

## **Bow Emergency Management Functional Needs Assessment**

During a disaster or an emergency, people with functional needs may require assistance with communication, medical support, or transportation. This voluntary assessment is part of an ongoing program through the Bow Emergency Management Office to identify people who may need assistance in the event of an emergency.

If you or someone you know needs individual help, it is important for you to let our office know. Just fill in the information and return the form. If you have any questions concerning your need for assistance during an emergency or if you are concerned about someone you know who may need specialized emergency help, you can call the: Bow Office of Emergency Management (**603-2233940 x 501**), Bow Fire Department (**603-228-4320**), or Bow Police Department (**603-228-1240**).

Completion and submission of this assessment does not guarantee services and should not take the place of personal preparation. Remember, in an emergency, you will be better prepared if you know how to help yourself and others, as well as how to receive help from others. If you or someone you know needs individual help in an emergency, it is very important for you to let us know. This assessment will be conducted annually. Thank You!

**This information will be kept confidential by the Town of Bow Emergency Management.**

**(Please complete the survey and return it to the address below.)**

Send the completed form to:

**Leland Kimball, Director**

**Emergency Management**

**Town of Bow**

**10 Grandview Road**

**Bow, NH 03304**

**Office: 603.223.3940 x 501**

**Cell: 603.568.8096**

**Email: lkimball@bownh.gov**

First Name:	Last Name:		Age or Date of Birth:	
Street Name:	Apt. #		Home Phone #:	
E-mail Address:	TTY #:		Cell Phone #:	
What is your living situation?	<input type="checkbox"/> With Spouse	<input type="checkbox"/> With Care Giver	<input type="checkbox"/> Live Alone	<input type="checkbox"/> Other, please specify:

### Functional and Medical Needs

Primary Language Spoken:	<input type="checkbox"/> Receive Home Health Care Services	
<input type="checkbox"/> Vision Disability	<input type="checkbox"/> Deaf or Hard of Hearing	<input type="checkbox"/> Cognitive Disability
<input type="checkbox"/> Breathing Problems and/or Uses Respirator	<input type="checkbox"/> Mental Health Disability	<input type="checkbox"/> On Dialysis
<input type="checkbox"/> Feeding Tube	<input type="checkbox"/> Intravenous Line	<input type="checkbox"/> Foley Catheter
<input type="checkbox"/> Diabetes and/or Uses Insulin	<input type="checkbox"/> Cardiac (heart) Problems	<input type="checkbox"/> Ostomy

Allergies (specify):  Environmental  Chemical  Medications:  Foods:

<input type="checkbox"/> Limited Mobility and uses mobility equipment (specify):
<input type="checkbox"/> Require the use of a Service Animal (briefly describe):

Can you transfer to a seat for transport?  YES  NO

If using a bed or wheelchair, specify type  Standard  Pediatric  Oversized  Reclining  
 Motorized

<input type="checkbox"/> Use Oxygen, specify type of equipment:
<input type="checkbox"/> Other physical or medical conditions not listed here:

### Transportation Needs

<input type="checkbox"/> Wheelchair accessible vehicle	<input type="checkbox"/> Ambulance	<input type="checkbox"/> Need a ride
--	------------------------------------	--------------------------------------

### Communication Needs

<input type="checkbox"/> Sign Language Interpretation	<input type="checkbox"/> Need Individualized Notification	<input type="checkbox"/> Other, please specify:
---	---	---

### Emergency Contact Information

Name of Next of Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address \_\_\_\_\_ Contact Phone Numbers: \_\_\_\_\_