and will need a ride from their home.
c. Individuals who live in a group setting or assisted living environment and will need a ride from such facilities.
d. Individuals who are in an in-patient medical facility or nursing home.
e. Individuals who are transient, such as people who are displaced and have no fixed address.
f. Individuals with limited English proficiency.

Communities should work together to coordinate evacuation plans in advance. Many people with disabilities do not drive and routinely use public para-transit systems operated by EMBARK public transit systems and may call on such services before, during, and after an emergency. If these services are unavailable during the emergency, plans must include a way to forward requests to emergency services or transportation coordinators and to alert customers the request has been forwarded. If long-term care facilities have contracted for accessible evacuation transportation, they must not all plan to use the same contractor, or if they do, they must be sure the contractor has sufficient vehicles to meet all needs.

Transportation is very important for the community responses to disasters. Access and functional needs (AFN) populations can be very dependent on public transportation for basic needs. When a disaster or emergency occurs the public transportation services will become more critical for activities of daily living (ADL's). Examples of these programs include local area agencies on the aging, mental health day-habilitation programs, and vocational rehabilitation programs. Steps should be taken to include social service providers, transportation providers, and transportation planning organizations in determining transportation needs and to develop agreements for emergency use of drivers and vehicles. Once plans are established, training opportunities should be determined. Exercises should be conducted to identify additional challenges posed by evacuating hospitals, individuals, and fixed facilities with varying access and functional needs.

Vans and buses vary as to the number of individuals they can accommodate, and the types of lifts, ramps, and wheelchair securing devices they employ. The process of inventorying these vehicles should identify overall occupant capacity, any limitations regarding the size or type of wheelchairs, or

limitations on other equipment they can safely transport. Operators need to be trained in the safe operation of lifts, ramps, tie downs, and other mechanical devices associated with vehicles.

Some public and private sector transportation providers are reluctant to provide service without memorandums of agreement (MOA) with State or local jurisdictions regarding liability and reimbursement. Such agreements typically require time, money, and legal representation that are usually resources not readily available in government. Additionally, private transportation providers often will not provide transportation without formal sheltering agreements being in place to eliminate unexpected complications.

3.3 Evacuations

Not all disasters require individuals to flee their homes or businesses. However, safe and effective evacuation of all people with varying levels of functional need should be a central objective. Planners should consider the demographic composition of the community, the transportation necessary for evacuation, and the capacity to provide shelters that meet the range of needs that exist within the community. Evacuation planning should take into account regulations, licensing, and other mandated responsibilities as well as resources, hazard analyses, and evaluation of emergency circumstances.

Issues such as personal assistance devices, service animals, supplies, and equipment, as well as help and support of family members, friends, pets, and/or directly employed aides are important to many people with access and functional need (AFN). Consider multiple formats for accessible communications when preparing evacuation communications. Allow for flexibility and accommodation beyond what is envisioned.

Responders trained on the importance of allowing individuals with disabilities to bring personal care assistants or family members, service animals, durable medical equipment (DME) and communication devices with them. Policies and procedures created to assure safe transport of DME and communication equipment of the public. Policies need to reflect an understanding that these supports are not optional.

The rule should be that if a person says it is important for them to bring particular people, animals, or equipment with them, they should be allowed to do so unless granting the request would likely result in imminent harm to the person or others.

Exercises to evaluate evacuation plans for fixed facilities, daycare programs, medical facilities, and large public buildings should be conducted routinely. These plans should include alarm systems and methods to personally notify people who are Deaf or hard-of-hearing (H-o-H), people who have mobility concerns, and people who have low vision or blindness, people with cognitive or intellectual disabilities, and people who speak English as a second

language can independently find exits and have safe rallying points for evacuations.

The demands of multiple-trip and long-distance travel will be especially challenging for some individuals both physically and mentally. Emergency managers should designate and advertise staging areas for long-distance transportation and provide additional transportation in the form of over-the-road buses, school buses, or intercity rail to shelter locations outside the jurisdiction. In general, over-the-road motor coaches rather than school buses, city buses, or para-transit vehicles are preferred for evacuating people between metropolitan areas. In many cases, there will be individuals living in the community who will not be able to get to designated staging areas on their own. Given available resources, plans should include mechanisms to assist these individuals. Once individuals are transported from their initial location to a pick-up point, adequate accessible vehicles should then be available to transport them to the designated shelter location.

3.3.1 Evacuation Considerations to Accommodate Access and Functional Needs

Depending upon the emergency/disaster and risk-to-benefit decision making, individuals requiring acute medical care will require evacuation 24 or more hours before the general population. The following considerations are essential for comprehensive community evacuation planning.

3.3.2 Adult Day and Congregate Care Facilities

Any health care facility licensed by the State of Oklahoma must be incompliance with the national codes and standards adopted by the Oklahoma State Fire Marshal's Office including, but not limited to, the Life Safety Code of the National Fire Protection Association (NFPA) and the International Building Code. These codes and standards include requirements for sprinkler systems, fire alarms, building code issues, means of egress, and other important fire safety measures. In the event that power is lost and must be restored in stages, it is recommended that local jurisdictions prioritize congregate settings where individuals are dependent on life-sustaining equipment.

The decision to evacuate a congregate care setting and/or individual with special health conditions residing in private residences requires careful planning and assessment of the risk. Local emergency management and fire departments should work with these facilities to help ensure their plans adequately and realistically address hazards and emergencies common to that location. During snow or ice storms it is extremely important to weigh the risks of moving people during a power-outage versus sheltering-in-place.

3.3.3 Child Care Facilities

The Child Care Licensing Requirements (Supplement III) established by the Oklahoma Department of Human Services (OKDHS) states that child care providers must be prepared to respond to a wide variety of emergency situations (see also OKDHS-OAC 340:110-3-11 “Emergency preparedness”). It may be evacuating children and taking them to a safe place or protecting them from outside threats by keeping them safe inside the facility. A disaster plan is critical and should be in place. The disaster plan should include response actions for natural, human-caused, or technological disasters including, but not limited to:

- Evacuation
- Fire
- Flooding
- Ice storms
- Lockdown and lockout
- Shelter-in-place
- Tornado

3.3.4 Workplaces and Public Venues

Business and public venue managers have the responsibility of developing plans to be prepared for an emergency and are encouraged to work with their local emergency manager regarding these plans. As part of the emergency planner’s preparedness message to employers, emphasis should be placed on:

a. The necessity for commitment to emergency preparedness from senior-level management within an organization.
b. The importance of timely and accurate emergency communications that are accessible to all employees and visitors, including individuals with access and functional needs.
c. A two-prong planning process that combines clear guidelines for all occupants of the premises, while being customizable to meet the unique circumstances of employees and visitors with access and functional needs (AFN).
d. Rigorous and regular practice of the employer’s emergency plan, providing opportunities to evaluate procedures and keeping the issue in the minds of agency managers and employees.

3.4 Mass Shelters

The Oklahoma Department of Emergency Management (OEM) is the lead organization for the ESF#6 Mass Care, Housing and Human Services at the State level. Local emergency management and the American Red Cross

(ARC) will work with OEM to designate and coordinate shelters during times of an emergency or a disaster. The management, operation, and staffing of the shelter is the shared responsibility of the local government and the ARC. Regardless of who operates a shelter, the Americans with Disabilities Act (ADA) generally requires shelter operations to be conducted in a way that offers individuals with disabilities the same benefits provided to people without disabilities (e.g., accessibility, reasonable modifications, effective communication, safety, comfort, general medical care, support of family and friends). To the maximum extent possible, shelter and support plans should include persons with access and functional needs along with others in the community and the co-location of a shelter for pets. When setting up a mass shelter, the following should be taken into consideration when addressing access and functional needs.

The Oklahoma Department of Emergency Management and Homeland Security (ODEMHS) and other OKVOAD agencies developed a mass care shelter plan. Contact ODEMHS for more information on the Oklahoma mass care shelter plan.

3.4.1 Needs Assessment

A needs assessment is the process of sorting individuals needing immediate medical attention from those that are healthy. In a disaster, a needs assessment can occur in several places: (1) at the evacuation site and/or on the bus before the evacuees depart the disaster area, (2) at the shelter site before/while leaving the bus, or (3) after the evacuee has already settled into the congregate area of the shelter. To be successful, all three assessments should occur; however, this may not always be the case.

A needs assessment at the evacuation site is the responsibility of the home state or disaster area. Past experience shows this is conducted rather hastily and should not solely be relied upon. The amount of time spent in transit and the immediate care needed following the trip may take a toll on some. Healthy individuals can become sick from a long ride to a shelter. A person with diabetes may have a drop-in blood sugar and persons who are incontinent may need to shower and change clothes. All of these situations are in the (AFN) framework for assistance. Planning and preparing for the buses to arrive with AFN populations is imperative.

3.4.2 Needs Assessment Teams

To prepare for arrival, the receiving site should plan on a specialized team to help identify and assist those with access and functional needs (as resources are available). A needs assessment team may consist of the following:

a) Home Health Aides (HHA)/Volunteers – to identify and assist with mobility and general needs.

b) Paramedics/ Nurses/ Medical Reserve Corps – to identify and respond to immediate medical needs.
c) Mental health staff – to identify immediate mental health states as well as coach needs assessment team members on how to identify dangerous personnel or how to cope with feelings that may arise during the receipt of disaster clients.
d) Language and/or Certified American Sign Language (ASL) Interpreters-Quality Assurance Screening Test (QAST Levels III-IV) to translate for people who have hearing/speech disabilities, people who are Deaf, people who are blind and Deaf, people who are hard-of-hearing (H-o-H), or people who have difficulty understanding English.
e) Runners – to assist people who have limited mobility with their belongings as directed by a mass care volunteer's, medical reserve corps volunteers, nurses, or paramedial staff.

3.4.3 Needs Assessment Criteria

Identifying persons with access and functional needs (AFN) as soon as possible may be vital in saving lives or reducing trauma. If possible, assess in groups before they enter the shelter. Ask the disaster clients if they have medical or access needs before they enter into the shelter. If this is not possible; ask for their medical or access needs at the registration desk. Some suggested criteria to look for or inquire about to expedite the identification of specific populations include but not limited to the following:

- Families with small children
- General health problems (for example incontinence etc.,)
- People who are blind or have low vision
- People who are Deaf or hard-of-hearing (H-o-H)- communication by American Sign Language (ASL)
- People who have intellectual or cognitive disabilities
- People needing assistance with mobility (wheel chair, cane, walker)
- People who feel sick (muscle aches, headaches, or nausea)
- People with a fever, cough, or sore throat
- People who have diabetes
- People who receive dialysis treatments
- People needing electricity for durable medical equipment (DME) usage
- People using oxygen (concentrators) tanks
- People who are receiving chemotherapy treatments
- People who communicate in languages other than English
- Senior citizens that need activities of daily living (ADL's) assistance
- Women who are pregnant
- People with urgent medical conditions

Note: The medical staff in the shelter will evaluate people with “critical” medical conditions. If the medical condition is too “critical” for the shelter, they will be transferred to a medical facility.

