Grundy County
EMERGENCY MANAGEMENT
1320 Union St., Room E-01
Morris, Illinois 60450-2426
(815) 941-3212

07/2023

ACCESS AND FUNCTIONAL NEEDS QUESTIONNAIRE

Please complete only if you live in Grundy County

Name: _____

Address: _____

Phone#: _____-_____-_____ Township: _____

Resident Type (Circle One)**:** Single Family - Mobile Home - Multi Family - Assisted Living

Living Situation (Circle One)**:** Alone - With Relatives - With Care Giver - Other _____

Care Givers Name: _____**Care Giver's Phone #:** _____-_____-_____

Access/Functional Need *(Check All That Apply):*

[ ] **Medical** - conditions that require ongoing medical professional assistance [physical, cognitive, emotional or sensory impairment] or assistive devices

[ ] **Supervision** - assistance with maintaining your ability to be independent

[ ] **Communication** - English is not primary language, Visually Impaired, Hard of Hearing or Deaf

[ ] **Transportation** - either you don't have or don't have access to transportation. Would you require special accommodations to be transported [wheelchair, ambulance]?

[ ] Yes [ ] No

[ ] **Independence** - Children who are too young to care for themselves and older adults who need assistance with their activities of daily living.

Brief Description of Boxes Checked: _____

_____

_____

List any durable medical equipment (Oxygen, Nebulizer, CPAP machine, wheelchair, etc.)**:**

_____

_____

PLEASE TURN OVER PAGE ►

Director
Joe Schroeder
jschroeder@grundycountyil.gov

Deputy Director
James Sheldon
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E.M. Specialist
Ricky Ortiz
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General Release and Consent:

By signing this form, I give my authorization for the information herein to be released only to the Grundy County Emergency Management, Grundy County Health Department, local public safety responders and receiving facilities for the purpose of evaluating my needs and providing emergency transportation and sheltering. 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.

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If you do not wish to be on this list, please check this box ☐

Printed Name:_____

Signature:_____

Or Representative: _____

Date: _____

Additional information: ***(if needed)***

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