

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 it is 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 help 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: *

Language (if not English):

Phone #: *

E-mail Address: *

Date of Birth: *

Street Address: *

Apartment No.: *

Type of Residence: *

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::