Special Needs Form

This survey is for individuals who may need assistance in the event of an emergency or evacuation. I understand that the information provided will be given to state and city/town emergency responders and providers. All information will be kept confidential.

☐ New entry, please enter the indicators checked on the Special Needs Form.

☐ Please change existing indicators to the ones checked on the Special Needs Form.

☐ Please remove any existing indicators presently being displayed.

By completing this form, I understand that I am responsible to notify Southington Commission on DisAbilities of any changes with regard to the special needs information listed. I further agree that I will indemnify, defend, and hold harmless Southington Commission on DisAbilities , and my municipality from and against any and all claims, suits and proceedings resulting from or arising out of the provision of this information.

I understand that this information will remain as part of my record and will be shared with my local emergency management director until such time as I notify Southington Commission on DisAbilities to either change or delete it.

Signature _____ Date _____

By typing your name in the above field you are confirming that you approve this form and that you are the aforementioned person requesting this service

Please mail these forms to:

Southington Commission on DisAbilities

P.O. Box 439

Marion, CT 06444

Confidential Information

SPECIAL NEEDS FORM

FIRST NAME	MI	LAST NAME
STREET ADDRESS		
CITY	STATE	ZIP CODE
HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ( )
EMAIL ADDRESS:		
Date of Birth: Gender: ☐ Male ☐ Female		

Please Mark and "X" in each box that applies

☐ **"B" Blind** – Someone at this location is blind or visually impaired

☐ **"COG" Cognitive Impairment** - Someone at this location has a cognitive impairment

☐ **"H/D" Hard of Hearing/Deaf** – Someone at this location is hard of hearing or deaf

☐ **"LSS" Life Support System** – Someone at this location is physically linked to equipment required to sustain their life

☐ **"MI" Mobility Impaired** – Someone at this location is bedridden, uses a wheelchair, or has mobility impairment

☐ **"PI" Psychiatric Impairment** – Someone at this location has a psychiatric impairment

☐ **"SI" Speech Impairment** – Someone at this location has a speech impairment

☐ **"S" Sensory Disfunction** – Someone at this location has a Sensory issue

Specify_____

☐ **"SA/PA" Service Animal or Personal Assistant** – Someone at this location has a service animal or personal assistant

☐ **"SD" Seizure Disorder** – Someone at this location has seizure disorder

☐ **"TDD" Telecommunications Device for the Deaf** – Someone at this location may be using a TDD/TTY.

☐ **"Other"** – Other needs that would prevent prompt evacuation or need for assistance

Please Explain: (i.e. Hoya lift, leg braces)_____

Signature_____ **Date**_____

By typing your name in the above field you are confirming that you approve this form and that you are the aforementioned person requesting this service

Confidential Information

SPECIAL NEEDS FORM – CONTINUED

Name of Emergency Contact to assist you in the event of an emergency or evacuation:

Name_____

Street Address_____

City_____ **State**_____ **Zip Code**_____

Phone Number_____ **Work**_____ **Cell Phone**_____

Signature_____ **Date**_____

Confidential Information

HIPAA

We fall under the group that is not required to follow the HIPAA Law. Due to the importance of this form for our residents and to ensure our residents that their information will **only** be used in the event of an emergency, the Southington Commission on DisAbilities will follow the HIPAA Law in accordance with not releasing information to any individual not required to have such information.

Click Here to Submit this Form by Secure Email