

# Washington County 911 PREMISE HISTORY - ADA (DISABILITY) APPLICATION FORM

This form is to assist Washington County Emergency Services in more effectively responding to an emergency situation that a member of your household with a disability may experience. Please complete the following voluntary questionnaire and return it by mail or drop it off at Washington County 911.

If you chose to respond, the information will be submitted into the Washington County 911 CAD system for use by 911 dispatchers. The purpose is to ensure that 911 dispatchers and emergency response personnel are aware, in advance, of any information you feel they would need to know about people with disabilities in your household in the event of an emergency.

**Responding to this questionnaire is purely voluntary.** You may choose to respond on behalf of all of your household members or only certain household members. If you choose to respond to this questionnaire, please be sure to provide your signature on the last page. (Your signature gives us the permission we need to process this information - without it the information cannot be processed.)

In addition, this information will be removed from our files periodically. Therefore this form must be submitted every two (2) years to ensure that our files are accurate.

**Please notify Washington County 911 at (812) 883-5999 if there is any change to the information you provide. (ie: change of address, phone number, etc.)**

## QUESTIONS

Your answers to the following questions will assist police, fire, and/or medical personnel when they are responding to an emergency or other call to your home, in identifying and/or assisting you, or a person in your household who has a

### 1. Head of Household / Parent / Caregiver / or Agency: (18 years of age or older)

Name: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Name: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: IN Zip: \_\_\_\_\_

### 2. Telephone Numbers:

Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_ TTY/TDD: \_\_\_\_\_

Pager: \_\_\_\_\_ Email: \_\_\_\_\_

**This form is available in Spanish.  
Si necesita una copia en español, por favor llamar al (812) 883-5999.**

**3. Primary Access:**

Front Door     Back Door     Side Door (Which Side): \_\_\_\_\_     Other: \_\_\_\_\_

**4. Does any member of your household have a disability / medical condition?**

**(Fill in blanks and check all that apply)**

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Race:** \_\_\_\_\_ **Sex:**  Male     Female    **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Eye Color:** \_\_\_\_\_ **Hair Color:** \_\_\_\_\_ **Scars / Identifying Marks:** \_\_\_\_\_

**Location in Residence (Geographical location and level):** \_\_\_\_\_

**Oxygen Tank:**  Yes     No    **If Yes:**  Mobile     Fixed    **If Fixed, Location:** \_\_\_\_\_

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Blind / Visually Impaired | <input type="checkbox"/> Deaf / Hearing Impaired | <input type="checkbox"/> Unable to Speak  |
| <input type="checkbox"/> Mental Retardation        | <input type="checkbox"/> Autism                  | <input type="checkbox"/> Physical Disability <input type="checkbox"/> Wheel Chair Bound |
| <input type="checkbox"/> Seizure                   | <input type="checkbox"/> Bedfast                 | <input type="checkbox"/> Mental Illness (Explain): _____                                |
| <input type="checkbox"/> Elderly                   | <input type="checkbox"/> Obese                   | <input type="checkbox"/> Other: _____   |

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**Eye Color:** \_\_\_\_\_ **Hair Color:** \_\_\_\_\_ **Scars / Identifying Marks:** \_\_\_\_\_

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**Eye Color:** \_\_\_\_\_ **Hair Color:** \_\_\_\_\_ **Scars / Identifying Marks:** \_\_\_\_\_

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Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Race: \_\_\_\_\_ Sex:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Scars / Identifying Marks: \_\_\_\_\_

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- Autism
- Physical Disability
- Wheel Chair Bound
- Seizure
- Bedfast
- Mental Illness (Explain): \_\_\_\_\_
- Elderly
- Obese
- Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Race: \_\_\_\_\_ Sex:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Scars / Identifying Marks: \_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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- Elderly
- Obese
- Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Do you live alone?  Yes  No

6. Is he/she likely to wander off?  Yes  No

7. Does he/she have a Medical Alert Device?  Yes  No

8. Any weapons in the home?  Yes  No

9. Please use the space below to provide any additional information you feel that Washington County 911 should be aware of in order to more effectively send emergency personnel to an emergency situation in your household. Is there a key holder to your property or someone to be notified in case of an emergency?

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**IMPORTANT:** By signing this questionnaire, I acknowledge that the information provided above was done so voluntarily for the sole purpose of assisting Police, Fire, and EMS through the Washington County 911 system and emergency response personnel, to more effectively respond to a potential emergency in or near my household. I also understand that providing this information does not entitle me or anyone in my household to preferential treatment, nor will it result in a more timely response by emergency response personnel. It is simply an attempt to provide emergency response personnel with information, which may be helpful when providing service to residence or occupants of my home.

**Signature:**

Head(s) of Household: \_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Please Mail Completed Form To:  
Washington County Sheriff's Department  
ATTN: 911 Dispatch  
801 Jackson Street  
Salem, IN 47167**

**If you have any questions about this form, please call:  
Washington County 911 at (812) 883-5999**