



03/2020

Do you live in Grundy County? Yes No

Name: _____

Address: _____

Phone#: _____ - _____ - _____ Township: _____

Resident Type (Circle One): Single Family - Mobile Home - Multi Family - Assisted Living

Living Situation (Circle One): Alone - With Relatives - With Care Giver - Other _____

Care Givers Name: _____ **Care Giver's Phone #:** _____ - _____ - _____

Access/Functional Need (Check All That Apply):

Medical - conditions that require ongoing medical professional assistance [physical, cognitive, emotional or sensory impairment] or assistive devices

Supervision - assistance with maintaining your ability to be independent

Communication - English is not primary language, Visually Impaired, Hard of Hearing or Deaf

Transportation - either you don't have or don't have access to transportation

Would you require special accommodations to be transported [wheelchair, ambulance]?

Yes No

Independence - Children who are too young to care for themselves and older adults who need assistance with their activities of daily living.

Brief Description of Boxes Checked: _____

List any durable medical equipment (Oxygen, Nebulizer CPAP machine, wheelchair, etc.): _____

PLEASE CONTINUE ONTO THE NEXT PAGE

OVER ►

Director
Joe Schroeder
jschroeder@grundyco.org

Deputy Director
James Sheldon
jsheldon@grundyco.org

E.M. Specialist
Blake Pettinelli
bpettinelli@grundyco.org

Do you have pets? [] Yes [] No

Quantity: _____ Type: _____

Quantity: _____ Type: _____

Quantity: _____ Type: _____

Quantity: _____ Type: _____

Do you have a service animal? [] Yes [] No

Quantity: _____ Type: _____

Quantity: _____ Type: _____

Quantity: _____ Type: _____

Quantity: _____ Type: _____

General Release and Consent:

By signing this form, I give my authorization for the information herein to be released only to the Grundy County Emergency Management, Grundy County Health Department, local public safety responders and receiving facilities for the purpose of evaluating my needs and providing emergency transportation and sheltering. Records relating to registration of persons with functional needs are exempt from the provisions of Freedom of Information inquiries. The information submitted relative to this document will be kept confidential and will be verified annually.

Signature: _____ **Date:** _____

Or Representative: _____ **Date:** _____

***** 03/2020

Official Use Only:

By: _____ Sub Area: _____

Township: _____ Fire District: _____

Ambulance: _____ Law Enforcement: _____