WCHD WINNEBAGO COUNTY HEALTH DEPARTMENT

Functional Needs (POPULATIONS REQUIRING FUNCTIONAL NEEDS SUPPORT SERVICES (FNSS)) Voluntary Registration

After completing this form return it to: Winnebago County Public Health ERC, PO Box 4009, Rockford, IL 61110, or email the form to: tjames@wchd.org . If assistance is needed, call (815) 720-4217.

Name:_____Date of Birth_____Male_____Female_____ Weight: _____

Your Street Address:_____City:_____Zip: _____
Your Mailing Address: _____
Home phone:_____Cell phone:_____Do you have a pet?_____Yes_____No
Do you presently live in: Apartment House Mobile Home_____Homeless
Primary Language:_____TDD/TTY (for hearing impaired)_____Yes_____No

NEEDS: Circle all medical needs that apply to you as defined by the categories listed in the information on the first page. You must meet one or more of these seven criteria to qualify as a Functional Medical Needs individual.

Please number 1 through 7, 1 being the most critical.

ADDITIONAL MEDICAL CARE FACTORS

_____24 hour caregiver, if medically necessary
_____Colostomy (self)_____Colostomy (with assistance)
_____Feeding Tube
_____Hearing Impaired
_____Heart Problems
_____Home Health/Personal Care Services
_____Illeostomy (self)_____Illeostomy (with assistance)
_____Insulin (self)_____Insulin (with assistance)
_____Life Support (emergency power)
_____Physically Disabled
_____Post-Traumatic Stress Disorder
_____Sight Impaired
_____Speech Impaired
_____Wound Care
_____Oxygen Dependent
_____Portable Oxygen Tank
_____Oxygen Concentrator
_____Developmentally Disabled
_____Traumatic Brain Injury (TBI)
_____Service Animal (such as guide dog)
_____Memory Impaired (Dementia)
_____Suction Unit
_____IV Fluids/Medications
_____Refrigeration of Medication
_____Methadone Treatment
_____Special Diet
_____Seizures

PRIMARY CONTACTS

Caregiver:_____Phone: (H)_____(W)_(C)_____
Emergency Contact Person:_____Phone: (H)_____(W)_(C) _____
Primary Physician:_____Phone: _____
Home Health/Personal Care Agency:_____Phone: _____
Pharmacist: _____ Phone: _____

Respiratory (oxygen) provider_____Phone: _____

WHAT IS YOUR DISASTER PLAN?

__ 1. Stay with family or others: If so, name, address, phone #: _____
__ 2. Stay at home. Do you have a generator?_____Yes_____No
__ 3. Evacuate to a POPULATIONS REQUIRING FUNCTIONAL NEEDS SUPPORT SERVICES (FNSS) sheltering location **(A caregiver must accompany you to the sheltering location and stay with you.)**
__ 4. No sheltering plan (You are urged to formulate a plan.
Will you require transportation to a shelter?_____Yes_____No (If no, you should develop a transportation plan.)
What are your transportation needs?_____Car_____Van with lift_____Ambulance
Do you need assistance with walking?_____Walks Unassisted_____Walks with Assistance____Wheelchair____Bed Bound

I certify that the above information is correct. I understand that I am responsible for all expenses associated with medical evacuation and shelter at a hospital. In the event of an emergency, I hereby authorize Winnebago County Emergency Management to release, use or disclose this information to other emergency response or human services agencies or officials. I also give first responders permission to enter my home in case of an emergency. I understand I have the right to revoke this authorization as outlined by the Winnebago County Notice of Private Practices.

_____Signature_____Date