Functional Needs Registration Form for the Premise Alert Program (PAP) for McLean County Emergency Services

The Illinois Premise Alert Program (Public Act 96-0788) provides for Public Safety Agencies in the State of Illinois to allow people with functional needs to provide information to emergency service providers to be kept in a database.

The information can then be provided to responders dealing with situations involving individuals with Functional Needs. The information provided by you will be kept confidential and used only to provide emergency responders in McLean County with the information needed to deal with situations or emergencies involving a person with functional needs.

The notification expires 2 (two) years after the date it was submitted. You may update or renew it at any time by filing a new form.

The information provided will be entered into a database maintained by McLean County Emergency Management Agency and nay be shared with other police, fire, dispatch or EMS agencies as needed to provide services to the individual.

The individual must understand that the information provided here will not result in any type of preferential treatment to the individual and that McLean County Emergency Responders, nor any other responding agencies will not be held liable for duties relating to the reporting of functional needs individuals.

I also understand that if any of the provided information changes, I must notify EMA by filing an amended request form. *The information will self-expire 2 (two) years from the date received by EMA and I must renew the form prior to the expiration date if I want the information kept in the database.*

A Functional Needs Individual is hereby defined by the State of Illinois as: Having a physical or mental impairment, or has or is at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also requires health and related services of a type or amount beyond that required by individuals generally. The undersigned is the named individual, a family member, friend, caregiver, or medical personnel familiar with the individual. By signing, I certify I have read and understand this form in its entirety and hereby give permission to McLean County EMA to enter this information into the Premise Alert Program database.

The person submitting this form may be contacted for verification purposes.

By signing this form I give my authorization for the medical information herein to be released to emergency services personnel and receiving facilities for the purpose of evaluating my needs and providing emergency treatment, transportation, and sheltering. Records relating to registration of Persons with Functional Needs are exempt from the provisions of Public Records Law. This information contained here will be kept confidential.

Signature **or Representative:** **Date:**

This form can be completed online at: https://health.mcleancountyil.gov/244/McLean-County-Functional-Needs-Registry

PLEASE ANSWER EVERY QUESTION

LAST NAME:_____ FIRST:_____ MI: _____

DOB:_____ SEX:___ PHONE:(Primary)_____(Secondary)_____

STREET ADDRESS:_____ APT/LOT#:_____

CITY:_____ZIP:_____ TODAY'S DATE:_____

Check One:
- ☐ First time registering
- ☐ This is an update
- ☐ Remove me from the registry

I Require Transportation: ☐ Yes ☐ No **Living Situation:** ☐ Alone ☐ with Relative ☐ Other

☐ Single Family Residence ☐ Mobile Home ☐ Apt/Condo Complex Name: _____

☐ Yes ☐ No Care Taker: (Name & Phone) _____

☐ Yes ☐ No Hospice, Team ID: (Name & Phone) _____

☐ Yes ☐ No Home Health Care: (Name & Phone) _____

☐ Do you have a Pet? How Many/Type? _____ Do you have a SERVICE Animal? ☐ Yes ☐ No

SPECIAL NEED (CHECK ALL THAT APPLY)

☐ Kidney Disease	☐ Emphysema/COPD	☐ Walker / Cane	☐ Feeding Tube	☐ Stroke
☐ Diabetes	☐ High Blood Pressure	☐ Wheelchair Assist	☐ Ventilator	☐ Dialysis
☐ Insulin Dependent	☐ Seizure	☐ Bedridden	☐ Sight Impaired	☐ Cancer
☐ Memory Impaired	☐ Breathing Treatment	☐ Incontinence	☐ Autism	☐ Alzheimer's
☐ Mental Health Impaired	☐ Oxygen (lpm/_____)	☐ Physical Disability	☐ Deaf / Hard of Hearing	
☐ Speech Impaired	☐ Down's Syndrome	☐ Developmental Disability		

☐ Electric Dependent, Why? _____

☐ Other _____

Emergency Contacts:

