



SPECIAL NEEDS DATABASE EmFinder APPLICATION

NAME OF SPECIAL NEEDS RESIDENT _____

ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIPCODE _____

PHONE # _____ SEX _____ AGE _____

NATURE OF SPECIAL NEEDS: ex. Mobility impaired, hearing impaired, vision impaired etc.

SPECIFIC LOCATION OF RESIDENT: DAY: _____

NIGHT: _____

PRIMARY CARE GIVER OR EMERGENCY CONTACT

NAME _____ EMAIL _____

ADDRESS _____

PHONE # _____ ALTERNATE PHONE # _____

RELATIONSHIP TO RESIDENT _____

SECONDARY CARE GIVER OR EMERGENCY CONTACT

NAME _____ PHONE _____

ADDRESS _____

RELATIONSHIP TO RESIDENT _____

EmSeeQ DEVICE SERIAL NUMBER _____

EmFinder ACCOUNT NUMBER _____

DATE DEVICE WAS DELIVERED BY MLFD _____

I understand that if my person with impairment is selected to receive an EmSeeQ device. I will be designated as their financial responsible party. As such, I understand that I am responsible for the monthly service payments to be paid directly to EmFinders. Until such time as the device, which is owned by Mt Lebanon EmFinder Program, is returned and received in good condition by an authorized representative of the program. I understand that I am also responsible for the care and regular charging of the device for 2 hours, twice a week and that if the device is returned in unsatisfactory condition I may be financially responsible for the replacement cost.

Applicant Signature

Authorized MLFD Representative

Print Name

Print Name

Date

Date

Address

Title

City State Zip

Please Return This Completed Form To:

Mount Lebanon Fire Department
Special Needs Assessment Program
555 Washington Road
Pittsburgh, PA 15228

Or Fax the Form to: 412-343-1697

For Office Use:
Person Taking Request _____
Date of Request: _____
Date Removed _____
Reason for Removal: _____

Phone Sticker Included _____ Yes _____ No
Date Entered in FLP: _____

Note: All information submitted will be held in strict confidence for use by the Emergency Services only. Please remember to keep us updated in case any information should change.