



Suffolk County Sheriff's Office

Vincent F. DeMarco, Sheriff



**PROJECT LIFESAVER
BRINGING LOVED ONES HOME**

Project Lifesaver Enrollment Application

This **Project Lifesaver** application is designed for Custodial Caregivers. By submitting this application to the **Suffolk County Sheriff's Office**, you will be considered for participation in the **Suffolk County Sheriff's Office Project Lifesaver Program**.

This application should be filled out by a **FAMILY, FRIEND, CAREGIVER or GUARDIAN** on behalf of the client who will be enrolled in the **Suffolk County Sheriff's Office Project Lifesaver Program**. You may be sent additional materials to complete.

Client's Name: _____
(name of individual for whom this application is being made)

Client's Photos

Must Submit Ten (10) Original 2x2 inch (minimum) Headshot Client Photos

Headshot Guidelines:

- Head should be directly facing the camera.
- Photo should capture from slightly above top of hair to middle of chest.
- Eyes should be open and looking at the camera.
- Eyeglasses should be worn if normally used by the client.

BRIEF STATEMENT

Why are you requesting the client participate in Project Lifesaver? _____

CLIENT DATA

Client Name: _____ Nickname: _____

Address: _____

City, State, Zip: _____

Telephone: _____ How long has the client been living at this address? _____

Client's former address(es):

CLIENT DESCRIPTION

Client's Date of Birth: _____ Current Age: _____ Sex: _____ M _____ F

Height: _____ Weight: _____ Build: _____

Race: _____ Hair Color: _____ Eye Color: _____

Complexion: (circle): Fair Medium Dark

Does the client wear: Glasses Contacts Hearing Aids

If "Yes," are they worn full-time?
Explain _____

Circle all that apply: Beard Moustache Bald Wig Cane Walker Limp Other

Explain _____

Other distinguishing physical characteristics (birth mark, mole, scar, tattoo, etc.):

Explain _____

Is the client's primary language English? Yes No If "No," what language? _____

CLIENT INFORMATION

Client's verbal/non-verbal skills (circle): None Poor Fair Good Excellent

Explain _____

If verbal, can the client communicate his/her name, address phone number, etc? Yes No

Explain _____

Does the client use an augmentative communication device? Yes No

If "Yes," what device, and how proficient is the client in communicating with others?

Explain: _____

Client's likes, dislikes and preoccupations: _____

List articles/items normally carried by client: _____

Is the client familiar with the area? Yes No How recent (months/years): _____

If "No," what area(s) are known/familiar to the client? _____

WANDERING/ELOPEMENT HISTORY

Is there any prior history of the client becoming "lost, wandering or eloping?" Yes No

If "Yes," describe the event(s) in detail with dates:

Location found: _____ By whom: _____

Actions taken: _____

Were law enforcement authorities notified or involved? Yes No

Explain: _____

MEDICAL/PSYCHOLOGICAL INFORMATION

Does the client have any known **medical** problems? Yes No

Explain: _____

Does the client have any known **psychological** problems? Yes No

Explain: _____

What is the client's diagnosis? _____ **When** was the client diagnosed? _____

Describe any other health-related medical conditions: _____

Medications List (frequency): _____

Client's Physician: _____ Telephone: _____

Address: _____

City, State, Zip: _____

HABITS/PERSONALITY

Does the client smoke? Yes No How often? _____

Does the client use alcohol? Yes No How often/type? _____

Does the client use (illicit) drugs? Yes No If "Yes:" Type? _____

Does the client have fears (dogs, cats, people, noises darkness, etc.)? _____

Will the client talk to strangers? Yes No Explain _____

Is the client a danger to self or others? _____

List client's hobbies/interests: _____

Additional information: _____

FAMILY/FRIEND/CAREGIVER INFORMATION

Name: _____ Relationship to Client: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Name of Employer: _____

Employer's Address: _____

City, State, Zip: _____

Work Phone: _____ Work E-Mail: _____

**CLIENTS RESIDING IN LONG TERM/MANAGED
CARE/NURSING HOME FACILITIES**

Facility/Organization: _____

Address: _____

City, State, Zip: _____

Contact Person: _____ Tel: _____ Fax: _____

List others (family, friends) the client may contact if they “wander.”

Name: _____ Relationship to Client: _____ Phone: _____

Address: _____

City, State, Zip: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Client: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

POWER OF ATTORNEY

Do you have Power of Attorney for the individual you are seeking to enroll in Project Lifesaver? If not, please provide the name, address and phone number(s) of the individual who does and describe their relationship to the client: Yes No N/A

Name of individual with **Power of Attorney**: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail _____

Relationship to Client: _____

LIABILITY INFORMATION/RELEASE

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

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

(A). I, (caregiver name) _____ attest that (client's 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's name) _____ **is not left unsupervised at any time**.

If statements A & B are not true, the potential client is ineligible for enrollment in Project Lifesaver. If any portion of the caregiver(s) responses are inaccurate, the client will no longer be eligible to participate in Project Lifesaver.

I understand that while Project Lifesaver utilizes a global 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 reason(s). I agree to assume any/all responsibility associated with participation in Project Lifesaver and ongoing unit maintenance.

I understand that the information I have provided in this application will be shared among the Suffolk County Sheriff's Office and other search and rescue agencies. I understand that none of the information I have provided or provide in the future, will be considered confidential or protected.

I understand that Project Lifesaver is a program sponsored by the Suffolk County Sheriff's Office and works in collaboration with other area agencies. Should the client be accepted into Project Lifesaver, he/she agrees to release and hold each agency and respective personnel 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 their participation in the Suffolk County Sheriff's Office Project Lifesaver Program.

I have read the Project Lifesaver "Fact Sheet" and agree to its terms and conditions. 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 his/her behalf.

Caregiver:
Print Full Name _____ Signature _____

Client:
Print Full Name: _____ Date: _____

The below section is to be completed by
SUFFOLK COUNTY SHERIFF'S OFFICE PROJECT LIFESAVER
SEARCH AND RESCUE SPECIALIST

Client name: _____

Date transmitter installed: _____ Photo attached: Yes No

Frequency: _____ Deviation: _____

Transmitter location: Wrist Ankle Neck Other: _____

Was the caregiver(s) shown how to test and daily record the transmitter? Yes No

Caregiver's name (print): _____

Caregiver's signature: _____

Sheriff's Office Project Lifesaver Specialist: _____ # _____

Date: _____

Return application to:

Sheriff Vincent F. DeMarco
Suffolk County Sheriff's Office
Project Lifesaver
100 Center Drive
Riverhead, New York 11901