

18. Client Functions/Disability/handicaps: _____

19. Medications taken regularly? Yes No

List any medication using correct name of drug and dosage being taken: _____

20. Consequences of NOT taking medications? _____

21. Cane/Walker/Wheelchair?: _____

22. Primary Doctor/Physician: _____ Phone No. _____

23. Any Psychological Problems? Yes No

Nature: _____

24. Usual Personality type; shy, outgoing, etc: _____

25. Which family member is the client closest to? _____ Relationship _____

26. Where was the Client born and raised? _____

SECTION B
CLIENT'S PHYSICAL DESCRIPTION

1. Height _____ ft. _____ in.
2. Weight _____ lbs.
3. Build _____
4. Hair color _____
5. Eye Color _____
6. Race _____ Skin Complexion: _____
7. False Teeth Yes No
8. Distinguishing marks, scars, tattoos, etc. Describe _____

9. If Client does not understand English, what language is understood? _____
10. Client can: Speak Write Non-Verbal
11. Does Client wear eyeglasses? Yes No Corrective lens (contacts): Yes No
If Client wears glasses or corrective eyewear, to what degree of vision loss do they have when not using the eyewear? None (no significant impairment) Fair Poor Extremely poor/blind
12. Does Client wear a hearing aid? Yes No What style? _____
If Client wears hearing aids, to what degree of hearing loss do they have when not using them?
None (no significant impairment) Fair Poor Extremely poor/deaf
13. Personal Articles Normally Carried by the Client: _____

14. Jewelry (Please describe) _____
15. Use Tobacco Products: Yes No Type: _____ Brand: _____
16. Candy/Gum: Yes/No Brand _____
17. Approximate amount of cash on hand? \$ _____ Where do they normally carry it: _____

e.g. Handbag, Purse or Wallet
18. Access to ATM: Yes No Bank Name & Location _____
19. Access to Credit Cards Yes No Visa/MC/other _____
20. Cell Phone: Yes No Service Provided (e.g. Verizon Wireless, Sprint, etc). _____
Ph #: _____ Smartphone? Yes No
GPS or Family Tracking Apps installed (e.g. "Find my Phone", Life360®, etc): _____

SECTION C
ALZHEIMER'S DISEASE

If client has been diagnosed with Alzheimer's disease (or suspected of), check here & answer the following

1. Does the Client remain oriented to Time and Person? Yes No

Explain: _____

2. Does the Client recognize familiar persons and faces? Yes No

Explain _____

3. Can the Client travel to familiar locations? Yes No

Explain _____

4. Does the Client have access to a vehicle? Yes No

Make _____ Model _____ Color _____ Plate# _____

5. Does the Client have decreased knowledge of current events or tend to re-live events in their life?

Yes No Explain _____

6. Does the Client sometimes clothe himself/herself improperly*? Yes No

**Example: Putting shoes on the wrong feet, adding underwear over clothing?*

Explain, if necessary: _____

7. Does the client remember his/her own name and the names of spouse and or children? Yes No

Explain: _____

8. What are the Client's sleep patterns? Yes No

Explain: _____

9. Does the Client suffer from frequent personality and emotional changes? Yes No

Explain: _____

10. Does the Client suffer from delusions (See imaginary visitors, talk to his/her own reflection in the mirror, imagine their spouse is an imposter, etc?) Yes No Explain: _____