3.4.2 Registration

For those that meet the criteria, ask them to exit the bus and provide them direction to the correct check-in area. These lines may take a little longer per person, but the proper amenities should be made. When setting up the mass care check-in stations, consider the care of access and functional needs populations (AFN) and the items they might need upon arrival:

- Baby changing table (diapers, baby wipes, baby bottles, baby formula, baby food, baby cribs/play-yards, and toddler food)
- Chairs
- Wheelchairs, walkers, canes, and cots including bariatric sizes (wheelchairs and cots)
- Language Translators including American Sign Language (ASL) certified in Quality Assurance Screening Test (QAST). The QAST certification is a method used by the Department of Rehabilitation Services to evaluate the proficiency of individuals interested in becoming employed as interpreters for the people who are Deaf or hard-of-hearing (Ho-H) in the state of Oklahoma. The interpreters who are certified in QAST levels III-IV can be used in emergencies.
    - Language Line can also be used for ASL intermediators. They utilize video remote interpreting (VRI) services.
    - OCCHD uses language line for verbal languages only. They use DeafLink –VRI for ASL.
- Extra aides/volunteers to assist people with personal items.
- Animal Support Teams- (pet care) and service animals.
- Extra aides/volunteers to escort people to and from the restroom (some may need personal assistance prior to check-in).

3.4.3 Guest Tracking

Guest tracking is essential in providing an accurate accountability of the guest population. The populations in emergency shelters can change suddenly and rapidly with the movement of guests. Tracking methods vary by primary location sites. No matter the type of tracking method used (electronic or paper), the essential personal information needed to provide proper care of individuals should be included. Examples of the type of personal information necessary include: name, home address, age, emergency contact information, immediate medical history, and medication list.

Ensure language accessible formats are available in this area. This is essential for accessible communications with people who speak English as a second

language, people who are Deaf and need a sign language interpreter, people who are blind or have low vision, people with low literacy skills, people who are non-verbal, and with cognitive or intellectual disabilities.

3.4.4 Tips for Accommodating Your Community

One of the most important tasks in emergency preparedness is evaluating your community before, during, and after the disaster. This involves knowing your community and their "access and functional needs (AFN)" prior to any natural, human caused or technological disaster situation. The following tips will assist you in this "whole community" approach when planning for AFN populations in local shelters. The Oklahoma Developmental Disabilities Council has an excellent resource pocket guide that provides further information titled: "Tips for First Responders".

3.4.5 People Who are Blind or Have Low Vision

- Provide a tour of the activated shelter using a proper guide technique to ensure their awareness of the facility layout and available accommodations, as well as the accessibility of all the areas. If unsure of the proper guide technique, ask the individual how to properly guide them. The tour should take them to all areas within the active shelter
- Provide all communication material and emergency alerts in accessible formats. Accessible communication formats include:
- American Sign Language (ASL) for individuals who are Deaf, blind, and Deaf/blind.
- Audio messages
- Braille
- Designated readers for all shelter documents if requested by the client.
- Documents with large black font that is bold and printed on cream color paper.
- Non- glossy paper and Lighted magnifying glasses.
- Plain language documents or easy reading documents.
- Spanish and other languages as needed and requested.
    - Please be aware privacy concerns for clients who requests a family member/ designated person for ASL or other foreign languages.
    - The best option is to use a professional translator/ interpreter for privacy concerns and accuracy of all information.
- Always state their name if known and identify yourself when you approach the individual, so they know you are speaking to them.
- Never use head gestures to acknowledge what they are saying to you. Remember, they cannot see your face gestures. In addition, do not use hand gestures, they cannot see which direction you are pointing.

- Provide a buddy system in the event an emergency occurs in the activated shelter. The buddy will ensure the safe movement of the individual if the need to evacuate or shelter-in-place occurs in the shelter.

3.4.6 People Who are Deaf or Hard-of-Hearing

- Provide all communication material and emergency alerts in accessible formats. Accessible formats include:
    - Large signs that state American Sign Language (ASL) interpreters are available in bold images and placed in front of all stations, and enter and exit locations in the shelter.
    - Audio messages that loop with information
    - Signs should have cream background color with large black and bold images on non-glossy materials.
    - American Sign Language (ASL) Interpreters, Quality Assurance Screening Test (QAST Certified Levels III-IV).
    - Certified and/or computer-based methods – Video Remote Interpreting (VRI) (Deaf Link Inc. or other VRI services,). These services should be 24 hours a day for efficient care of access and functional needs (AFN) populations during shelter activation.
    - Short ASL videos (they can loop on screen—large flat screen televisions, written documents, maps, or pictographs detailing emergency procedures.
    - Neck loops for people who are hard-of-hearing (H-o-H).
    - Visual strobe alarm or vibrating pad for alarms (e.g., smoke, tornado)
- Ensure the person is aware of all activated areas within the shelter. Provide a tour of the activated shelter with an ASL interpreter.
- Establish eye contact with the individual, not with the interpreter, if one is present.
- Hearing aids do not guarantee the person can hear and understand speech. They increase volume, not necessarily clarity in information transfer.
- Keep in mind when providing verbal instructions to people who are hard-of-hearing (H-o-H) that:
    - Side conversations or background noises may interrupt the emergency information you are trying to convey.
    - The person may have difficulty understanding the urgency of your message, so be patient.
- Provide the person with a flashlight to signal their location in the event they are separated from the rescue team. This will facilitate signing in the dark.

- Provide a buddy system in the event an emergency occurs in the activated shelter. The buddy will ensure the awareness of the individual of alarms, warnings or announcement of general information related to the activated facility.

3.4.7 People Who Have Mobility Disabilities

- Provide tour personnel for assistance in this function. The tour will provide services to people with limited mobility movement and/or strength. A descriptive layout/map of the activated shelter for location and awareness of all areas within the active shelter should be provided to all people in accessible formats (large print, braille, and different languages). Certified American Sign Language (ASL) Interpreters can provide this information to people who are hard-of-hearing (H-o-H), or people who are Deaf.
- Keep all aisles clear of objects in your shelter.
- Always ask the person how you can help before attempting any assistance.

3.4.8 People Who Have Cognitive or Intellectual Disabilities

- Provide a tour and descriptive layout/map of the activated shelter for location and awareness of all areas within the facility. A tour should take them through all areas within the active shelter.
- Provide instructions/rules of activated shelter in simple and short sentence format (7th grade reading level or lower).
- Have information in “Easy Read” format for understanding of information.
    - Point to your identification (ID) picture as you say who you are and your role in the shelter.
    - Use pictures and objects to illustrate your words. Easy Read format of information.
    - Repeat questions and answers if necessary. Be patient!
    - Give extra time for the person to process and respond to what you are saying.
    - Provide, if possible, quiet time for rest to lower stress and fatigue.
    - Repeat reassurances (for example, “You may feel afraid. That’s Ok. We’re safe now”).
    - Point to any protective equipment as you speak about the use of the item.

3.4.9 Easy Read for People Who Have Cognitive or Intellectual Disabilities

Easy read is a form of writing that people with cognitive or intellectual disabilities developed to assist in reading written language.

Easy Read Information is:

- Information that is clear and easy to read and understand.
- Developed to support people with learning (intellectual) disability better understand written information.
- Different from plain English and plain language but uses the same principles and builds on them.
- Written information, supported by pictures.
- Uses everyday words and has no jargon or acronyms.

Easy Read information is for people who have difficulty reading and understanding written information.

Easy Read information is for some people who:

- Have a learning disability
- Have low literacy levels
- Use English as a second language
- Are elderly
- Are Deaf

Some people will be able to read Easy Read information independently.

For others, they will require someone to facilitate the information.

For more information on Easy Read use the link is below.

https://www.odi.govt.nz/guidance-and-resources/a-guide-to-making-easy-read-information/

3.4.10 People who are on the Autism Spectrum

For people with autism, learning to interact with first responders is critical. On the other hand, it is just as essential for first responders to understand autism and be prepared to respond effectively and safely to situations that arise involving individuals on the spectrum. For more information go to: www.AutismFoundationOK.org

The Autism Safety Project provides First Responders with information and guidelines for communicating with people with autism spectrum disorder (ASD) in emergency situations.

- Remember children and adults with autism may be drawn to water. If you are facing a natural disaster with waters rising this quickly you will want to take extra precautions if you are not fully out of harm's way.
- If your loved one with autism has a tendency to wander from safety, make sure you have a multifaceted safety plan in place.
- Remember to bring familiar items that will help your child adjust to their new surroundings and ease the stress of the transition with some of their comforts from home – favorite toys, DVDs, and computer games.

- Make an emergency contact list - even if you have them in your phone, also write them down! Include names and numbers of everyone in your personal autism support network, as well as your medical providers, local law enforcement, emergency responders.
- Make sure your emergency information list notes any communication difficulties, including the best way to communicate with you or your loved one with autism.
- Grab your Individual Education Plan (IEP) and any medical records or evaluations you may have on hand. Your IEP is a federal document and can help you settle your child in an alternate school setting more quickly if you have it on hand.
- Pack any needed Assisted Technology Devices and don't forget the chargers! Just in case record the device name, manufacturer's name & information, model and serial numbers, vendor (Store's/Seller's) name and info, date of purchase and copy of receipt if available, copy of Doctor's or Therapist's prescription if available and contact and funder's (i.e., Medicare, Medicaid, Insurance Co.) name, contact info, & policy numbers.
- iPads (and other medical equipment) that are used by someone with autism to communicate are covered under medical losses/disability equipment. During the intake call with FEMA, you may be asked about medical devices, and whether anyone is dependent on a computer or other equipment.
- Pack enough medicines or special dietary needs for at least three weeks. Shipments of new supplies to impacted areas may be difficult or impossible. Bring copies of prescriptions with you or be sure you have refills scheduled with a national pharmacy that can access them electronically.
- If you regularly visit doctors or specialist for treatments or interventions or if you receive regular services such as home health care, treatment or transportation, talk to your service provider about their emergency plans. Identify back-up service providers in the areas you might evacuate to. If you use medical equipment in your home that requires electricity to operate, talk to your health care provider about what you can do to prepare for its use during a power outage.
- If you have a service animal, be sure to include food, water, and collar with ID tag, medical records and other emergency pet supplies.
- During an emergency quick and unanticipated changes in routine and environment can cause increased anxiety and stress for people with autism. If staying in a shelter bring headphones or earplugs to help with noise. You may also consider bringing a roll of duct tape to place labels, visual support or even lay out visible perimeters of your family's assigned "space" in a communal style shelter.

