SPECIAL NEEDS FORM

ATTN: TOWN OF SIX MILE AND OTHER STATE, COUNTY, AND LOCAL AUTHORITIES

If you have a disability or access/functional need that will require assistance during an emergency evacuation, please fill out and return this information to Six Mile Town Hall. It is very important needs are identified before the emergency and communicated to Emergency Preparedness authorities and retained in Town Hall as well. This information will be kept confidential by all authorities and shared only among emergency preparedness authorities.

Contact Information for Person/s Needing Assistance (please print)

Name: _____

Street Address: _____

City: _____State:_____Zip_____

ACCESS/TRANSPORTATION

____ Do not drive or have friends/family who can drive you

____ Cannot walk – require a wheelchair (# of patients _____)

____ Bedridden or medical equipment no easily transported (# of patients_____)

____ Use cane or walker (# of patients _____)

FUNCTIONAL NEEDS

____ Deaf/hard of hearing (# of patients _____)

____ Visually impaired/ring doorbell (# of patients _____)

____ Speech impediment (# of patients _____)

____ Use service animal (# of patients _____)

____ Oxygen dependent (# of patients _____)

____ Life support dependent (# of patients _____)

____ Cognitive/memory impairment (# of patients _____)

____ Other (explanation in comments

Comments:

_____

_____

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Telephone: Home _____ Text Y or N; TTY: Y or N; VP: Y or N

Cell _____ Text Y or N; TTY: Y or N; VP: Y or N

Email Address _____

Contact me: ____ I would like to discuss my special assistance needs in case of an emergency.

____ I would like to register to receive calls in case of an emergency in my area.

Emergency contact: _____

Name: _____

Telephone: H_____ Work _____ Cell _____

Person completing this form if different than listed above:

Name: _____

Phone: _____

NOTE: IF A RESIDENT CARE FACILITY, DENOTE NUMBER OF PATIENTS _____

AND NUMBER OF PATIENTS WITH FUNCTIONAL NEEDS ABOVE _____

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