11. Is the client a danger to themselves or others if left alone for a long period of time? Yes No

Explain: _____

SECTION D
CLIENT'S LIFE EXPERIENCE

1. Familiar with area? Yes No How recently _____ *Days/Months/Years*

If not local, what other areas are known to Client? _____

2. Taken outdoor classes? Yes No Where? _____ When? _____

3. Taken first-aid training? Yes No Where? _____ When? _____

4. Involved in Boys/Girls Scout? Yes No Explain: _____

5. Is the client a veteran: Yes No Branch of Military: _____

Approx Dates of Service: _____ MOS ("job") in Military: _____

6. Recreational Outdoor Experience? Yes No Explain: _____

7. Overnight Camping Experience? Yes No Explain: _____

8. Prior history of wandering? Yes No Explain dates/ locations/outcomes: _____

Location found: _____

9. Does Client go out alone? Yes No Where to?: _____

10. General Athletic Interest/Abilities _____

11. Is Client afraid of dogs? Yes No

12. Is Client afraid of the dark? Yes No

13. Is Client afraid of loud noises? Yes No

14. Does the client have an attraction towards: Railroads/Trains Water/River Playgrounds

OTB/Gambling/Casinos Sport Events/Facilities Senior Activity Centers

Other: _____

15. Will the Client talk to strangers? Yes No

16. Will the Client use public transportation: Yes No Which one: _____

SECTION E
CAREGIVER #1

1. Name: _____
 2. E-Mail: _____
 3. Phone 1 (primary): _____ Phone 2 (secondary): _____
 4. Address: _____
 5. Relationship to client: _____
 6. Caregiver Special Notes: _____
-

CAREGIVER #2

7. Name: _____
 8. E-Mail: _____
 9. Phone 1 (primary): _____ Phone 2 (secondary): _____
 10. Address: _____
 11. Relationship to client: _____
 12. Caregiver Special Notes: _____
-

CAREGIVER #3

13. Name: _____
 14. E-Mail: _____
 15. Phone 1 (primary): _____ Phone 2 (secondary): _____
 16. Address: _____
 17. Relationship to client: _____
 18. Caregiver Special Notes: _____
-

SECTION F
FAMILY/FRIEND INFORMATION
(individuals the client may contact if lost/wandering/eloped)

1. Name: _____ Phone: _____

Address: _____

Relationship to client: _____

2. Name: _____ Phone: _____

Address: _____

Relationship to client: _____

3. Name: _____ Phone: _____

Address: _____

Relationship to client: _____

SECTION G
LIABILITY INFORMATION/RELEASE

Please read this section carefully and sign prior to submitting the application.

I, (caregiver name) _____, acknowledge that the information I have provided in this application is true and accurate. I understand that acceptance into the Watervliet Police Department's Project Lifesaver Program does not replace the need for constant supervised care of the client.

(A) I, (caregiver name) _____, attest that (client name) _____ is personally supervised by me and/or by another responsible adult, 24 hours a day, 7 days a week.

(B) I, (caregiver name) _____, attest that (client name) _____ is not left unsupervised at any time.

If both statements (A) and (B) above are NOT TRUE, the potential client is ineligible for enrollment in the Project Lifesaver Program. If any portion of the caregiver(s) responses are inaccurate, the client will no longer be eligible for participation in the Project Lifesaver Program.

I understand that while Project Lifesaver utilizes a tracking device that aids in locating individuals who wear the transmitter, there may be times when an individual cannot be located due to device malfunction or other unforeseen circumstances. I agree to assume any/all responsibility associated with participation in the Watervliet Police Department's Project Lifesaver Program. I understand that the information I have provided in this application will be shared within the Watervliet Police Department, Albany County Sheriff's Office Communication Center (dispatch), and with other search and rescue agencies/organizations. I understand that none of the information I have provided, or provide in the future, will be considered confidential or protected. I also understand that Project Lifesaver is a program sponsored by the Watervliet Police Department and works in collaboration with other area agencies.

By my signature below, I affirm that I agree to the above information and that I represent the client and proclaim that I have full power and authority as the duly authorized representative of the applicant to register and act on their behalf.

Print Caregiver's Name: _____

Caregiver's Signature: _____ Date: _____

RESERVED FOR WATERVLIET POLICE USE:

1. **Picture of client taken:** ()YES ()NO
2. **Completed form reviewed w/ caretaker to ensure accuracy & thoroughness:** ()YES ()NO
3. **Discussed program & demonstrated equipment:** ()YES ()NO
4. **Provided with Caregiver Instructions Form:** ()YES ()NO
5. **Applicable Paperwork Received:** () Client Profile () Program Agreement
() Deposit Receipt () Other: _____
6. **Transponder Placed on Clients:** Date: _____ () Wrist = circle side: Right / Left
() Ankle = circle side: Right / Left () Other: _____
7. **Transponder Frequency:** _____
8. **Due Date for Battery Change (no less than 55/days, no more than 60):** _____
9. **Uploaded Information in Project Lifesaver Portal:** ()YES ()NO
10. **Completed & Sent ACSO BOLO Form:** ()YES ()NO
11. **Misc Notes:**