For local assistance with education on people who are on the Autism Spectrum please contact the Autism Foundation of Oklahoma (AFO)- Emily Scott – Executive Director. www.AutismFoundationOK.org

3.4.11 People with Bariatric Needs

A. Provide a tour (breaks should be used for rest periods depending on your customer) or descriptive layout/map of the activated shelter for location and awareness of all areas within the facility.
B. Provide beds, wheelchairs, and chairs for accommodation of access and functional needs.

3.4.12 Seniors

a. Provide a tour or descriptive layout/map of the activated shelter for location and awareness of all areas within the facility.
b. Repeat questions and answers if necessary. Be patient! Some elderly persons may respond more slowly to a crisis and may not fully understand the extent of the emergency.
c. Reassure the person that they will receive medical assistance without fear of being placed in a nursing home.
d. Explain to the senior that this relocation is only temporary. Seniors may fear being removed from their homes, be sympathetic and understanding.
e. Provide a buddy system if you suspect the person has dementia or Alzheimer's. Do not leave the person unattended.

3.4.13 Children and Youth

Children comprise approximately 25 percent of the nation's population. During a disaster many families, young people (18-21), children, and infants will be affected by the relocation of their home base of living. During any given weekday, 67 million children are in schools or daycare during the fall, spring, or winter months nationwide during the year. Studies have shown that 63 percent of parents would disregard an evacuation order and go directly to their child's school or daycare in an attempt to collect their children, even if they have received instructions to do the opposite.

Every emergency shelter must have a reunification process to bring parents, legal guardians, and grandparents together with their children or child that they are separated from because of the emergency/disaster. The following information below contains general information, "guidelines", and "suggestion" that might help state and/or local agencies that have interest in children reunification during disasters.

State Child Welfare Agencies- *(*e.g., Department of Social Services, Department of Health and Human Services, Department of Children and Family Services, Department of Public Health)

a. Support the safety and needs of children separated from parents or legal guardians seeking children during a disaster.
b. Coordinate with the appropriate agencies and organizations for culturally and linguistically appropriate temporary care and shelter of unaccompanied children.
c. Coordinate with law enforcement and the judicial system to ascertain the legal responsibilities of various agencies to accomplish the following:
    i. Provide temporary and, if necessary, long-term care of the minor.
    ii. Verify the identity and custody rights of adults seeking the release of the child.
    iii. Safely release the child to a verified parent or legal guardian.
d. Support human services roles and functions including reunification in disaster response and recovery operations in accordance with defined roles and emergency preparedness plans.
e. Develop consensus among agencies and organizations responsible for the management (e.g., processes, procedures, credentialing, and training) of the needs of children and families, including those with disabilities and other access and functional needs.
f. Provide guidance and assistance to local child welfare agencies and childcare centers with their emergency preparedness planning and reunification activities.
g. Plan for the potential need for emergency foster care in a mass casualty event in which many children are left orphaned.
h. Support the development of all-hazards emergency preparedness planning inclusive to children with disabilities and other access and functional needs to address lockdown procedures in daycares and summer camps, evacuation, sheltering-in-place, relocation, and reunification of children with their parents or legal guardians.
i. Reinforce the need for family contact information and authorization for emergency transportation and medical care before a disaster happens.

Local Child Welfare Agencies- (e.g., Department of Social Services, Department of Human Services, Department of Children and Family Services, Department of Public Health)

a. Support the safety and needs of children separated from parents or legal guardians and parents or legal guardians seeking missing children during a disaster.
    i. Coordinate with the appropriate agencies and organizations for the temporary care and shelter of unaccompanied children. Confirm that of adults seeking the release of the child.
b. Coordinate with law enforcement and judicial system to ascertain the legal responsibilities of various agencies to accomplish the following:
    i. Provide temporary and, if necessary, long-term care of the minor.

ii. Implement standardized guidance to verify the identity and custody rights.
iii. Safely release the child to a verified parent or legal guardian.
iv. Work within the judicial system to ensure that proper legal procedures are followed and keep the safety of the child in mind at all times.
v.

3.4.14 Local Education Systems

a. Develop and maintain school emergency preparedness plans and processes that address lockdown procedures (to protect from imminent threats such as active shooter), shelter-in-place (to protect from the threat of contamination or weather events), evacuation, relocation, and reuniting students or legal guardians.
    i. Details included may vary from school to school
    ii. Schools are strongly encouraged to establish relationships and consider sharing their emergency preparedness plans with first responders and/ or local emergency managers in an effort to better coordinate overall reunification efforts in the event of a large-scale or catastrophic incident. It is also recommended that schools be included in local emergency planning drills.
    iii. School emergency preparedness plans are typically implemented to address the likelihood that a no-notice or short-notice event may strike while children are attending school.
    iv. Depending on the situation, schools may deviate from plans and release children early or hold them later than planned to promote the safety of the students in their charge. In these instances, parents and legal guardians should be properly notified.
    v. All plans should address the needs of children with disabilities and other access and functional needs.
    vi. When developing emergency preparedness plans, community emergency management teams should include general and special teachers, case managers or related personnel, local disability services and advocacy specialists and/or municipal American Disabilities Act specialists.
    vii. Plans should address the use of school facilities during non-school hours (e.g., afterschool programs, summer and recreational activities).
    viii. Schools are the nexus of parent, child, and community life, and separated families or unaccompanied children may seek out schools for information, sheltering, or reunification.
b. Clearly communicate school emergency preparedness plans with parents, legal guardians, and caregivers and encourage them to develop a family plan identifying a local meeting point (location) and an

out-of-state relative or friend for each family member to contact in the event that all local communication lines are down.

3.4.15 Local Coroners/Medical Examiners

a. Investigate fatalities that occur as a result of a disaster and provide assistance in the identification of deceased persons, including children.
b. Direct the collection of ante mortem data through extension communication with families and other means. Data collection may include the following:
    i. Physical description of the victim (e.g., approximate age, height, weight, gender, hair color);
    ii. Description of clothing and jewelry
    iii. Description of unique characteristics (e.g., tattoos, scars, birthmarks);
    iv. Dental records, medical records, implant or joint replacement serial numbers, and fingerprint records
    v. DNA reference samples from the family members
c. Establish death notification procedures in coordination with a team of mental health professionals a spiritual support provider.
d. When a deceased child cannot be identified by name, enter information pertaining to the child (e.g., fingerprints, deoxyribonucleic acid (DNA), scars, marks, tattoos) into the Department of Justice (DOJ's) National Missing and Unidentified Persons System (NamUs). NamUs is a national, centralized repository and resource center for missing persons and unidentified decedent records.

3.4.16 Nongovernmental and Private Sector Organizations

Within the nonprofit sector, voluntary agencies are the cornerstone for the delivery of mass care services following disasters. When incidents displace or otherwise disrupt survivors' access to life-sustaining goods and services, government agencies and stakeholders from the nonprofit and private sector involved in the provision of human services activate to minimize pain and suffering caused by disasters. In addition to the provision of shelter (including for household pets and service animals), food, water, clothing, temporary respite care, and basic health, mental and behavioral health support, Non-Governmental Organizations (NGOs) and private sector organizations also assist with family reunification.

Note: Temporary respite care of children involves provision of a secure, supervised, and supportive play experience for children in a Disaster Recovery Center, assistance center, shelter, or other service delivery site. Parents, guardians, or caregivers should remain onsite and maintain responsibility for their child or children.

1. National Center for Missing and Exploited Children

a. Serves as the Nation's resources center on the issues of missing and sexually exploited children. Provides information, training, technical assistance, and resources nationwide to law enforcement, parents, children (including child victims), and other professionals.
b. Works in partnership with Federal, state, and local law enforcement agencies to assist in the reunification of displaced children with their parents or legal guardians.
c. Deploys Team Adam (retired law enforcement officials) to the location of a declared disaster to gather information about displaced children and provide technical assistance and support.
d. Activates the National Emergency Child Locator Center (NECLC), a toll-free hotline, teletype service dedicated to receive reports of displaced children, at the request of a state that has been impacted by a disaster.
e. Promotes the Unaccompanied Minors Registry (UMR), a nationwide data collection tool aimed at expedition the reunification of an unaccompanied minor with his/her legal guardian, following a disaster.
f. Shares posters of displaced children with a network of nationwide partners and media outlets to assist in the reunification of those children with their families. Information shared with the public includes name, date of birth, date missing, last known location, and other identifying information such as height, hair color, and eye color.
g. Works closely with state missing-child clearinghouses to help ensure a comprehensive approach to child protection.
h. Provides missing-child clearinghouses to help ensure a comprehensive approach to child protection.

2. American Red Cross
    a. Attempts to reach out to the minor's parent or legal guardian (if the child is aware of contact information)
    b. If unsuccessful, contacts law enforcement and child welfare agencies and transfers the child to their care and supervision.
    c. Documents the minor's arrival, changes in circumstances, and other information using the ARC Unaccompanied Minors Report Form.
    d. Makes every effort to designate two volunteers or paid staff members to supervise an unaccompanied minor until they are safely conveyed to the appropriate authorities.
    e. Refers an unaccompanied minor with urgent health needs to the appropriate medical facilities and documents the circumstances.

3. Save the Children
    a. Provides temporary respite care for children in the shelter environment, including dedicated children's areas.
    b. Assists care providers, emergency planners, and communities in preparing to safeguard children during and after disasters.
    c. Delivers community and school-based programs to help children and their adult caregivers to recover emotionally after a disaster.
4. Southern Baptist Disaster Relief (Southern Baptist Convention)
    a. Provides temporary respite care for children affected by disasters.
    b. Provides mobile units equipped with appropriate equipment and supplies to care for children.
    c. Provides volunteers who are trained, background checked, and credentialed to care for children in a safe, secure area.
    d. Provides a temporary resource for parents in need or a safe, secure environment for their children when the operation of established day care centers is interrupted due to disaster.
    e. Establishes temporary childcare in local facilities such as churches, shelters, multi-agency compassion centers, service centers, and/or other facilities where a safe, secure and comfortable environment for children can be provided.
5. Children's Disaster Services (Church of the Brethren): Provides temporary respite care for children in the shelter environment.
6. Corporation for National and Community Service: Provides support to missing persons call centers.
7. Faith-based and community organizations (typically those smaller voluntary organizations unaffiliated with National Organizations Active in Disaster)
    a. Provide assistance in the development of family reunification plans.
    b. Partner with local, state, and Federal agencies in the sheltering and feeing of disaster survivors.
    c. Provide trained staff to assist in the care of minors.
8. Private sector partners
    a. Encourage employees to develop family reunification plans as part of continuity of operations planning.
    b. Support reunification efforts as part of the whole community concept.
    c. Display bulletin boards with posters and identifying information of missing children.

d. May allow local, state, and Federal emergency managers and non- governmental organizations (NGOs) to use parking lots for reunification staging.
e. Display messages concerning missing children one electronic billboards along major roads and highways.
f. Social media and Web sites serve as powerful tools for individuals to communicate their post-disaster whereabouts and condition to friends and relatives. Individuals are encouraged to use social media, Web sites, text messaging, and other digital tools to communicate their whereabouts and condition with family, friends, relatives, and co-workers.
    i. Goggle Person Finder is a web application available in over 40 languages that allow individuals to post and search for the status of relatives or friends affected by a disaster. It also presses agencies, NGOs, and other to contribute to the database and receive updates. The Google Crisis Response team makes a determination to turn on Google Person Finder based on the scale of a disaster. Web sites can also choose to embed Google Person Finder as a gadget on their own pages. (Note: FEMA does not endorse any nongovernmental Web sites, companies, or applications).

