



# 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?

Do you have a service animal(s)?

Quantity \_\_\_\_\_ Types \_\_\_\_\_

Quantity \_\_\_\_\_ Types \_\_\_\_\_

---

Emergency Contact #1

Emergency Contact #2

Name \_\_\_\_\_ Phone \_\_\_\_\_ Name \_\_\_\_\_ Phone \_\_\_\_\_

**Signature Required on the back of this page**

**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@lasallescouny.org

<b>Official Use Only:</b> GIS Date: _____	Record # _____	By: _____
Fire District _____	Ambulance _____	
Law Enforcement _____	Township _____	

Verification Date	By	Status