Warner Emergency Management

Functional Need 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 annual program through the Warner Emergency Management Department 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, call the; Warner Emergency Management (603-748-0560) or Warner Police Department (603-456-3433).

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 Warner Emergency Management

PLEASE complete the survey and return it to the address below:

Edward Mical

Emergency Management Director

Town of Warner

P.O. Box 265

Warner, NH 03278

Cell: 603-748-0560

Email: emd@warner.nh.us

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?	❑ With Spouse	❑ With Care Giver	❑ Live Alone	❑ Other, please specify:

Functional and Medical Needs

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

Allergies (specify): ❑Environmental ❑Chemical ❑Medications: ❑Foods:

❑ Limited Mobility and uses mobility equipment (specify):

❑ 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

❑ Use Oxygen, specify type of equipment:

❑ Other physical or medical conditions not listed here:

Transportation Needs

❑ Wheelchair accessible vehicle	❑ Ambulance	❑ Need a ride

Communication Needs

❑ Sign Language Interpretation	❑ Need Individualized Notification	❑ Other, please specify:

Pet Needs

Name of Pet:	Type (dog, cat, etc):	Breed:
Approximate Weight:	❑ Carrier ❑ Cage	❑ Leash ❑ Muzzle

Emergency Contact Information

Name of Next of Contact: _____ Relationship: _____

Address _____ Contact Phone Numbers: _____