Project Lifesaver of Hamilton County, Inc.
C/O Hamilton County Sheriff's Office
18100 Cumberland Rd.
Noblesville, IN 46060
317-776-6PLS
www.plshamilton.org
David@plshamilton.org

All forms and attachments can be e-mailed to David McCormick at David@plshamilton.org or mailed / dropped off at the Hamilton County Sheriff's Department.

Applicant/Caregiver requesting service must provide the following before transmitter placement:

- Letter or diagnosis sheet from the potential clients' Physician or Social worker describing the individual's diagnosis and the risk for wandering or fleeing from caregivers undetected. (OR)
- A referral letter or police report from Law Enforcement indicating the individual has wandered or ran from the caregiver.
- Provide photo of Client
- Read and Understand Program Contract

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Program Contract

If applicant is accepted into the Project Lifesaver of Hamilton County, Inc. Program, the following terms shall apply as agreed to upon the signing of the contract:

I acknowledge that the information I have provided is true and accurate to the best of my knowledge. All information provided has been given voluntarily, and I consent to the collection, use and disclosure of such information for the purposes of Project Lifesaver. Furthermore, I hereby represent and warrant that I have full power and authority as the duly authorized representative of the Client named below, to register and act on his/her behalf. My Power of Attorney and/or Power of Personal Care, if needed are attached.

THEREFORE, IN CONSIDERATION of the mutual promises and obligations contained herein, the sufficiency of which is acknowledged, the parties agree as follows, each to their respective obligations:

1. I understand that when I enroll a Client in Project Lifesaver of Hamilton County, Inc., that it does not replace the need for constant supervised care of the person. I am, and remain, primarily responsible for supervised care and take full responsibility of protecting this person from wandering. I also understand that I, family member or a caregiver, must always be present in the home with the Client.

2. I understand that Project Lifesaver equipment is designed to be an additional aid to help locate a missing person and that there is no warranty, representation or guarantee that a person will be found because they are wearing a Project Lifesaver bracelet. Project Lifesaver equipment is designed to provide law enforcement personnel with an additional technology in attempting to locate the Client. I also acknowledge that this is an experimental program for aiding in the search and rescue of persons suffering from diminished mental capacity or other disability.

3. In order for Project Lifesaver to work, I have a responsibility to obey the instructions of the Program, follow all training, and make sure that the person that I enroll is wearing the Project Lifesaver transmitter bracelet. If it has been removed or is defective; I will call my volunteer Client Manager immediately.

4. When I notice that the Client has wandered off, I must immediately call 911 and report the Client as a missing person inform Dispatch the Client is wearing Project Lifesaver transmitter. I understand and acknowledge that the Project Lifesaver device cannot predict or report that the Client has wandered off. It is used solely as an aid for emergency personnel when notified the Client is missing. I understand that while Project Lifesaver is an electronic tracking device that assists in locating persons who wear the bracelet device, there may be unforeseen times or circumstances when individuals cannot be located even while wearing the transmitter bracelet. I will not hold Project Lifesaver of Hamilton County, Inc. or any of its employees or volunteers, county or city Law Enforcement or Fire and Rescue Agencies (collectively the "Releases") involved liable for failure to locate the person using the system, and hereby release all such Releases from any claim, cause of action, loss or damages arising from any inability or delay in locating the Client.

5. I understand that all information I have provided in this application may be shared among Local Law Enforcement, Fire and Rescue, and other necessary agencies in the community where I reside. Therefore, I understand that none of the information I have provided or will provide in the future can be considered confidential or protected or private when used for the purposes of the Project Lifesaver of Hamilton County, Inc. Program, [notwithstanding the provisions of the Personal Information Protection and Electronic Documents Act].

6. I specifically waive any rights to confidentially to the Client's medical records by Project Lifesaver International or Project Lifesaver of Hamilton County, Inc. which includes dissemination of such information. I confirm that I have the authority by which to waive such rights.

7. I agree to release and hold each agency and all of their respective personnel, officers and volunteers harmless from any and all claims of liability and/or damage, and waive any and all rights to seek recourse for any losses or injury that may occur as a result of participation in the Project Lifesaver Program.

8. I understand that the transmitter and tester remain the property of Project Lifesaver of Hamilton County, Inc. and when no longer being used by the Applicant to whom it was assigned will be returned undamaged to Project Lifesaver of Hamilton County, Inc. to be assigned to another participant in the Program. I shall remain liable for any loss or damage to all such equipment and for the replacement cost of $350.00 for all such equipment until returned to Project Lifesaver.

9. I understand that if I fail to use the tester device at least once per day and record the results on the supplied test result monthly inspection sheet or if I fail to notify Project Lifesaver of Hamilton County, Inc. if I test the transmitter device and find no signal indication, or if the Client refuses to wear or removes the device 3 (three) times, then the Client may be involuntarily removed from the program. All property will then be returned to Project Lifesaver of Hamilton County, Inc. and I will return to the original security measures, which were in place prior to enrollment in Project Lifesaver, and without recourse to Project Lifesaver.

_____

APPLICANTS/CAREGIVERS NAME (PRINTED)

_____

APPLICANTS/CAREGIVERS SIGNATURE

_____

DATE

_____

CLIENTS NAME

_____

CLIENT MANAGER PROJECT LIFESAVER OF HAMILTON COUNTY, INC.