3.4.17 People with Service Animals

a. Do not separate the owner from the service animal
b. Remember – a service animal is not a pet
c. Do not touch or give the animal food or treats without the permission of the owner
d. Keep in mind when the dog or miniature horse is wearing its harness, it is on duty.
e. Hold the leash and not the harness in the event you are asked to take the dog or miniature horse while assisting the individual
f. Remember, service animals are not registered and there is no proof the animal is a service animal. If the person tells you, it is a service animal, treat it as such. However, if the animal is out of control or presents a threat to the individual or others, remove it from the site. Find a place for the animal and the owner to stay during the duration of the emergency

An active emergency shelter takes planning. It is not necessary to segregate populations according to their access and functional needs. Access and functional needs groups can encompass a wide variety of disabilities or conditions. Detailed planning using the layout of the shelter prior to the activation can ensure a more functional environment and create smoother

operations. Examples of these needs may include: a medical clinic area, sleeping/quiet area, and family or group gathering areas such as entertainment, childcare, or meal areas.

3.4.18 Personal Assistance Services to General Populations

Many times, mass care shelters will have populations that exceed the resources of personal care assistance. When this occurs, Federal Emergency Management Agency (FEMA) can provide personal assistance services to the shelter. The information contained below comprises the guidelines for requesting FEMA Personal Assistance Services (PAS) Program.

3.4.19 FEMA Personal Assistance Services (PAS) Program

The Federal Emergency Management Agency (FEMA) Personal Assistance Services (PAS) Program are formal and informal services provided by paid personal attendants, friends, family members, and/or volunteers that enable children and adults with access and functional needs to maintain their independence. Following a disaster, at-risk individuals and access and functional needs may require PAS in order to maintain their independence in a general population shelter. The FEMA PAS contract is available when shelters lack sufficient staff, training, or equipment to provide this level of assistance.

The provision of personal assistance services (PAS) supports the activities of daily living (ADL) including grooming, eating, bathing, toileting, dressing and undressing, walking, transferring, and maintaining health and safety. Depending on an individual's needs, higher levels of (PAS) care can include the provision of skin care, catheterization, colostomy care, administering medications, and some respiratory assistance.

3.4.20 When Is It Available?

When shelter health staff cannot identify a member or a friend to serve as a caregiver, the shelter health team can assign qualified shelter volunteers to provide assistance, or they can work with the shelter manager and/or through the Emergency Operations Center (EOC) to contact a local agency to provide (PAS).

When the need for PAS exceeds the state's capability, during a presidentially declared disaster, the Governor may request (PAS) through Federal Emergency Management Agency (FEMA). The (PAS) is provided as Individual Assistance (IA) under the Stafford Act, Emergency Support Function (ESF) #6-Mass Care, Emergency Assistance, Housing and Human Services, Section 403, to augment the ability of States, Tribes, and US Territories in helping individuals with access and functional needs maintain their health, safety, and independence in a general population shelter.

3.4.21 What Is the Structure of The Personal Assistance Services (PAS) Program?

Within 24 hours, the (PAS) contractor deploys up to 50 PAS staff. The contract requires that the (PAS) staff be licensed by the state that request its services for the general population shelter. Furthermore, the (PAS) contractor may provide necessary/required supplies that are not readily available, but immediately needed-such as activities of daily living (ADL) or higher-level (PAS) care materials. The cost-share for a state or US territory to receive the (PAS) contract is typically 25%, like other Emergency Support Function (ESF) #6 support. While there is no minimum number of (PAS) staff that Federal Emergency Management Agency (FEMA) can deploy, twenty (20) (PAS) providers are the recommended minimum number to be cost-effective.

3.5 Emotional and Spiritual Care

The Oklahoma Conference of Churches is a member of the Oklahoma Volunteer Organizations Active in Disasters (OK-VOAD). Within this “inclusive” Emotional and Spiritual Care organizations there are fifteen denominations 1,500 local Christian congregations. There are at least six interfaith organizations such as the following: Baha’i, Buddhism, Hinduism, Judaism, Muslim, and Sikhism that comprise the community partners in the Emotional and Spiritual Care team. Emergency planning in diverse communities should include all Faith Based Organizations (FBO’s) for local, county, or state responses. Trusted Faith Based Leaders will bridge gaps in local and state community emergency planning. The contact information for the Oklahoma Conference of Churches local clergy, spiritual care provider, or faith community is provided below for individual or group Emotional or Spiritual Guidance:

3.6 Shelter-in-Place

Evacuation will not always be possible or desirable in an emergency and people with access and functional needs must also prepare to shelter in place. Local plans should include ways to check on people and get personal care assistance to those who need it. Local plans should also include guidance for individual preparedness during shelter-in situations. Individual needs vary, but during a prolonged emergency, some individuals will need assistance from others in meeting their basic needs. Plans should call for linkages with community-based organizations, home care, and other agencies for assistance. Clear instructions on how to request assistance should be provided to people who are sheltering.

Deciding to evacuate a congregate setting and individuals with special health care needs residing in private residences requires careful planning and assessment of risk. Most states require facilities to have plans in place for

emergencies. These facilities are ultimately responsible for their residents. Local Emergency Operations Plans (EOPs) should pre-identify these locations and have an estimate of the number of individuals residing in each. Emergency managers and facility managers should work together to help ensure plans adequately and realistically address hazards and emergencies common to that location.

When advance warning permits and when shelter-in-place poses a greater risk to the individual than evacuation, individuals who require acute medical care should be evacuated 24 hours before the general population. Facilities in neighboring jurisdictions should be ready to receive those displaced individuals (agreements should be in place before the incident) and proper resources, including medical supplies and appropriate staff, should be in place at the receiving facilities.

During ice storms or snowstorms when power outages are imminent, facility locations should weigh the risks of evacuation versus shelter-in-place. During previous disasters Oklahoma has witnessed the evacuation of nursing facilities to nearby nursing or community facilities only to have those locations lose power as well. To avoid moving customers in the cold and on icy surfaces with the possibility of slips, trips, and falls, the facility should work with the emergency management to plan for shelter-in-place. If possible, the facility should have a back-up generator. If this is not possible, emergency managers should work with the local energy co-op partners Emergency Support Function (ESF) #12 to prioritize those facilities to come back online.

3.7 Pet Shelters/Kennels

When people evacuate it is important to remember that many may bring their “pets” and in today’s age, many of them are thought of as family. There are several types of animals that may arrive at a shelter so it’s important to understand the laws around them and be prepared ahead of time to receive them. The Pets Evacuation and Transportation Act of 2006 (PETS Act) amends the Robert T. Stafford Relief and Emergency Assistance Act to ensure that State and local emergency preparedness operational plans address the needs of individuals with household pets and service animals following a major disaster or emergency. [10]

[10] The Pets Evacuation and Transportation Act 120 U.S.C. § 1725 (2006)

When setting up a pet shelter, keep placement in mind. Setting up the pet shelter directly next to the general population shelter will allow owners to come out and tend to their own pets. In local areas, animal shelters or animal control centers may be able to assist in identifying or providing necessary equipment, food and water supplies, and the "physical building" of the pet shelter during emergencies. The following equipment and supplies should be considered when planning for and setting up a pet shelter:

- Cages
- Collars
- Food, water, and feeding dishes
- Leashes
- Medications for pest control
- Vaccinations

The Oklahoma Department of Agriculture, Food & Forestry is the state agency that directs the animal shelter operations. Contact the Oklahoma Department of Agriculture, Food & Forestry -Animal Industry Services at (405) 522-6136 for their staff and procedures for comprehensive animal care during emergencies.

3.8 Animals in Shelters

Many times, domesticated animals will relocate with their owners. Sometimes, the families and their domesticated animals will need to find shelter after natural or human-made disasters. Domesticated animals can hold many functions with their families' lives. The information below will help to define what types of functions, services, and behavior animals can demonstrate during and after a disaster occurs in a community.

3.9 Service Animals

Service animals are permitted in all places (may not be confined to a kennel) that serve the public as long as the animal is not out of control or otherwise posing a direct threat to the health or safety of individuals. Access includes transportation with their owners/handlers during evacuations. In accessing forms of transportation, planners should cover the presence of service animals and the potential need to assist animals during evacuations.

3.9.1 Service Animals Must Be Under Control

Under the Americans with Disabilities Act (ADA), service animals must be harnessed, leashed, or tethered, unless these devices interfere with the service animal's work or the individual's disability prevents using these devices. In that case, the individual must maintain control of the animal through voice, signal, or other effective controls.

3.9.2 Inquiries, Exclusions, Charges, and Other Specific Rules Related to Service Animals

When it is not obvious what service an animal provides, only limited inquiries are allowed. Staff may ask two questions: (1) is the dog a service animal required because of a disability, and (2) what work or task has the dog been trained to perform. Staff cannot ask about the person's disability, require medical documentation, require a special identification card or training documentation for the dog, or ask that the dog demonstrate its ability to perform the work or task.

Allergies and fear of dogs are not valid reasons for denying access or refusing service to people using service animals. When a person who is allergic to dog dander and a person who uses a service animal must spend time in the same room or facility, for example, in a school classroom or at a displaced shelter, they both should be accommodated by assigning them, if possible, to different locations within the room or different rooms in the facility.

A person with a disability cannot be asked to remove his service animal from the premises unless: (1) the dog is out of control and the handler does not take effective action to control it or (2) the dog is not housebroken. When there is a legitimate reason to ask that a service animal be removed, staff must offer the person with the disability the opportunity to obtain goods or services without the animal's presence.

Establishments that sell or prepare food must allow service animals in public areas even if state or local health codes prohibit animals on the premises.

People with disabilities who use service animals cannot be isolated from other patrons, treated less favorably than other patrons, or charged fees that are not charged to other patrons without animals. In addition, if a business requires a deposit or fee to be paid by patrons with pets, it must waive the charge for service animals.

If a business such as a hotel normally charges guests for damage that they cause, a customer with a disability may also be charged for damage caused by himself or his service animal.

Staff is not required to provide care or food for a service animal. Note: However, the disaster animal services in Oklahoma will be notified when animals appear in the shelter or the disaster areas. They provide food, water, cages, medical supplies, and assistance during emergencies for pets and service animals.

