1320 Union St., Room E-01
Morris, Illinois 60450-2426
(815) 941-3212

07/2021

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:** __________________

** **07/2021**

Official Use Only:

By: ____Sub Area: _____________

Township: ______________________________________ Fire District: _______________________________

Ambulance:_________________________________ Law Enforcement: ______________________________