



# BEREA SAFETY DEPARTMENTS RESIDENTIAL HISTORY ADA (DISABILITY) FORM



The Berea Safety Departments have created this form specifically designed to help us improve our response to calls with the residents of our city who may have a disability. Please complete the following voluntary questionnaire and either drop it off at the Berea Police Department or email it to [dclark@bereapolice.org](mailto:dclark@bereapolice.org).

If you choose to respond, the information will be submitted into the Southwest Emergency Dispatch CAD system for use by the Berea dispatch team. The purpose of this form is to ensure that 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 completely voluntary. You may choose to respond on behalf of all of your household members or only certain household members. If you choose to respond, 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. If you choose not to complete the form, the timeliness or quality of emergency response will not be affected. This form simply provides our safety services with an advantage before they arrive on scene.

We ask that if you move, or the situation in the home changes, please contact us so we can make the necessary adjustments in our alert system.

## QUESTIONS

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

**1. Head(s) of Household** (Self, Parent, Caregiver, or Agency)

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_

APT# \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

**2. Contact Information:**

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

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

Email \_\_\_\_\_



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**3. Emergency Contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**4. Does any member of your household have a disability/medical condition? (Mark all that apply)**

**Name** \_\_\_\_\_ **Age** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Race** \_\_\_\_\_

**Gender** \_\_\_\_\_ **Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Eye Color** \_\_\_\_\_ **Hair Color** \_\_\_\_\_

**Scars/Identifying Marks** \_\_\_\_\_

**Blind** \_\_\_\_\_ **Low vision** \_\_\_\_\_ **Deaf** \_\_\_\_\_ **Hard of hearing** \_\_\_\_\_ **Difficulty Communicating** \_\_\_\_\_

**Intellectual Disability** \_\_\_\_\_ **Mental Illness** \_\_\_\_\_ **Autism** \_\_\_\_\_ **Physical Disability** \_\_\_\_\_ **Seizure** \_\_\_\_\_

**Other:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Name** \_\_\_\_\_ **Age** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Race** \_\_\_\_\_

**Gender** \_\_\_\_\_ **Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Eye Color** \_\_\_\_\_ **Hair Color** \_\_\_\_\_

**Scars/Identifying Marks** \_\_\_\_\_

**Blind** \_\_\_\_\_ **Low vision** \_\_\_\_\_ **Deaf** \_\_\_\_\_ **Hard of hearing** \_\_\_\_\_ **Difficulty Communicating** \_\_\_\_\_

**Intellectual Disability** \_\_\_\_\_ **Mental Illness** \_\_\_\_\_ **Autism** \_\_\_\_\_ **Physical Disability** \_\_\_\_\_ **Seizure** \_\_\_\_\_

**Other:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ Race \_\_\_\_\_

Gender \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Eye Color \_\_\_\_\_ Hair Color \_\_\_\_\_

Scars/Identifying Marks \_\_\_\_\_

Blind \_\_\_\_\_ Low vision \_\_\_\_\_ Deaf \_\_\_\_\_ Hard of hearing \_\_\_\_\_ Difficulty Communicating \_\_\_\_\_

Intellectual Disability \_\_\_\_\_ Mental Illness \_\_\_\_\_ Autism \_\_\_\_\_ Physical Disability \_\_\_\_\_ Seizure \_\_\_\_\_

Other: \_\_\_\_\_

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

**5. How many household members?** \_\_\_\_\_

**6. Is the person with a disability in your household likely to wander off? Yes \_\_\_\_\_ No \_\_\_\_\_**

**7. Fill out the following and identify the person(s) to whom it is applicable:**

Any prescription medication or emergency medical treatment needed:

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

Favorite attraction or locations where they may be found:

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

Atypical behaviors or characteristics that may attract attention:

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

Favorite toys, objects or discussion topics (likes, dislikes):

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



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Approach, calming or de-escalation techniques most likely to work:

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Method of communication, if nonverbal, sign language, picture board, written words:

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Identification information: Do they carry or wear identifying jewelry, tags, ID card etc.:

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Sensory or dietary issues, if any:

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Please use the space below to provide any additional information you feel that the Berea Safety Departments should be aware of in order to more effectively respond to an emergency situation in your household.

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Is there a key holder to your property or someone to be notified in case of an emergency?

Yes \_\_\_\_\_ No \_\_\_\_\_ Name \_\_\_\_\_ Phone \_\_\_\_\_

**IMPORTANT:** By signing this form, I acknowledge that the information provided above was done so voluntarily for the sole purpose of assisting the Berea Safety Departments, through their emergency dispatch center and to their 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 residents or occupants of my home.

Signature Head(s) of Household \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_