

# Special Needs Alert Program



## What is SNAP?

The Special Needs Alert Program, or SNAP, provides First Responders with resources needed to identify and assist individuals with special needs who find themselves in an emergency situation.

Enid residents can now complete a simple information form and a SNAP alert will be created in a secure communications database.

A SNAP alert defines the individual's condition and/or needs to First Responders prior to them arriving to an incident to improve their response, interaction and communication with the individual.

The alerts may also assist responders in identifying an individual with special needs who needs assistance.

## Who should participate?

Individuals with a physical or mental impairment; including those with an increased risk for chronic physical, developmental, behavioral, or emotional conditions that require specialized assistance to best serve their needs and provide for increased safety for the individual and First Responders.

Individuals with dementia and/or Alzheimer's.

## Use of Information

Enrollment in the Special Needs Alert Program will establish two alerts in our communications database.

1. **Personal Alert:** This alert is tied to the name, date of birth and description of the individual. It will never expire.

2. **Location Alert:** This alert is tied to an address. It must be updated annually to remain active.

When an officer is dispatched to a call for service, the database will notify officers of any SNAP alerts attached to a person involved or the location of the incident. The SNAP alert is not a label but only an additional resource to allow the officer to best respond to the incident.

Information related to a Location Alert will need to be updated annually, or when such information changes.

Provided information will be sent to police, fire and/or EMS personnel responding to calls via in-vehicle technology depending upon the nature of the call. Information provided allows First Responders to take extra steps to assist those individuals based upon their specific needs.

## How to participate

You can download a form to fill out and return from our website: [www.enid.org/services/police](http://www.enid.org/services/police), pick up a form from our Records Division located in our lobby at 301 W. Garriott between 8 a.m. and 6 p.m. Monday through Friday and return it filled out, fill out a form electronically and email it to [EnidSNAP@enid.org](mailto:EnidSNAP@enid.org), use the survey on our site to populate the needed information or email [EnidSNAP@enid.org](mailto:EnidSNAP@enid.org) to request an electronic copy of the form.

# Participation Form

**If you are a parent, guardian or caregiver of an individual with medically diagnosed special needs, please complete the following form to participate in the program. Answer all questions completely and accurately as the information will be used to create an alert in our database. If you have questions regarding any portion of the form, send an email to [EnidSNAP@enid.org](mailto:EnidSNAP@enid.org).**

**Information on the individual in need of a SNAP alert:**

First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Nickname: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cellphone: \_\_\_\_\_

Race: \_\_\_\_\_

Gender: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Hair Color/Length: \_\_\_\_\_

Eye Color: \_\_\_\_\_

Please list any physical identifiers that could aid in identification (scars, birthmarks, tattoos, physical conditions): \_\_\_\_\_

\_\_\_\_\_

**Photo:** Please send a digital head and shoulders photo of the individual (.jpeg or .png file type and less than 10 mb in size) to [EnidSNAP@enid.org](mailto:EnidSNAP@enid.org). Make sure to include the individual's name and date of birth in the email.

## What are the individual's special needs? Check all that apply:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Visually Impaired | <input type="checkbox"/> Seizure Disorder            | <input type="checkbox"/> Cognitive / Developmentally Delayed          |
| <input type="checkbox"/> Legally blind     | <input type="checkbox"/> Speech Impaired             | <input type="checkbox"/> Mood disorder / Mental Illness               |
| <input type="checkbox"/> Hearing impaired  | <input type="checkbox"/> Prosthesis                  | <input type="checkbox"/> Parkinson's                                  |
| <input type="checkbox"/> Deaf              | <input type="checkbox"/> Cerebral Palsy              | <input type="checkbox"/> Alzheimer's / Dementia                       |
| <input type="checkbox"/> Immobile          | <input type="checkbox"/> Down Syndrome               | <input type="checkbox"/> Autism Spectrum Disorder / Asperger Syndrome |
| <input type="checkbox"/> Non-verbal        | <input type="checkbox"/> Muscular Dystrophy          |   |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Traumatic Brain Injury      |   |
| <input type="checkbox"/> Other: _____      | <input type="checkbox"/> Paralysis (full or partial) |   |

## Which of the following apply to this individual? Check all that apply:

- |   |  |
|---|--|
| <input type="checkbox"/> Responds to verbal commands      | <input type="checkbox"/> Fluent in language other than English |
| <input type="checkbox"/> Communications/Speech Delay      | <input type="checkbox"/> Fear of Strangers                     |
| <input type="checkbox"/> Communicates with PECS           | <input type="checkbox"/> Shy/Withdrawn                         |
| <input type="checkbox"/> Communicates with Sign Language  | <input type="checkbox"/> Sensitivity to sound                  |
| <input type="checkbox"/> Scared of fast movements/crowds  | <input type="checkbox"/> Uses hearing aids                     |
| <input type="checkbox"/> Use of eyeglasses                | <input type="checkbox"/> Color sensitivity                     |
| <input type="checkbox"/> Responds well to touch           | <input type="checkbox"/> High pain tolerance                   |
| <input type="checkbox"/> Sensitivity to lights/sirens     | <input type="checkbox"/> Wheelchair/walker/cane                |
| <input type="checkbox"/> Aggressive or Violent Tendencies | <input type="checkbox"/> Tendency to wander                    |
| <input type="checkbox"/> Memory Loss                      | <input type="checkbox"/> Fascination with water                |
| <input type="checkbox"/> Strict Medication Schedule       | <input type="checkbox"/> Tendency to hide                      |
| <input type="checkbox"/> Other: _____                     |  |

## Other pertinent information to be shared about the registrant:

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## Tendencies, behaviors and insights:

What upsets this individual? \_\_\_\_\_

Are they known to wander? \_\_\_\_\_

What is their safety item or something that calms them? \_\_\_\_\_

What is their favorite place or a common place they may attempt to visit?

\_\_\_\_\_

If Dementia or Alzheimer's, what memory/place are they most likely to recall?

\_\_\_\_\_

Does this individual have any serious medical conditions that put them at risk without medication? \_\_\_\_\_

Are there any addresses within city limits that this individual knows how to get to?

\_\_\_\_\_

Doctor's Office/Hospital preference? \_\_\_\_\_

Does this individual operate at their age level? If not, what age level do they operate at?

\_\_\_\_\_

Does this person trust strangers? \_\_\_\_\_

Does anyone assist you with caretaking? Has this individual been to their house? Where do they live? \_\_\_\_\_

How are you referred to as caregiver? (mom/mommy/dad/daddy) \_\_\_\_\_

Does this individual wear a geolocation device? \_\_\_\_\_

Does this individual have a special needs identification bracelet? \_\_\_\_\_

Does this individual frequent any parks/stores/public access locations within city limits?

\_\_\_\_\_

# Primary Emergency Contact:

First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cellphone: \_\_\_\_\_

Email address: \_\_\_\_\_

# Secondary Emergency Contact:

First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cellphone: \_\_\_\_\_

Email address: \_\_\_\_\_

# Authorization for Alert:

By submitting this form, I certify that the information provided is true and accurate to the best of my knowledge. I understand that I voluntarily provided this information listed in the form and that it will not result in any type of preferential treatment from First Responders. I hereby authorize the Enid Police Department to create an alert using the above information and consent to that information being shared with local first responders.

\_\_\_\_\_ (Initial) I agree

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Signature/Date



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