Project Lifesaver of Hamilton County, Inc.
www.plshamilton.org
David@plshamilton.org
Program Application

Applicant / Primary Caregiver Information:

Name: _____ Relation to Client: _____

Address: _____
Street *City/Town* *State/Zip*

Primary Phone: _____ Alternate Phone: _____

Email address: _____

Caregiver 2

Name: _____ Relation to Client: _____

Address: _____
Street *City/Town* *State/Zip*

Primary Phone: _____ Alternate Phone: _____

Email address: _____

Client Description:

Name: _____ _____
First *Middle* *Last* *Nickname*

Date of Birth: _____ Height: _____ Weight: _____ Eye Color: _____

Gender: ☐ *Male* ☐ *Female* Hair Color: _____

Ethnicity: _____ Skin Complexion: ☐ *Light* ☐ *Medium* ☐ *Dark*

Build: ☐ *Thin* ☐ *Heavy* ☐ *Muscular* Facial Hair? ☐ *Yes* ☐ *No*

Does the Client regularly wear Glasses? ☐ *Yes* ☐ *No*

Does the Client wear a watch or any other jewelry on the wrist? ☐ *Yes* ☐ *No*

Distinguishing Features: _____

_____

General Appearance: *(Anything additional - not covered above)*: _____

_____

Client's Residence:

Address: _____

Street *City/Town* *State/Zip*

Township: _____ Subdivision: _____

Fenced yard? ☐ *Yes* ☐ *No* Pool or Retention pond? ☐ *Yes* ☐ *No*

What preventative measures have been taken in the home to prevent the client from wandering?

_____

Other pertinent info about the home: _____

_____

Physicians:

Physician 1: _____ Specialty: _____ Phone: _____

Physician 2: _____ Specialty: _____ Phone: _____

Client Medical History: (*Please list any major medical condition)*

Medical Condition 1: _____

Description: _____

Medical Condition 2: _____

Description: _____

Medical Condition 3: _____

Description: _____

Medications: *(Please list all Long-Term prescriptions)*

Rx 1: _____ Dosage: _____ Condition: _____

Consequences of **NOT** taking Rx 1: _____

Rx 2: _____ Dosage: _____ Condition: _____

Consequences of **NOT** taking Rx 2: _____

Rx 3: _____ Dosage: _____ Condition: _____

Consequences of **NOT** taking Rx 3: _____

If Alzheimer's disease or Dementia has been diagnosed, answer the following:

Does the Client remain oriented to Time and Person?	☐ *Yes*	☐ *No*
Does the Client recognize familiar people?	☐ *Yes*	☐ *No*
Client travel to familiar locations?	☐ *Yes*	☐ *No*

If Autism or Down syndrome has been diagnosed, answer the following:

Does the Client have unusual reactions to sensory environment (touch, sound, bright lights, odors, and /or animals)?	☐ *Yes*	☐ *No*
Does the Client engage in self-stimulatory behavior? (Hand-flapping, finger flicking, rocking, spinning, or shaking parts of their body)?	☐ *Yes*	☐ *No*
Is the Client attracted to water?	☐ *Yes*	☐ *No*
Does the Client know how to swim?	☐ *Yes*	☐ *No*
Is the Client insensitive to pain?	☐ *Yes*	☐ *No*
Does the Client have trouble with direct eye contact?	☐ *Yes*	☐ *No*
Does the Client dart away from you unexpectedly (bolt and run)?	☐ *Yes*	☐ *No*

All Client/Caregiver Questions:

Is the Client continuously supervised? (A caretaker is present 24 hours a day, 7 days a week)	☐ *Yes*	☐ *No*
Does the Client attend school or other supervised care program outside the home?	☐ *Yes*	☐ *No*

Does the Client have mobility problems? ☐ *Yes* ☐ *No*

Does the Client have a history of aggressive or violent behavior? ☐ *Yes* ☐ *No*

Has the Client ever been in trouble with the law? ☐ *Yes* ☐ *No*

Could the Client be considered DANGEROUS to themselves or to others? ☐ *Yes* ☐ *No*

Does the Client sometimes dress 'improperly'? ☐ *Yes* ☐ *No*

Does the Client presently operate a motor vehicle? ☐ *Yes* ☐ *No*

Does the Client have access to a vehicle? ☐ *Yes* ☐ *No*

Does the wear a medical ID bracelet or other device to identify disability? ☐ *Yes* ☐ *No*

Does the Client suffer from frequent personality and/or emotional changes? ☐ *Yes* ☐ *No*

Does the Client know/respond to his/her own name? ☐ *Yes* ☐ *No*

Is the Client Deaf? ☐ *Yes* ☐ *No*

Is the Client Mute? ☐ *Yes* ☐ *No*

How is the Client able to communicate?

☐ *Speak* ☐ *Write* ☐ *Sign* *Other:* _____

Does the Client speak English? ☐ *Yes* ☐ *No* If No, what language? _____

Most recent place of employment: *(if applicable)*

_____

What is the "most effective" way to approach the Client?

_____

If the Client is anxious or agitated what is the best way to calm them?

_____

Please list any other information that you feel needs to be shared concerning the Client.

Applicant/ Caregiver (Printed): _____

Applicant/Caregiver Signature:
Date:

To be completed by a Project Lifesaver of Hamilton County, Inc.

Date Received: _____

Program Contract ☐ Photograph ☐ Proof type: Physician ☐ Social Worker ☐ Law Enforcement ☐

Client Representative: _____ Department: _____

Initial battery install date: _____ Transmitter Frequency: _____

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Physician Statement

Patient's Name: _____

Diagnosis: _____

Do you believe patient is prone to wandering?

_____

Physician's Name: _____

Physician's Address: _____

Physician's Phone: _____

Physician's Signature: _____

Date: _____