HEADS UP! PROGRAM APPLICATION

Danville Fire Department – Emergency Communications

600 Lynn Street, Danville, VA 24541 – phone 434-799-5206 fax 434-797-8800

Purpose: To provide information to public safety agencies related to an individual's disability, medical issue, mobility, or other condition of which emergency responders should be aware. This does not take the place of an individual's responsibility to plan and prepare for transportation and/or sheltering in the event of an emergency. All information provided will remain completely confidential and will be used only by authorized personnel to assist in an emergency. The original of this form shall be secured in a locked file, and distribution or copying of this form is strictly prohibited.

Instructions: *Complete all parts of this form.* Please PRINT the information. A separate form must be prepared for each special needs individual residing at a single location. When complete, sign and return the form to the address or fax number above. Form can be completed online at www.danvilleva.gov/HeadsUp

PERSONAL INFORMATION

Last Name	First Name	MI	Birthdate (mm/dd/yyyy)	Sex ☐ M ☐ F
Street Address		City	Zip	Mobile Home? ☐ Y ☐ N
Name of Housing Complex, MH Park, Apartment Building, etc.		Building, Apt, Room #	Floor #	Elevator? ☐ Y ☐ N
Primary Phone Number	Secondary Phone Number / TDD	Living Situation ☐ Lives Alone ☐ With Spouse ☐ With Children ☐ With Parent ☐ With Other		Ramp? ☐ Y ☐ N

EMERGENCY CONTACTS *(Must provide at least one phone number.)*

Name	City, State	Primary Phone Number	Secondary Phone Number
(1)			
(2)			

SPECIAL NEED DETAILS *(Check and complete each that applies to the applicant's condition.)*

Mobility

☐ Walks by self ☐ Walks with assistance (cane, walker) ☐ Wheelchair ☐ Bedridden

If bedridden, may the applicant be moved by wheelchair? ☐ Y ☐ N

Communication

☐ Speech Impaired ☐ TDD ☐ ASL ☐ Other language spoken (describe)

☐ Other communication difficulties (describe)

Life-Sustaining Medical Equipment

☐ Oxygen in use ☐ IV Therapy ☐ Respirator (Ventilator)

☐ Suction Machine ☐ Nebulizer ☐ Other (Explain)

Other Needs

☐ Hearing Impaired ☐ Anxiety/Depression ☐ Allergies (Explain)

☐ Sight Impaired ☐ Mental Health Impaired (Explain) ☐ Service Animal

☐ Memory Impaired ☐ Catheter or Drain ☐ Weight > 300 lbs.

☐ Autism Spectrum Disorder (Explain)

EMERGENCY ALERT / MEDICAL ALERT / LIFE CALL DEVICE

Device Type	Alarm Company	Phone Number

HOME HEALTH CARE AGENCY

Agency Name	Point of Contact	Phone Number

AUTHORIZATION

I understand this information will be utilized to plan appropriate care and treatment during an emergency. I understand that only those persons who have a need to know this information will have access to it. I understand that it is my responsibility to keep the provided information current. I understand I am responsible for all expenses incurred in association with medical evaluation and special sheltering in a hospital or nursing facility. I accept the conditions as specified and grant permission for Danville Fire Department to record this information in the Computer Aided Dispatch system for reference and to release this information to emergency response agencies via two-way radio in the event of an emergency.

Signature ☐ Applicant ☐ Guardian	Date
Guardian Name (printed)	Phone Number

** ECC USE ONLY **	Received By:	Date Processed:	Processed By: