Functional & Access Needs Database

DISCLAIMER: By completing this form I acknowledge that this is not a guarantee of service between LaSalle County and myself and that LaSalle County may share this information during times of emergencies with local first responders to coordinate my emergency transportation, communication or shelter needs.

Last Name: _____ Address: _____

First Name: _____ _____

Date of Birth/Sex: _____ City: _____

Phone 1: _____ Zip Code: _____

Phone 2: _____ Primary Language: _____

Residence Type (circle one): Single Family—Mobile Home—Multi-Family—Assisted Living

Living Situation (circle one): Alone—with relatives—with care giver—Other _____

Care Giver's Name: _____ Care Giver's Phone: _____

Functional/Access Need (Check all that apply)

[ ] Medical—conditions that require ongoing medical professional assistance or assistive devices

[ ] Supervision—assistance with maintaining your ability to be independent

[ ] Communication—English is not your primary language and a language translator is needed

[ ] Transportation—either don't have or don't have access to

[ ] Independence—Children who are too young to care for themselves and Older Adults who need assistance with their activities of daily living

Description: _____

_____

List any required durable medical equipment (Oxygen, nebulizer CPAP machine, wheelchair, etc.). _____

_____

Durable Medical Goods Provider (Apria, Lincare, etc.) _____

Durable Medical Goods Provider phone number _____

Do you have Pets?

Quantity _____ Types _____

Do you have a service animal(s)?

Quantity _____ Types _____

Emergency Contact #1

Name _____ Phone _____

Emergency Contact #2

Name _____ Phone _____

Signature Required on the back of this page

Revised 2/3/2014

General Release and Consent

By signing this form, I give my authorization for the information herein to be released only to the LaSalle County Health Department, LaSalle County Emergency Management Agency, local public safety responders and receiving facilities for the purpose of coordinating my needs and for coordinating emergency transportation and sheltering. I further acknowledge that this is not a guarantee of service between myself and LaSalle County and further recognize that LaSalle County does not provide anything other than the coordination of efforts with local responders. 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 _____ or Representative _____ Date _____

Return Completed Form Using One Of The Following:

LaSalle County Emergency Management Agency
711 E. Etna Rd.
Ottawa, IL 61350

Fax: 815 434-2623
Email: LaSalleCoEMA@lasallecounty.org

Official Use Only: GIS Date: _____ Record # _____ By: _____

Fire District _____ Ambulance _____

Law Enforcement _____ Township _____

Verification Date	By	Status

Revised 2/3/2014

Official Use Only:

Registrant Name: _____ **GIS Record #** _____

Verification Date	By	Status

Official Use Only:

Registrant Name: _____ **GIS Record #** _____

Verification Date	By	Status