

9-1-1 SPECIAL NEEDS REPORTING

Home Phone: (____) _____ - _____ Other Contact: (____) _____ - _____

Name: _____

Address: _____

Town/City: _____ Description/ Description _____

Check all that apply:

- B-Blind** – Someone at the location is blind or visually impaired.
- COG – Cognitive Impairment** – Someone at this address has a cognitive impairment.
- H/D – Hearing Impaired/ Deaf** – Someone at this address is hearing impaired or deaf.
- LSS – Life Support System** – Someone at this address is physically linked to a life support system.
Specify the type of support system _____
- MI – Mobility Impaired** – Someone at this address is bedridden, requires a wheelchair, or has mobility impairment. Please specify _____
- PI – Psychiatric Impairment** – Someone at this address has a psychiatric impairment.
- SI – Speech Impairment** – Someone at this address has a speech impairment. Is this person able to verbally communicate in the event of an emergency? _____ What services will be needed to enable communication? _____
- TDD – Telecommunications Device for the Deaf** – Someone at this address may be using a TDD/TYY.
- L – Language** – Someone at this address speaks only a language other than English. Specify the language/ dialect. _____
- M- Medical** – Someone at this address has a medical condition that may require specialized equipment or treatment. Please specify _____
- SA – Service Animal** – Someone at this address requires the use of a service animal. Type _____
- Please **remove** any special needs previously reported at this address.
- Please **change** previous reports to indicate only the needs shown above.

Sign: _____ Date: _____

Clinton Communications Center, 170 East Main Street, Clinton, CT 06413
860-669-8686

The information requested in completing this questionnaire is provided voluntarily, and will remain confidential. It is intended to provide public safety personnel with information to better prepare them in the event of an emergency.