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone: _____

Prearranged: ☐ Hospital ☐ Nursing Home ☐ Alternate Living Facility

Facility Name: _____

Doctor's Name: _____Phone: _____

Mail to: McLean County EMA, 104 W. Front St. B10, Bloomington, IL 61701

Official use only:

Transport to: ☐ General Shelter ☐ Functional Needs Shelter ☐Hospital _____

☐ Register for Functional Needs Shelter Only ☐ Source Code _____

Type of Transport: ☐ Own Vehicle ☐ Van/Bus ☐ Wheelchair ☐ Stretcher/Ambulance

Fire District: _____ **Grid:** _____ **Evacuation Level:** _____ **Shelter Name:** _____

Comments: _____

REFUGIO DEL CONDADO DE McLEAN / ÍNSCRIPCIÓN DE NECESIDADES ESPECIALES

APELLIDO: _____ NOMBRE: _____ INIC. FECHA DE NACIMIENTO: SEXO:

DIRECCIÓN POSTAL: _____ APTO. / LOTE NÚM. _____

CIUDAD: _____ CÓDIGO POSTAL: TELÉFONO: _____

NECESITO TRANSPORTE: ☐ Sí ☐ No

Situación de vivienda ☐ Solo ☐ con un Pariente ☐ Otra

☐ Casa de una sola familia ☐ Casa rodante ☐ Apto / Condo, Nombre del complejo: _____

☐ Cuidador: ____ ☐ Hospicio, Identificación del equipo: _____ ☐ Asistencia a la salud en el hogar: _____

☐ ¿Tiene mascotas? ¿Cuántas? / ¿Qué tipo? _____ ¿Tiene algún animal que le presta SERVICIOS? ☐ Sí ☐ No

NECESIDAD ESPECIAL (MARQUE TODOS LOS QUE CORRESPONDAN)

☐ Enfermedad renal	☐ Enfisema	☐ Andador /Bastón	☐ Tubo de alimentación
☐ Diabetes/ Depende de insulina	☐ Memoria deficiente	☐ Ayuda con silla de ruedas	☐ Aparato de ventilación
☐ Presión arterial alta	☐ Convulsiones	☐ En cama	☐ Diálisis
☐ Salud mental deficiente	☐ Incontinencia	☐ Vista deficiente	☐ Habla deficiente
☐ Dependiente de electricidad	☐ Cáncer	☐ Oxígeno (lpm)	☐ Silla geriátrica

¿Por qué? _____

☐ Tratamiento respiratorio ☐ Sordo / Algo sordo ☐ Ataque cerebral (Stroke)

Contactos de emergencia

Nombre: _____ Teléfono: _____

Nombre: _____ Teléfono: _____

Arreglos de antemano: ☐ Hospital ☐ Hogar de ancianos ☐ Lugar de vivienda alterno

Nombre de la instalación: _____

Nombre del médico: _____ Teléfono: _____

Al firmar este formulario doy mi autorización para que la información médica que contiene el mismo se le divulgue al Departamento de Salud del Condado, a la Administración de Emergencias, a los Socorristas de Seguridad Pública e instalaciones que reciben el formulario con el objetivo de evaluar mis necesidades y proporcionar transporte y refugio de emergencia. Los registros relacionados con la registración de Personas con Necesidades Especiales están exentos de las disposiciones de la Ley de Registros Públicos. La información que esto contiene se mantendrá confidencial.

Firma _____ **o Representante:** _____ **Fecha:** _____

Solo para uso oficial (Official use only):

Transport to: ☐ General Shelter ☐ Special Needs Shelter ☐ Hospital ☐ Other
☐ Register for Special Needs Shelter Only

Type of Transport: ☐ Own vehicle ☐ Van / Bus ☐ Wheelchair only ☐ Stretcher/Ambulance

Fire District: _____ **Grid:** _____ **Evacuation Level:** _____ **Shelter Name:** _____

Comments:

_____

_____

Revisado 8/30/11