

**PHILADELPHIA POLICE DEPARTMENT**

**PREMISE HISTORY - ADA (DISABILITY) APPLICATION FORM**

This form is to assist the City of Philadelphia in more effectively responding to an emergency situation that a member of your household with a disability may experience. Please complete the following voluntary questionnaire and return it by mail, or drop it off at the nearest Police District.

If you choose to respond, the information will be submitted into the Philadelphia Police Department’s CAD system for use by Philadelphia’s 911 dispatchers. The purpose is to ensure that 911 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 purely voluntary.** You may choose to respond on behalf of all of your household members or only certain household members. If you choose to respond to this questionnaire, 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.)

In addition, this information will be removed from our files periodically therefore this form must be submitted every two (2) years to ensure that our files are accurate.

**Please notify Police Radio Training at 685-3940 if there is any change to the information you provide. (i.e. change of address, phone number, etc.)**

**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, in identifying and/or assisting you, or a person in your household who has a disability.

**1. Head of Household / Parent / Caregiver / or Agency: (18 years of age or older)**

NAME \_\_\_\_\_ AGE \_\_\_\_\_  M  F

NAME \_\_\_\_\_ AGE \_\_\_\_\_  M  F

ADDRESS \_\_\_\_\_

(APT.) \_\_\_\_\_ PHILADELPHIA, PA (ZIP) \_\_\_\_\_

**2. Telephone Numbers:**

HOME ( ) \_\_\_\_\_ WORK ( ) \_\_\_\_\_

CELLPHONE ( ) \_\_\_\_\_ TTY/TDD ( ) \_\_\_\_\_

PAGER/BEEPER ( ) \_\_\_\_\_ EMAIL \_\_\_\_\_

**This form is available in large print and Spanish  
Si necesita una copia en espanol, por favor llamar al (215) 685-3940.**

-OVER-

**3. Does any member of your household have a disability / medical condition?**

**(Fill in blanks and Check all that apply)**

Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
mo day yr

Race \_\_\_\_\_ Sex  Male  Female Height \_\_\_\_\_ Weight \_\_\_\_\_

Eye Color \_\_\_\_\_ Hair Color \_\_\_\_\_ Scars/Identifying marks \_\_\_\_\_

Blind  Low vision  Deaf  Hard of hearing  Communication

Mental retardation  Mental Illness  Autism  Physical Disability

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

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Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
mo day yr

Race \_\_\_\_\_ Sex  Male  Female Height \_\_\_\_\_ Weight \_\_\_\_\_

Eye Color \_\_\_\_\_ Hair Color \_\_\_\_\_ Scars/Identifying marks \_\_\_\_\_

Blind  Low vision  Deaf  Hard of hearing  Communication

Mental retardation  Mental Illness  Autism  Physical Disability

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

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Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
mo day yr

Race \_\_\_\_\_ Sex  Male  Female Height \_\_\_\_\_ Weight \_\_\_\_\_

Eye Color \_\_\_\_\_ Hair Color \_\_\_\_\_ Scars/Identifying marks \_\_\_\_\_

Blind  Low vision  Deaf  Hard of hearing  Communication

Mental retardation  Mental Illness  Autism  Physical Disability

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

**4. Do you live alone?**  Yes  No

**5. Is he/she likely to wander off?**  Yes  No

**6. Fill out the following:**

**Any prescription medication or emergency medical treatment needed?** \_\_\_\_\_

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**Favorite attraction or locations where they may be found:** \_\_\_\_\_

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**Atypical behaviors or characteristics that may attract attention:** \_\_\_\_\_

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**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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-OVER-

**7. Please use the space below to provide any additional information you feel that the Philadelphia Police or Fire Department should be aware of in order to more effectively respond to an emergency situation in your household. Is there a key holder to your property or someone to be notified in case of an emergency?**

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**IMPORTANT:** By signing this questionnaire, I acknowledge that the information provided above was done so voluntarily for the sole purpose of assisting the Police and Fire Departments, through their 911 system and 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 \_\_\_\_\_

**Please Mail Completed Form to:  
Philadelphia Police Department  
Attn: Police Radio Training  
Communications Division Room 213  
Franklin Square  
Philadelphia, PA 19106**

**If you have any questions about this form, please call:  
Police Radio Training at (215) 685-3940 (voice) or  
(215) 685-3944 (fax) or (215) 685-3943 (TDD/TTY)  
police.radio\_training@phila.gov (EMAIL)**