KANKAKEE COUNTY EMA

ACCESS & FUNCTIONAL NEEDS

Dear County Resident:

Kankakee County Emergency Management Agency maintains a listing of persons in the County that may have Access and Functional Needs (AFN) during an emergency. AFN refers to individuals who need assistance due to any condition (temporary or permanent) that limits their ability to act during a natural or man-made major emergency in their area. This includes individuals with physical, developmental or intellectual disabilities, chronic conditions or injuries, limited English proficiency, older adults, children, low income, and/or transportation disadvantaged.

If you or someone in your household may have an AFN during a major emergency, please fill out the Access and Functional Needs Form so we may be able to contact you should a major emergency occur. Please either return the form to us via USPS to:

Kankakee County EMA
3000 S. Justice Way
Kankakee, IL 60901

You may also email it to KankakeeCoEMA@k3county.net.

Any information that you provide is protected by the privacy act and will remain with Kankakee County and not be released unless there is an emergency.

Should you have any questions, please call 815-802-7172, Monday – Friday, 8:00am – 4:00pm.

Thank you for your time.

Sincerely,

Kankakee County Emergency Management Agency

Kankakee County EMA - Access and Functional Needs Database Registration

DISCLAIMER: By completing this form, I acknowledge that this is not a guarantee of service between Kankakee County and myself and that Kankakee County may share this information during times of emergencies with first responders to coordinate my emergency transportation, communication or shelter needs if possible.

Circle One: First Time Registering Update Moved out of Kankakee County/Deceased

Name: _____ **Date of Birth:** _____

Address: _____ **Primary Language:** _____

_____ **Home Phone:** _____

Township: _____

Cell Phone: _____ **Cell Phone Carrier:** _____

Residence (Circle One): ◯ Single Family Home ◯ Mobile Home ◯ Multi Family/Apartment ◯ Assisted Living

Building Access Code/Key Location: _____

Living Situation: ◯ Alone ◯ With Caregiver ◯ With Relative/Roommate

Authorized Caregiver's Name: _____ Phone: _____

Name of Relative/Roommate: _____ Phone: _____

Functional/Access Need – Select all that Apply:

☐ Medical – conditions that require ongoing medical professional assistance or assistive devices

☐ Communication – English is not your primary language; visually impaired; hard of hearing or deaf

☐ Transportation – do not have access to transportation or require special accommodations

☐ Independence – unable to care for self

Description of Checked Need: _____

_____

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

_____

*Are **ALL** of the support needs resulting in the need for evacuation assistance temporary? *Example: The individual is bedridden due to pregnancy/recovery from a procedure or accident.*

☐ Yes ☐ No – Conditions are expected to be permanent

*Seasonal Resident? ☐ No ☐ Yes: From _____ to _____

* Is Evacuation assistance needed 24 hours a day? ___ No ___ Yes

If no, what hours will you need evacuation assistance? _____

Animals in Household

Please list each animal in household with their Type, Breed, Name and a Description (size, disposition, etc.)

_____

IMPORTANT NOTICE AND STATEMENTS OF UNDERSTANDING

I Understand:

- Registration is voluntary and hereby request registration in the "Access and Functional Needs Program"
- The notification expires 1 (one) year after the date submitted. You may update or renew any time by filing a new form.
- Emergency shelters may be made available to provide protection during a period of immediate danger.
- I will take the things I need with me to the shelter should I choose to go to the shelter.
- I will ensure that a pet carrier or crate and necessary items are available for my pet being taken to a pet friendly shelter or boarding facility. I am responsible for any charges from the shelter or boarding facility.
- I will need to make alternative arrangements in the event that I am unable to return to my home after an event.
- I will be responsible for any charges and costs associated with hospitalization or other medical facilities, including care and medical transportation, if they should become necessary.
- I may be asked to evacuate my residence. All reasonable attempts will be made to give advance notice. I understand that upon declining transportation I may not have another opportunity to request this service.
- The information provided here will not result in any type of preferential treatment to the individual and that the Kankakee County Emergency Responders, nor any other responding agencies, will not be held liable for duties relating to the reporting of functional needs individuals.

I Agree:

- By signing this form, I give my authorization for medical information contained herein to be released to the Kankakee County Health Department, State and County Emergency Management Agencies and receiving facilities for the purpose of evaluating my needs and providing emergency transportation and sheltering. The information contained in here will be kept confidential except as outlined herein.
- The information contained herein is true and correct to the best of my knowledge. I have read and understand the information on this form.
- By signing, I grant permission to health care providers, transportation agencies and responders as necessary to provide care, and to disclose any information that is necessary to respond to my needs.
- The undersigned hereby releases from liability the County of Kankakee, the Kankakee Sheriff's Department and other first responder agencies, their employees, officers, volunteers and agents from any and all claims, including claims of negligence, resulting in any physical/mental injury, illness (including death) or economic or property loss I may suffer or any and all other loss that may result from my participation in this undertaking including but not limited to, travel to and from the shelter or any events incidental to this undertaking.

Signature of Registrant/Authorized Caregiver Date

Kankakee County EMA Only:

Date Entered into Database - _____

Expire Date - _____