3.9.3 Miniature Horses

In addition to the provisions about service dogs, the Department's revised the Americans with Disabilities Act (ADA) regulations have a new, separate provision about miniature horses that have been individually trained to do

work or perform tasks for people with disabilities. (Miniature horses generally range in height from 24 inches to 34 inches measured to the shoulders and generally weigh between 70 and 100 pounds.) Entities covered by the ADA must modify their policies to permit miniature horses where reasonable. The regulations set out four assessment factors to assist entities in determining whether miniature horses can be accommodated in their facility. The assessment factors are (1) whether the miniature horse is housebroken; (2) whether the miniature horse is under the owner's control; (3) whether the facility can accommodate the miniature horse's type, size, and weight; and (4) whether the miniature horse's presence will not compromise legitimate safety requirements necessary for safe operation of the facility.

3.10 Household Pet

A household pet is a domesticated animal, such as a dog, cat, bird, rabbit, rodent, or turtle that is traditionally kept in the home for pleasure rather than for commercial purposes. Normally these types of animals should be kept out of the mass shelter and in a nearby pet shelter for care. Household pets do not include reptiles (except turtles), amphibians, fish, insects/arachnids, farm animals (including horses), nor animals kept for racing purposes.

3.11 Therapy Animals

Therapy Dogs receive extensive training but have a completely different type of job from service dogs. Their responsibilities are to provide psychological or physiological therapy to individuals other than their handlers; who are usually their owners. These dogs have stable temperaments and friendly, easy-going personalities. Typically, they visit various institutions like hospitals, schools, hospices, psychotherapy offices, nursing homes and more. Unlike service dogs, therapy dogs are encouraged to socialize and interact with a variety of people while they're on-duty.

Somewhat similar to service dogs, therapy dogs can have a variety of jobs. While most people are familiar with therapy dogs who visit places like hospitals, nursing homes and hospices to provide emotional therapy, these are not the only environments in which therapy dogs can be beneficial. Therapy dogs may also visit schools, day cares, group homes and rehabilitation centers. Their roles vary, from dogs who give learning disabled children the confidence to read out loud to actively participating in physical rehabilitation therapy. In some cases, a therapy dog will work in a particular establishment exclusively, like a psychotherapy practice.

Therapy dogs may be trained by just about anyone, but must meet the standards set by a particular organization to be certified and actively participate within the respective organization. They are usually handled by their owners, but in some cases of Animal Assisted Therapy, the therapy dog may be handled by a trained professional.

It is important to note that, despite thorough training, certification and the therapeutic benefits therapy dogs provide, they do not have the same jobs or legal designation as service dogs. While some institutions offer therapy dogs access on a case by case for the benefit of patients, guests, customers or clientele, the handlers or owners of therapy dogs do not have the same rights to be accompanied by these dogs in places where pets are not permitted.

3.12 Emotional Support Animals

Emotional Support Animals are not required to undergo specialized training. Their primary roles are to provide their disabled owners with emotional comfort. Emotional support animals can benefit a person with disabilities, or a person with mental illness. The seemingly basic gift of companionship and unconditional affection can be just the right therapy to counter a condition like debilitating depression.

3.13 Psychiatric Service Dogs

Psychiatric service dogs are service dogs that provide assistance to people with psychiatric disabilities, such as severe depression, anxiety disorders, and post-traumatic stress disorder (PTSD).

Examples of work or tasks that psychiatric service dogs perform include:

- Providing safety checks or room searches for individuals with PTSD
- Blocking persons in dissociative episodes from wandering into danger (for example, traffic). Table of these categories are on the next page.

Differences between Service, Therapy, and Emotional Support Animals

Characteristics	Service Animals	Therapy Dog	Emotional Support Animal
Handlers' rights to be accompanied by these dogs in establishments open to the public are protected by the Americans with Disabilities Act (ADA).	x		
Dogs must be temperamentally sound to tolerate a wide variety of experiences, environments and people.	x	x	
These dogs may live with their disabled owners in housing with a "no-pets" policy in place.	x		x

Dogs visit hospitals, schools, hospices, and other institutions to aid in psychological or physical therapy.		x	
Handlers encourage these dogs to accept petting and socialize with other people while they're on-duty.		x	
Dogs are individually trained to perform tasks or do work to mitigate their handlers' disabilities.	x		
Petting, talking to or otherwise distracting these dogs can interfere with their job and pose a serious danger to the dog and handler.	x		
Dogs' primary functions are to provide emotional support, through companionship, to their disabled owners.	x		

4.0 Partners

4.1 State Level

State agency resources are coordinated in emergencies by the Oklahoma Department of Emergency Management (OEM) when local resources are depleted. The list of partner agencies below offers planning information and guidance specific to access and functional needs populations and may be contacted if you have questions while putting your plan together. In an emergency it is important to remember the proper channel for requesting assets is through your local emergency management agency. They will forward the request to the Oklahoma Department of Emergency Management. From there, your request will be coordinated with the appropriate state agency.

The following agencies are in partnership with Oklahoma State Department of Health (OSDH) and Oklahoma Department of Emergency Management & Homeland Security (ODEMHS).

- American Red Cross (ARC)
- Library for the Blind and Physically Handicapped (OKDHS)
- Oklahoma Department of Emergency Management and Homeland Security (ODEMHS)
- Oklahoma Department of Human Services (OKDHS)
- Oklahoma Department of Environmental Quality (OKDEQ)
- Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)
- Oklahoma Department of Rehabilitation Services (DRS)
- Oklahoma Developmental Disability Council (OKDDC)
- Oklahoma Medical Reserve Corps (OKMRC)
- Oklahoma-Voluntary Organizations Active in Disaster (OK-VOAD)

4.2 State Partners and Contact Information

Agency: American Red Cross (ARC)

Primary Contact Name: Johnnie Munn

Email:(Johnnie.Munn@redcross.org)

Telephone Contact: (918) 633-9620

Services/Resources: Will take care of immediate “disaster needs” (housing, medication, durable medical equipment (DME), etc.

Agency: NamUs
Primary Contact: Mike Nance

Mobile number: 918-527-0080
Email address: MNance@rti.org

Agency: Oklahoma Department of Rehabilitation Services (Visual Services)
Primary Contact: Cheryl Snow- Supervisor
Mobile number: (405) 522-3382
Email address: Csnow@okdrs.gov
Secondary Contact: Elizabeth Scheffe
Mobile number: (405) 522-3359
Email address: Escheffe@okdrs.gov
Services/Resources: Trainers for visual cultural awareness, stimulators, blindfolds, red- white-tipped canes. (No cost services)

Agency: Department of Rehabilitation Services (Visual Services) & Library for the Blind and Physically Handicapped
Primary Contact Name: Brain King, Public Information Officer (PIO)
Office: (405) 521- 3514
Services/Resources: Information on signature guides, teaching cultural awareness on visual disabilities.

Agency: Oklahoma Department of Emergency Management- Individual Assistance
Primary Contact Name: Luke Pratt, Individual Assistance Officer
Office: (405) 521-2481
Email: Luke.Pratt@oem.ok.gov
Second Contact: Cindy Brown
Email address: cindy.brown@oem.ok.gov
Mobile number: 405-593-7058
Services/Resources: OEM is the primary coordinating emergency response agency for the state of Oklahoma. In addition, OEM is in charge of coordinating ESF#6, Mass Care, and Sheltering response.

Agency: Oklahoma Department of Health and Human Services
Primary Contact: William Whited, State Long-Term Ombudsman
Office: (405) 521-6734
Email: William.Whited@okdhs.org
Services/Resources: Long-Term Care, Senior Advocates. (Assistance in communities).

Agency: Oklahoma Department of Mental Health and Substance Abuse Services
Primary: Ashley House
Clinical Behavioral Care, Disaster Coordinator
Oklahoma Department of Mental Health and Substance Abuse Services (OKMHSAS)
Work Cell: 405- 248- 9335
Ashley.House@odmhsas.org
Secondary: Penny Mitchell, LADC-MH-C, Program Manager Open Access/APS Team Lead.
Office: (405) 445-2983
Email: Penny.Mitchell@odmhsas.org
Services/Resources: Coordinate behavioral health professionals and vans available for transport of clients/ individuals.

Agency: Oklahoma Department of Rehabilitation Services
Primary Contact: David Hankinson, Program Manager, Services to the Deaf and Hard-of-Hearing
Office: (405) 522-7930 (OKC)

Services/Resources: Contact list for Certified American Sign Language (ASL) Interpreters. They can also supply educational information on the Deaf community.

4.3 For Relay services call:

https://www.okdrs.gov/guide/relay-oklahoma

4.3.1 Relay Oklahoma

Oklahoma Relay provides a full telephone interpreting service between people who can hear and those who are deaf, hard-of-hearing, deaf-blind or speech-disabled. Communications Assistants (CAs) have computers that enable them to hear the voice users as well as read the signals from the TTY users.

- Oklahoma Relay Numbers
  (800) 522-8506 Voice to TTY/VCO/HCO/STS
  (877) 243-2823 Voice to CapTel
- (800) 722-0353 TTY to Voice/Hearing Carry-Over
- (800) 522-5065 ASCII to Voice
- (866) 826-6552 Voice Carry-Over
- (877) 722-3515 Speech-to-Speech
- (888) 269-7477 Voice/CapTel Customer Service

Agency: Oklahoma State Department of Health,

Emergency Preparedness & Response Services

Primary Contact: Glenda Ford-Lee, MHR, Statewide At-Risk Population's Coordinator
Office: (405) 543-8499
Email: GlendaFL@health.ok.gov
Primary Contact: Scott White, OSDH Emergency Manager
Email: ScottW@health.ok.gov
Services/Resources: Coordination and research of Access and Functional Needs Populations as a whole. OSDH can provide training presentations, and outreach on resources for people with disabilities and afn care.

Long Term Care Service: Provide contact and outreach to licensed nursing facilities across the state.
Oklahoma State Department of Health, Emergency Preparedness and Response Services, Medical Reserve Corps
Primary Contact: Lezlie Borak, Coordinator
Office: (405) 426-8606
Email: Lezlie.Borak@health.ok.gov
Services/Resources: Coordinate statewide access of pre-identified public health and medical volunteers that maybe used in public health initiatives and response.

Agency: Developmental Disabilities Council of Oklahoma
Jenifer (Jen) Randle, M.Ed.
Developmental Disabilities Council of Oklahoma Executive Director
Mobile number: (405) 212 –7558

4.4 Functional Assessment Support Team

FAST Contacts- All FAST contacts are made through the OK- EM EOC

Agency: Oklahoma State Department of Health, Emergency Preparedness and Response Services
Primary Contact Name: Glenda Ford-Lee, MHR- Lead
Mobile: (405) 543-8499
GlendaFL@health.ok.gov
Services/Resources: Durable medical equipment (DME), medical supplies, trainings in Access and Functional Needs, presentations in emergency preparedness, shelter staff assistance.

