Functional Needs Registry Form

Everybody Has **Needs -** Do the Right People Know What Yours Are?

If you or someone in your household has a disability or a special medical need, the people whose job i to respond when you call for help in an emergency need to know.

Whether it affects your entire community, your street or just your home, seconds can make a life-or-death difference. Having specific details about your special situation will significantly help us h you.

EMERGENCY RESPONSE DATA FORM:

Filling out this form is strictly voluntary and **the data will be kept strictly confidential**. It will be available only to local emergency assistance officials. **Please print clearly and provide all information.**

* denotes required information

Date completing this form : *

First Name: *

Middle Name:

Last Name: *

Male or Female: *

Prefer N

Language (if not English):

Phone #: *

E-mail Address: *

Date of Birth: *

Street Address: *

Apartment No.: *

Type of Residence: *

Single Family House

City/Town: *

State: *

Zip Code: *

In an Emergency, please contact

First Name: *

Last Name: *

Relationship to you: *

Phone # (primary): *

Phone # (secondary):

For the following, please answer Yes or No

Do you have Alzheimer's; Dementia or Psychiatric Disability?: *

- Yes
- No

Are you confined to bed?: *

- Yes
- No

Do you have a Developmental Disability (i.e. Autism; Mental Health issues, Intellectual Disability; etc?) If y please describe below.: *

- ○ Yes
- ○ No

Describe developmental disability :

Are you on Dialysis?: *

- ◉ Yes
- ○ No

Are you hard of hearing or deaf?: *

- ○ Yes
- ◉ No

Do you live alone?: *

- ○ Yes
- ○ No

Mobility Impaired-do you need assistance walking?: *

- ○ Yes
- ○ No

Mobility Impaired-do you use a walker or cane?: *

- ○ Yes
- ○ No

Mobility Impaired-do you use a wheelchair or scooter?: *

- ○ Yes
- ○ No

Are you on life support?: *

- ○ Yes
- ○ No

Are you oxygen dependent?: *

- ○ Yes
- ○ No

Will you require transportation if you need to be evacuated?: *

- ○ Yes
- ○ No

Do you have your own transportation?: *

- Yes
- No

Do you have a service animal?: *

- Yes
- No

Do you have pets?: *

- Yes
- No

Are you ventilator dependent?: *

- Yes
- No

Are you visually impaired or blind?: *

- Yes
- No

Can you communicate verbally?: *

- Yes
- No

Other Concerns::