

Exceptional Needs Registry Application

The Fire and Police Departments seek to serve all the residents of the community with the utmost respect and dignity. The Town of Hingham has created the **Exceptional Needs Registry** as a method to enable first responders who are called in to assist an individual with unique circumstances.

The attached, two-sided form combines the Massachusetts 911 Disability Indicator form with the Town of Hingham Exceptional Needs form. The information on both sides will remain **confidential** and will only be accessed if a call to 911 is generated by a telephone number associated with the person listed on the form with a disability.

This application is available online at HPD.org/exceptionalregistry or can be picked up at the following locations:

- **Central Fire Station**- 339 Main Street
- **Police Department** - 212 Central Street
- **Town Hall Main Office** - 210 Central Street
- **Hingham Public Library**- 66 Leavitt Street
- **Senior Center** – 224 Central Street

Please return the completed form and a photograph to the Hingham Police Department:

Email - ExceptionalRegistry@hpd.org

In Person - 212 Central Street (In an envelope labeled 'SSRECC')

Fax - 781-741-1483

If you would like assistance completing the form, please contact the Commission on Disabilities cod@hingham-ma.gov.

All information is kept CONFIDENTIAL and can be removed per request of the resident.

The Town of Hingham Exceptional Needs Form

Exceptional Resident Contact Information (Items with asterisk are required)

***Name** (First, Middle, Last): _____ Date of Birth: ____/____/____
Nickname/s (if any): _____
Name of person completing form if not resident: (First, Middle, Last, Relationship) _____
To which gender identity do you most identify? (Check all that apply)
Male ___ Female ___ Transgender Male ___ Transgender Female ___ Gender Variant/Non-Conforming ___
Not Listed _____ Prefer not to answer _____
***Address**: _____ Apt # _____ ***Primary Phone #** _____ 2nd Phone # _____
Emergency Contact & Phone # (This may be Doctors, Family, Friends)
1. _____ 2. _____ 3. _____

Description of Exceptional Resident

Official Diagnosis: _____
Special Circumstance/s: _____
Disability/s: _____
Primary Language: _____
Do you require an Interpreter: Yes ___ No ___
Do you use TTY: Yes ___ No ___
What is your preferred method of communication: (i.e. if nonverbal: ALS, picture boards, notebook, assistive technologies)

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____
Other identifying marks: (Scars, Tattoos) _____
Identification Information (i.e. Do you wear ID Tags, ID Card, Tracking Device, Medical Alert Bracelet)

List of medication/s (if any): _____
Is there a history of: **Substance Abuse** Yes No **Trauma** Yes No **Domestic Violence** Yes No
Do you have any known triggers? (i.e. loud noises, physical contact, flashing lights) _____
Are there helpful calming techniques responders should be aware of? (i.e. watching a favorite TV show, discussing a favorite item / subject, possible reward for cooperation) _____

Any other helpful information (i.e. Service animal, lip-reader, tendency to self-harm, forgets to take medication)

Transportation Information in event of emergency (check all that apply)

I would arrange my own transportation to a shelter in an emergency Yes ___ No ___
I would require transportation but could walk a short distance (less than a ¼ mile) Yes ___ No ___
I have limited mobility and would require assistance getting on and off a bus Yes ___ No ___
I am confined to a wheelchair and would require a wheelchair van. Yes ___ No ___
I require electric power for life support equipment. Describe: _____
I have specialized medical or other needs. Describe: _____

PLEASE update this form when any information changes. (i.e. phone #, Address, Diagnosis, Triggers). If you have previously filled out a form, we ask that you do it again so we can confirm our current records are up to date.

Attach a Photograph - Include photo with completed form

Massachusetts 9-1-1 Disability Indicator Form

9-1-1 Disability Indicator Form LANDLINE, WIRELESS & VoIP - Individual Record

The filing of this document will alert public safety officials that an individual with the calling phone number (landline and/or wireless) has a disability that may hinder evacuation or transport. This information is confidential and will ONLY appear on the dispatcher's NG9-1-1 screen when a 9-1-1 call originates from the phone number(s) provided below.

***PLEASE NOTE: IT IS IMPORTANT TO SUBMIT A NEW DISABILITY INDICATOR FORM UPON CHANGE OF SERVICE PROVIDER AND ADDRESS. ***

- 1. **LANDLINE** Telephone Number: (____)_____
- 2. **LANDLINE** Telephone Service Provider: _____
- 3. **WIRELESS** Telephone Number: (____)_____
- 4. **WIRELESS** Telephone Service Provider: _____
- 5. **VoIP** Telephone Number: (____)_____
- 6. **VoIP** Telephone Service Provider: _____
- 7. Name: _____
- 8. Address: _____
- 9. Town & Zip code: _____

Please check approved designations for inclusion in the 9-1-1 Database to assist public safety dispatchers in responding to an emergency at your address: **Any changes should be communicated to your designated Municipal Coordinator promptly.**

Check all that apply to indicate that someone at the address:

- "LSS" Life Support System:** has equipment required to sustain their life.
- "MI" Mobility Impaired:** is bedridden, wheelchair user or has another mobility impairment.
- "B" Blind:** is legally blind.
- "DHH" Deaf or Hard of Hearing:** is deaf or hard of hearing.
- "TTY":** may be communicating via TTY.
- "SI" Speech Impaired:** has a speech impairment.
- "CI" Cognitively Impaired:** is cognitively impaired.
- PLEASE REMOVE any designation presently on file.**
- PLEASE CHANGE existing designators to those shown above.**

NOTICE: By initiating this document I understand that I am responsible for notifying my Municipal Coordinator of any changes with regard to the status of the above disability indicator(s). I further agree, I will indemnify, defend and hold the State 911 Department, Comtech, DDTi and my public safety dispatch location and municipality harmless from and against any claims, suits and proceedings (including attorney fees associated therewith) resulting from or arising out of the initial provision or updating of this information.

I understand this information will remain as part of my 9-1-1 record until such time as I notify my 9-1-1 Municipal Coordinator to change or delete the same.

Signed: _____ (Consumer) DATE: _____

Signed: _____ (Municipal Coordinator) DATE: _____