Agency: Oklahoma City County Health Department
Primary Contact Name: Elizabeth Billingsley, RN

Elizabeth_Billingsley@occhd.org
Telephone: (405) 219-9680
Second Contact: Jennifer Krawic
Email address: Jennifer_krawic@occhd.org
Mobile number: (405) 215-4959
Third Contact: Blaine Bolding
Email address: blaine-bolding@occhd.org
Mobile number: (405) 795-4321
Services/Resources: Resources and Expertise: Emergency Preparedness and Response, vaccinations, medical clinics, WIC, PODs (Points of Dispensing), health education, mobile food market, mobile clinics and strike teams as needed, consumer protection, Community health workers in our community and community initiatives. disease investigation.

Agency: Sign Language Resource Services, Inc.
Primary Contact Name: Stephanie Nichols
Telephone: (405) 721-0800
Services/Resources: American Sign Language (ASL) Interpretation and evaluation.

Agency: Oklahoma Department of Human Services, State Long-Term Care
Primary Contact Name: William Whited, State Ombudsman (Seniors)
Telephone: (405) 521-6734
Services/Resources: Senior Long-Term Care placement and services.

Agency: Oklahoma Department of Emergency Management & Homeland Security (ODEMHS)
Primary Contact Name: Luke Pratt, Individual Assistance Office
Telephone: (405) 521-2481
Services/Resources: OEM is the primary coordinating emergency response agency for the state of Oklahoma. In addition, OEM is in charge of coordinating ESF#6, Mass Care, and Sheltering response.

Agency: Oklahoma Department of Mental Health and Substance Abuse Services
Primary Contact Name: Ashley House, Clinical Behavioral Care, Disaster Coordinator
Oklahoma Department of Mental Health and Substance Abuse Services (OKMHSAS)
Mobile Number: 405- 248- 9335
Ashley.House@odmhsas.org

Penny Mitchell, LADC-MH-C, Program Manager Open Access/APS Team Lead.
Office: (405) 445-2983
Email: Penny.Mitchell@odmhsas.org
Services/Resources: Coordinate behavioral health professionals and vans available for transport of clients/ individuals.

Agency: Transportation Bus Services
Telephone: (405) 235-7433
Email: www.http://embarkok.com
Services/Resources: Buses, accessible vans in the Oklahoma City, Midwest City, and Norman. Older adult services and people with disability services are available for clients.

Agency: Variety Care
Primary Contact Name: Isis Palomino
Mobile: (405) 371-1636
Email: ipalomino@varietycare.org
Area of Expertise: Social Services Access Coordinator. Registered Courtroom Interpreter, Child Passenger Safety Tech.
Second Contact: Maria Peguero
Mobile: (405) 482-6691
Email: mpeguero@varietycare.org
Area of Expertise: Community Health Worker
Third Contact: Katy Knight
Email: Knight@varietycare.org
Services/Resources: Healthcare Center. Provide the following services: medical, vision, WIC, dental, behavioral health, social services, Medicaid and marketplace enrollment. Bilingual Staff.

Agency: Oklahoma Disability Law Center, Inc.
Primary Contact Name: Joy Turner
Mobile number: (405) 409-5759
Email address: joy@okdlc.org
Second Contact: Faythe McMillin
Work number: (405) 896-6761
Email address: faythe@okdlc.org
Third Contact: Name: Nancy Ward
Office number: (405) 695-6964
Email address: nancy@okdlc.org

Resources and Expertise: People with Disabilities; Law regarding individuals with Disabilities (The Americans with Disabilities Act, Section 504 of the Rehabilitation Act); teaching/presenting.

Organization: Autism Foundation of Oklahoma
Primary Contact: Emily Scott
Executive Director
Autism Foundation of Oklahoma
Mobile number: (405) 237-8390 or (405) 434- 5507
Email address: escott@autismfoundationok.org
Services/Resources: Education, advocacy, kits.

Organization: Oklahoma University Health Science Center
Primary Contact: Erica L Herrera, BA.
Lead Family Coordinator
Oklahoma Family Support 360 Center
Center for Learning and Leadership/UCEDD
http://www.ouhsc.edu/thecenter

Appendix A- Federal Laws for Inclusive Planning

Americans with Disabilities Act (ADA)

Under Title II of the ADA, emergency programs, services, activities, and facilities must be accessible to people with disabilities and generally may not use eligibility criteria that screen out or tend to screen out people with disabilities.

https://www.ada.gov/pcatoolkit/chap7emergencymgmt.htm

504 of the Rehabilitation Act

Section 504 of the Rehabilitation act of 1973, as amended, (29 U.S.C. 794 - PDF) prohibits discrimination against otherwise qualified individuals on the basis of disability:

Programs and activities that receive financial assistance from HHS; 45 C.F.R. Part 84 and Programs or activities conducted by HHS. 45 C.F.R. Part 85

https://www.hhs.gov/civil-rights/for-individuals/disability/laws-guidance/index.html#:~:text=Section%20504%20of%20the%20Rehabilitation,assistance%20from%20HHS%3B%2045%20C.F.R.&text=Programs%20or%20activities%20conducted%20by%20HHS.

Service Animals

The Department of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) for title II (State and local government services) and title III (public accommodations and commercial facilities) on September 15, 2010, in the Federal Register. These requirements, or rules, contain updated requirements, including the 2010 Standards for Accessible Design (2010 Standards).

Service Animal Overview

This publication provides guidance on the term “service animal” and the service animal provisions in the Department’s regulations.

- Beginning on March 15, 2011, only dogs are recognized as service animals under titles II and III of the ADA.
- A service animal is a dog that is individually trained to do work or perform tasks for a person with a disability.
- Generally, title II and title III entities must permit service animals to accompany people with disabilities in all areas where members of the public are allowed to go.

How Service Animal Is Defined

Service animals are defined as dogs that are individually trained to do work or perform tasks for people with disabilities. Examples of such work or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, reminding a person with mental illness to take prescribed medications, calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack, or performing other duties. Service animals are working animals, not pets. The work or task a dog has been trained to provide must be directly related to the person's disability. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.

This definition does not affect or limit the broader definition of "assistance animal" under the Fair Housing Act or the broader definition of "service animal" under the Air Carrier Access Act.

Some State and local laws also define service animal more broadly than the ADA does. Information about such laws can be obtained from the relevant State attorney general's office.

Miniature Horses

In addition to the provisions about service dogs, the Department's ADA regulations have a separate provision about miniature horses that have been individually trained to do work or perform tasks for people with disabilities. (Miniature horses generally range in height from 24 inches to 34 inches measured to the shoulders and generally weigh between 70 and 100 pounds.) Entities covered by the ADA must modify their policies to permit miniature horses where reasonable. The regulations set out four assessment factors to assist entities in determining whether miniature horses can be accommodated in their facility. The assessment factors are

(1) whether the miniature horse is housebroken;

(2) whether the miniature horse is under the owner's control;

(3) whether the facility can accommodate the miniature horse's type, size, and weight; and

(4) whether the miniature horse's presence will not compromise legitimate safety requirements necessary for safe operation of the facility.

https://www.ada.gov/service_animals_2010.htm

Public Law 111 - 274 - Plain Writing Act of 2010

Public Law 111-274. Date Approved- October 13, 2010

Full Title An act to enhance citizen access to Government information and services by establishing that Government documents issued to the public must be written clearly, and for other purposes.

Bill Number - H.R. 946. Report Number- H Rept. 111-432

Statutes at Large Citations- 124 Stat. 2861, 2862 and 2863
https://www.govinfo.gov/app/details/PLAW-111publ274

ADA- Effective Communication

The ADA requires that title II entities (State and local governments).

Title III entities (businesses and nonprofit organizations that serve the public) communicate effectively with people who have communication disabilities.
https://www.ada.gov/effective-comm.htm

The Americans with Disabilities Act (ADA)

Under Title II of the ADA, emergency programs, services, activities, and facilities must be accessible to people with disabilities and generally may not use eligibility criteria that screen out or tend to screen out people with disabilities.

https://www.ada.gov/pcatoolkit/chap7emergencymgmt.htm

Service Animals

The Department of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) for title II (State and local government services) and title III (public accommodations and commercial facilities) on September 15, 2010, in the Federal Register. These requirements, or rules, contain updated requirements, including the 2010 Standards for Accessible Design (2010 Standards).
https://www.ada.gov/service_animals_2010.htm

Miniature Horse (Service Animal)

In 2010 the ADA wasrevised to include miniature horses.

(Miniature horses generally range in height from 24 inches to 34 inches measured to the shoulders and generally weigh between 70 and 100 pounds.

https://www.ada.gov/service_animals_2010.htm

504 Rehabilitation Act

Section 504 of the Rehabilitation act of 1973, as amended, (29 U.S.C. 794 - PDF) prohibits discrimination against otherwise qualified individuals on the basis of disability:

Programs and activities that receive financial assistance from HHS; 45 C.F.R. Part 84 and

Programs or activities conducted by HHS. 45 C.F.R. Part 85

https://www.hhs.gov/civil-rights/for-individuals/disability/laws-guidance/index.html#:~:text=Section%20504%20of%20the%20Rehabilitation,assistance%20from%20HHS%3B%2045%20C.F.R.&text=Programs%20or%20activities%20conducted%20by%20HHS.

Stafford Act

Robert T. Stafford Disaster Relief and Emergency Assistance Act, PL 100-707, signed into law November 23, 1988; amended the Disaster Relief Act of 1974, PL 93-288. This Act constitutes the statutory authority for most Federal disaster response activities especially as they pertain to FEMA and FEMA programs. https://www.fema.gov/disaster/stafford-act

Appendix B – Resource List of Community and State Partners

The item is below are suggestions of resources that organizations statewide can provide in an emergency response. This list is not complete for any specific state or local agency emergency response.

- Adult and children clothing
- Air mattress
- Ambulances
- American Sign Language Interpreters (Certified by Quality Assurance Screening Test) (QAST) Levels III-IV
- Accessible Audio equipment
- Baby beds (cribs) and baby supplies (clothing, diapers, formula, and toys)
- Bariatric wheelchairs, walkers, canes, crutches, standard wheelchairs, and red tipped canes
- Blankets
- Case mangers
- Child care services
- Child guidance staff
- Community workers
- Foreign Language Interpreters
- Mental health counselors
- Nurses and home health aides
- Pet and Service Animal supplies
- Social workers
- Veterinarian Services
- Video Remote Interpreting (VRI) services

Appendix: C- Alphabetical Resource List

The list below is for community and state partners includes that can assist you in inclusive local emergency planning.

The following agencies named below are suggestions of community/state partners that can assist in emergency planning.

- Animal Control
- Community Based Organizations (CBO's)
- Community Hospitals
- County Health Departments
- Faith Based Organizations (FBO's)
- Local Community Businesses
- Local Educational Institutions Facilities (elementary, secondary, colleges, and universities)
- Local Emergency Managers
- Local Emergency Medical Services
- Local Energy Companies
- Local Fire and Police Stations
- Local Mental Health Organizations
- Local Transportation Services (cabs, buses, school buses)
- Local Veteran Organizations
- Oklahoma Conferences of Churches
- Oklahoma Mental Health and Substance Abuse Services (ODMHASAS)
- Oklahoma Department of Agriculture, Food & Forestry- Animal Industry Services
- Oklahoma Voluntary Organizations Active in Disaster (OKVOAD)
- Salvation Army
- United Way

Appendix D – Accessibility Toolkit List

Preparedness equipment for all hazards involving people with disabilities, senior citizens, and the deaf community centralized into an accessible toolkit. The equipment is customized to fit each community and their specific demographical needs. The following items can assist the care of people with access and functional needs.

- Toolkit from Autism Foundation of Oklahoma
- Canes
- Certified American Sign Language (ASL) interpreters list for your community
- Collapsible ramps
- Contact list for accessible portable showers and bathrooms
- Crutches
- Dark glasses
- Forms, rules and instructions in accessible formats such as the following: audio, braille and large print (16-18 font), Times Roman, bold, non-glossy and cream color paper)
- Laptop or smart phone for computer-based communications with ASL provider
- Magnifying glass with light
- Shelter signs with large, bold, black font, and braille words
- Signature guides
- Sound Plus WIR 239 TV Listening System
- T.V. Ears Pro Loop
- Telephone handset amplifier
- Video Remote Interpreting (VRI) services
- Walkers
- White cane(s)
- Wireless computer network

The lists of items above are just examples of what a local or county activated shelter could have in an Accessibility Toolkit. Each community will have specific resource needs that may not be included in the list above, but still needed in their community. Working with community-based organizations (CBO's), faith-based organizations (FBO's), advocacy groups for senior citizens, and organizations that focus on the access and functional needs populations can expand your lists of items for the accessibility toolkit.

Appendix E- Planning Checklist for Diapering Stations in Shelters

Building and Placing a Diapering Station

- Is diapering station as far from water stations, food prep and dining areas as possible?
- Is the diaper changing surface made of non-porous material?
- Is there a rail or similar barrier that surrounds the diaper changing surface to help protect children from falls?
- Is one station available for every 8 diapered children?
- Is the diapering station within arm's reach of sink? Sink should not be used for food preparation, dishwashing, or dispensing water to drink.

Stocking the Station

- Is sink stocked with liquid soap? If diapering station cannot be placed within reach of an existing sink and a temporary handwashing station cannot be set up, provide hand sanitizer containing 60% alcohol. Place sanitizer within reach of caregiver, but out of reach of children (ideally in a fixed wall dispenser).
- Are paper towels or air dryers available for drying hands?
- Is a lidded, plastic-lined trash receptacle (preferably with a foot-operated opening mechanism) available in the diapering area?
- Are clean paper towels, butcher paper, or other disposable materials available for lining the changing table?
- If shelter will provide diapers and wipes, are these placed within reach of caregivers but away from diapering surface?
- Is appropriate disinfectant solution* in reach of caregivers, but out of children's reach?

*EPA-registered disinfectant appropriate for the diapering surface or freshly prepared bleach solution.

Education

- Are signs posted to instruct caregivers to wash their hands and child's hands with soap and water immediately after the diaper change?
- Are signs posted to use the diapering station sink for handwashing but not for drinking, cooking, or washing dishes or clothing?
- If diapering station is not near sink or temporary handwashing station, are signs posted at diapering station to direct caregivers to nearest sink?
- Are instructions posted about how to use the disinfectant solution? Consider labeling spray bottle with instructions in large type, or including these instructions on posters about diapering procedures.

For more information go to the following website: https://www.cdc.gov/healthywater/emergency/planning-checklist-for-diapering-stations-in-shelters/

Print-and-Go Fact Sheet

Planning Checklist for Diapering Stations in Shelters pdf icon [PDF – 1 page] (English)

Planning Checklist for Diapering Stations in Shelters pdf icon [PDF – 1 page] (Española)

Appendix F - Radiation and Your Health

A nuclear power plant accident, a nuclear explosion, or a dirty bomb are examples of radiation emergencies. If something like this happens, you may be asked to get inside a building and take shelter for a period of time instead of leaving. The walls of your home can block much of the harmful radiation. Because radioactive materials become weaker over time. Staying inside for at least 24 hours can protect you and your family until it is safe to leave the area. Getting inside of a building and staying there is called “shelter in place”.

There are three simple steps to be taken during a radiation emergency.

Step One: Get Inside

In a radiation emergency you may be asked to get inside a building and take shelter for a period of time.

- This action is called “sheltering in place”.
- Get to the middle of the building or a basement, away from doors and windows.
- Being pets inside.

Step Two: Stay Inside

Staying inside will reduce your exposure to radiation

- Close and lock windows and doors
- Take a shower or wipe exposed parts of your body with a damp cloth
- Drink bottled water and eat food in sealed containers.

If you are indoors during the radiation emergency:

1. Stay inside. Close and lock all windows and doors. Go to the basement or the middle of the building. Radioactive material settles on the outside of the buildings; so, the best thing to do is stay as far away from the walls and the roof of the building as you can.
2. If possible, turn off fans, air conditioners, and forced-air heating units that bring air from the outside. Close fireplace dampers.

If you are in a car, bus, or other vehicle during a radiation emergency:

A. Get inside a building right away. Cars do not provide good protection from radioactive material. If you can get to a brick or concrete multi-story building or basement within a few minutes, go there. But being inside any building is safer than being outside. Once inside, go to the basement or the middle of the building.
   Radioactive material settles on the outside of buildings, so the best thing to do is stay as far away from the walls and roof of the building as you can.

B. Carefully remove your outer layer of clothing before entering the building, if you can. Radioactive material settles on your clothing and your body, like dust or mud. Once inside, wash the parts of your body that were uncovered when you were outside. Then put on clean clothing, if you can. This will help limit your radiation exposure and keep radioactive material from spreading.
C. If you have loved ones in schools, daycares, hospitals, nursing homes, or other places during a radiation emergency:
    - Stay where you are! Going outside to get loved ones could expose you and them to dangerous levels of radiation.
    - Children and adults in schools, daycares, hospitals, nursing homes, or other places will be instructed to stay inside until emergency responders know that it is safe to evacuate.
    - Schools, daycares, hospitals, nursing homes, and other places have emergency plans in place to keep people safe at the facility.
D. If you have pets:
    - Bring pets inside with you, if you can. Bring indoors any supplies from outside that your pets might need for at least 24 hours.

Step Three: Stay Tuned

Emergency officials are trained to respond to disaster situations and will provide specific actions to help keep people safe.

- Use radios, televisions, computers, mobile devices, and other tools to get the latest information.
- Emergency officials will provide information on where to go to get screened for contamination.

The following information is from CDC. The website is:

https://www.cdc.gov/nceh/radiation/emergencies/index.htm#:~:text=In%20a%20radiation%20emergency%3A,you%20and%20your%20family%20safe.

Appendix G - AFN Planning for Community Resources Template

Throughout this document community outreach and resources was explained in various formats. Information provided on school programs, community programs, and non-profit organizations in the state of Oklahoma. Information also provided on state and federal guidelines that offer assistance during emergencies. Each component carriers an impact in “whole community planning”.

Knowing your community resources, community partners, federal and state partners is a major part of all hazard’s emergency planning. Knowing your local community statistics in areas of: gender, age, language, social-economic levels, and disabilities; ensures your local community plans will be effective in preparedness, response, and recovery from disasters.

The template below can be used to simplify the location of resources for your local community plans. Each community in our state is comprised of different resources, abilities, disabilities, and of course different access and functional needs during disasters. The template just simplifies the location and identification of these resources before a disaster occurs in your community. Which in turns allows you more time as a planner to prepare and respond to the disaster in your local community. Each table has at least three lines to increase the possibility of communications and response. I hope this helps you in your whole community, local emergency planning.

Community Resources Template

Name of the County_____

Name of the Local Emergency Response Coordinator _____

Name of the Emergency Manager _____

Emergency Manager telephone number _____

Emergency Manager email address _____

Date: _____ Review Date: _____

Durable Medical Equipment (DME) Resources

Name of Agency/ Contact Person	Address of Agency	Telephone #	Email address

List of DME that can used during emergencies:

_____

_____

Home Health Agencies

Name of Agency/ Contact Person	Address of Agency	Telephone #	Email address

Other information needed for this resource

Local Hospitals

Name of Agency/ Contact Person	Address of Agency	Telephone #	Email address

Other information for this resource

_____

_____

Out Patient Medical Clinics (AM/PM) Clinics

Name of Agency/ Contact Person	Address of Agency	Telephone #	Email address

Other information for this resource

_____

_____

Pharmacies

Name of Agency/ Contact Person	Address of Agency	Telephone #	Email Address

Other information for this resource

Nursing Schools

Name of Agency / Contact Person	Address of School	Telephone #	Email Address

Other information for this resource

Veterinary Hospitals/ Schools

Name of School / Contact Person	Address of School	Telephone #	Email Address

Other information for this resource

ARC/Food Pantry/ Non-Profit Organizations

Name of Agency /Contact Person	Address of Agency	Telephone #	Email Address

Other information for these resources

_____

_____

Local Disability Organizations – For People Who Are Blind or Have Low Vision

Name of Agency/ Contact Person	Address of Agency	Telephone #	Email Address

Other information for this resource

_____

_____

Local Disability Organization for People who are on the Autism Spectrum

Name of Agency / Contact Person	Address of Agency	Telephone #	Email Address

Other information for these resource

Local Disability Organization for People who are Hard-of-Hearing or who are Deaf

Name of Agency / Contact Person	Address of Agency	Telephone #	Email Address

Other information for these resource

Local Disability Organization for People with Mobility Disabilities

Name of Agency / Contact Person	Address of Agency	Telephone #	Email Address

Other information for these resources

Local Organization for People Senior in Age

Name of Agency / Contact Person	Address of Agency	Telephone #	Email Address

Other information for these resources

Local Organizations that Speak Spanish

Name of Agency / Contact Person	Address of Agency	Telephone #	Email Address

Other information for those resources

Local Displaced Shelter Organizations

Name of Agency / Contact Person	Address of Agency	Telephone #	Email Address

Other information from these resources

Local Organizations that Speak Other Languages - Outreach

Name of Agency / Contact Person	Address of Agency	Telephone #	Email Address

Other information from these resources

_____

_____

Community Youth Organizations (example- YMCA, Boys and Girls Club)

Name of Agency / Contact Person	Address of Agency	Telephone #	Email Address

Other information from these resources

_____

_____

Local Faith Based Organizations (FBO's)

Name of Agency / Contact Person	Address of Agency	Telephone #	Email Address

Other information from these resources

_____

_____

Local Community Based Organizations (CBO's)

Name of Agency / Contact Person	Address of Agency	Telephone #	Email Address

Other information from these resources

_____

_____

Local Utilities for Community (water, electric, gas)

Name of Agency / Contact Person	Address of Agency	Telephone #	Email Address

Other information from these resources

_____

_____

Local Mental Health Organizations

Name of Agency/ Contact Person	Address of Agency	Telephone #	Email Address

Other information from these resources

_____

_____

Appendix: H – Accessible Communications for Shelters, Multi-Agency Resource Centers (MARC's), and Disaster Recovery Center's (DRC's)

The number one complaint in every disaster is ineffective communications. The primary gap in disasters start with communications. Having accessible communications before, during, and after a disaster is very important for community safety, response, and recovery. Below is a checklist that will assist agencies, non-profits, faith-based organizations, or individual's in "accessible communications for shelters, multi-agency resource centers (MARC's) and disaster recovery centers (DRC's). Simply having documents on the computer does not make them accessible for everyone in your community.

The checklist below is a simple format for ensuring accessible communications for the "whole community".

Please understand this checklist below can be added to at any time. This list is considered a "living document"; that can be expanded as we learn more on access and functional needs population's planning and needs for disaster responses in our state. The bullets below will also have the reason why the formatting is important for emergency planning and responses during disasters. The number one rule is as follows: If you have the information in English; you should have it in Spanish, American Sign Language (ASL), and any other language used for emergency messaging.

The information below is also important for education in inclusive, equitable, and diverse emergency planning and responses for local, regional, or state emergency response agencies.

- Large Print documents (16-18-20, and 22 size fonts, Arial, Bold) Flyers
  - This format is useful for people with visual disabilities.
  - This format is useful for people who are older in age.
    - When creating your large print document just make the font size larger.
    - Use Black or Dark Blue for your font color for high contrast (non-glossy paper, white paper) on your computer flyers or printed documents for your community.
    - Don't forget to put ASL services on your fliers for people who are Deaf or Hard-of-Hearing. You can use the graphic for ASL or put ASL Services available.
- Audio Format information messages
  - This format is useful for people who have visual disabilities
  - This format is useful for people who are hard-of-hearing
  - This format is useful for people who have cognitive disabilities

- This format is useful for people who are older in age
- This format is useful for people with low literacy

- American Sign Language (ASL) messages
  - This format is useful for people who use ASL for communication (people who are Deaf or people who are Hard-of- Hearing)
  - If possible, use Certified ASL interpreters (for accurate language interpretation services)
  - If this is not possible, think about the safety of your clients and the importance of “accurate” information transference.
  - Medical information should only be interpreted by a certified ASL interpreter.
  - Legal information should only be interpreted by a certified ASL interpreter.
  - Video Remote Interpreting (VRI) services will allow the interpretation to occur your “smart device” or computer on an “as needed” bases. Use your smart phone, tablet, or computer for these services. (e.g., facetime, goggle Duo, etc.) These services will reduce the people in your facility and can be used on the “as needed” bases.
- Information in Spanish (audio and written format)
  - This format is useful for people who use Spanish as their primary language
  - This format is useful for people who have low literacy in the English language and use Spanish for important decision-making decisions.
  - Ensure you have “accurate” Spanish interpretation.
  - Ensure you have television or radio stations that focus on these specific populations.
    - The basic rule is as followings: If you have the information in English on the television; they ensure you have the same in other languages.
- Foreign Language Documents and Messages (audio and written format)
  - This format is useful for people with low literacy in English and need their primary language for important decision-making decisions.
  - Ensure you have “accurate” foreign language interpretation.
  - Ensure you have television or radio stations that focus on these specific populations.
    - The basic rule is as followings: If you have the information in English on the television; they ensure you have the same in other languages. (If possible)
- Easy Reading Documents (Graphics)
  - This format is useful for people who cognitive disabilities.

- This format is useful for people who are on the Autism Spectrum.
- This format is useful for people who are older in age.
- This format is useful for people with low literacy.
    - For people did not attend college or trade school.
    - For people that did not attend high school.
    - For people who have cognitive disabilities. (e.g., stroke, traumatic brain injury,
- Understand that culturally competent “graphics” should be “inclusive” for the communities.

- Plain Language Documents (computer, audio, and written)
    - Create your documents in “plain language”.
    - Use terms that are easily understood by everyone. Instead of stating involuntarily undomiciled; use without permeant house or housing.
    - Instead of stating submission of applications; use the following- how do I apply?
    - Do not make the form complicated.
    - Do not use acronyms.
    - This format is useful for people who cognitive disabilities.
    - This format is useful for people who are older in age.
    - This format is useful for people with low literacy.
        - For people did not attend college or trade school.
        - For people that did not attend high school.
        - For people who have cognitive disabilities. (e.g., stroke or traumatic brain injury)

References

Federal

1. ADA Best Practices Tool Kit for State and Local Governments. U.S. Department of Justice. Chapter 7, Emergency Management under Title II of the ADA with Addendums 2 and 3. http://www.usdoj.gov/crt/ada//pcatoolkit/chap7shelterchk.htmhttps://www.ada.gov/pcatoolkit/chap7shelterchk.htm
2. ADA Requirements: Service Animals www.ada.gov/service_animals_2010.htm
3. The Autism Foundation of Oklahoma (AFO) www.AutismFoundationOK.org
4. Blue Campaign www.dhs.gov/bluecampaign
5. CDC GIS https://www.cdc.gov/gis/what-is-gis.htm
6. Effective Emergency Management: Making Improvements for Communities and People with Disabilities. National Council on Disability. August, 2009. http://www.ncd.gov
7. National Human Trafficking Resource Center www.traffickingresourcecenter.org or nhtrc@polarisproject.org
8. U.S. Department of Health and Human Services & Office of the Assistant Secretary for Preparedness and Response. http://www.phe.gov/Preparedness/planning/abc/Documents/pas-131107.pdf
9. U.S. Department of Health & Human Services – Disaster Preparedness http://www.hhs.gov
10. U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Mental Health Services http://www.samhsa.gov
11. U.S. Department of Health and Human Services- Public Health Emergency https://www.phe.gov/Preparedness/planning/abc/Pages/behavioralhealth.asp
12. Center for Disease Control and Prevention https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-l#:~:text=61%20million%20adults%20in%20the,Graphic%20of%20the%20United%20States.
13. Exec. Order No. 13985, January 20, 2021, Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government. https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive- order-advancing-racial-equity-and-

support-for-underserved-communities-through-the-federal-government/

14. Plain Language Writing
https://www.govinfo.gov/app/details/PLAW-111publ274
15. Radiation Information
https://www.cdc.gov/nceh/radiation/emergencies/whattodo.htm

National

1. Individuals with Disabilities or Access & Functional Needs
http://www.ready.gov
2. National Organization on Disability http://nod.org/disability_resources
3. Invisible Disabilities
https://www.umass.edu/studentlife/sites/default/files/documents/pdf/Invisible%20Disabilities%20List%20%26%20Information.pdf
4. Easy Read
https://www.odi.govt.nz/guidance-and-resources/a-guide-to-making-easy-read-information/

State of Oklahoma

1. Center for Interdisciplinary Learning and Leadership

http://www.ouhsc.edu/thecenter/

2. Oklahoma Area Wide Aging Services

http://www.okdhs.org/services/Pages/olderoklahomans.aspx

3. Oklahoma Rehabilitation Services – Relay Services

https://www.okdrs.gov/guide/relay-oklahoma

4. Oklahoma Rehabilitation Services. Oklahoma with mobility disabilities
https://www.okdrs.gov/guide/home

Acronyms

AAR - After Action Report

ADA - Americans with Disabilities Act

ADHD- Attention Deficit Hyperactivity Disorder

ADLs - Activities of Daily Living

AFN- Access and Functional Needs

AIDS - Acquired Immune Deficiency Syndrome

ARC - American Red Cross

ASL - American Sign Language

CA's- Communication Assistants

CBO's - Community Based Organizations

CDC - Centers for Disease Control and Prevention

C-FAST- Children's-Functional Assessment Support Team

CHW- Community Health Worker

CLAS- Cultural and Linguistic Appropriate Services

C-MIST- Communication, Maintaining Health, Independence, Safety and Support, and Transportation

COIN- Community Outreach Information Network

dBA – Decibels

DOJ- Department of Justice

DHS - Department of Homeland Security

DME - Durable Medical Equipment

DRS- Department of Rehabilitation Services

EMI - Emergency Management Institute

EMS - Emergency Medical Service

EMSA- Emergency Medical Services Agency

EOC- Emergency Operations Center

EOP - Emergency Operations Plan

EPRS- Emergency Preparedness and Response Services

ESF - Emergency Support Function

FBO's - Faith Based Organizations
FEMA - Federal Emergency Management Agency
GIS - Geographic Information System
HHA's - Home Health Aides
HIPAA - Health Insurance Portability & Accountability Act
HIV - Human Immunodeficiency Virus
H-o-H - Hard-of-Hearing
HSEEP - Homeland Security Exercise & Evaluation Program
IA- Individual Assistance
IBS- Irritable Bowel Syndrome
ICS - Incident Command System
ID- Identification
IEP- Individual Education Plan
IV- Intravenous
LGBTQ+- Lesbian, Gay, Bi-sexual, Transgender, and Queer/Questioning
LTC – Long-Term Care
MCH- Maternal Child Health
MMRS - Metropolitan Medical Response System
MOA - Memorandums of Agreement
MOU - Memorandums of Understanding
MRC- Medical Reserve Corps
NamUs- National Missing and Unidentified Persons System
NFPA - National Fire Protection Association
NCTSN- National Child Traumatic Stress Network
NGO - Non-Governmental Organization
NHTRC- National Human Trafficking Resource Center
NOD - National Organization on Disability
NPP - Notice of Privacy Practice
NRF - National Response Framework
ODAFF - Oklahoma Department of Agriculture, Food & Forestry

ODMHSAS - Oklahoma Department of Mental Health and Substance Abuse Services

OEM - Oklahoma Department of Emergency Management

OKDDC- Oklahoma Developmental Disability Council

OKDHS- Oklahoma Department of Human Services

OKMRC - Oklahoma Medical Reserve Corps

OK-VOAD- Oklahoma Volunteer Organizations Active in Disasters

OMH- Office of Minority Health

OSDH- Oklahoma State Department of Health

OSHA- Occupational Safety and Health Administration

PAS- Personal Assistance Services

PETS Act - Pets Evacuation and Transportation Act

PSD- Psychiatric Service Dog

PTA- Parent- Teacher Association

PTSD- Post-Traumatic Stress Disorder

QAST- Quality Assurance Screening Test

RESPOND- Rapport, Explain, Services, Proactive, Offer, Negotiate, Determine

SNAP- Supplemental Nutrition Assistance Program

SNAPS- Snap Shots of State Population Data

SNS- Strategic National Stockpile

SVI- Social Vulnerability Index

TB - Tuberculosis

TTY - Text Telephone

TVPA- Trafficking Victims Protection Act

VRI- Video Remote Interpreting

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