OFFICE OF THE SHERIFF
COUNTY OF SALEM

CORRECTIONAL FACILITY

125 CEMETERY ROAD
WOODSTOWN, NEW JERSEY 08098
PHONE (856) 769-4300
FAX (856) 769-3578

JOHN CUZZUPE
WARDEN/UNDERSHERIFF

CHARLES M. MILLER
SHERIFF

ALLEN J. CUMMINGS, UNDERSHERIFF

DOUGLAS S. BELL, CHIEF

ADMINISTRATIVE OFFICE

94 MARKET STREET
SALEM, NEW JERSEY 08079
PHONE (856) 935-7510 (EXT. 8375)
FAX (856) 935-8880

OFFICE OF EMERGENCY SERVICES
COMMUNICATIONS DIVISION

135 CEMETERY ROAD
WOODSTOWN, NEW JERSEY 08098
PHONE (856) 769-2900
FAX (856) 769-4229

SCOTT HAINES, DIRECTOR

Salem County Project Lifesaver Enrollment Application

Instructions:

Please complete the enrollment package which includes an application and contract to be signed. The application and contract must be completed and submitted by the family member/caregiver (authorized representative).

Applicant Criteria:

- Applicant must be diagnosed by a qualified medical professional with Alzheimer's, Autism, Down Syndrome, Dementia or a related disorder that can cause the applicant to wander and place them at risk.
- The applicant is not involved with unescorted activities such as walks, shopping or medical appointments that would create increased opportunities for wandering.
- The applicant must live in Salem County.
- The applicant must be accompanied by a caregiver 24 hours a day, 7 days a week.
- The wrist transmitter remains the property of the Salem County Sheriff's Office. Once the individual is no longer utilizing the unit, it is returned to the Salem County Sheriff's Office..
- The applicant must not operate a motor vehicle.
- Caregivers must understand and agree that the locating technology used in the Project Lifesaver Program is not intended as a substitute for responsible child care or caregiver practice.

If you have any questions regarding the application please call (856) 935-7510 Ext. 8378. Upon receipt, your enrollment application will be reviewed and, if approved, you will be contacted to schedule a date and time for the Project Lifesaver representative to meet with you and your family. At the meeting, the contract will be signed, the bracelet will be installed and the caregiver will receive instructions about eh equipment and how to test it daily. Appropriate procedures on how to handle an emergency notification in the event that an applicant becomes lost will also be reviewed at this time.

Section 1: Applicant Information

Please provide information about the person you are enrolling in Project Lifesaver. This enrollment application is being utilized for both adult and juvenile enrollees so some questions will not apply to your situation.

FIRST NAME:_______________LAST NAME:________________ M.I._______

ADDRESS/LOCATION INFORMATION

Home address:____

City:________________________State:______ZIP code:_____________Years at address______

Phone (home):______________________________Phone (cell):___________________________

IF THE APPLICANT ATTENDS A SCHOOL OR A DAY PROGRAM:

School/Program:____

Address:____

Phone:_____________________________Contact name at this location:___________________

Days/hours attends:____

PERSONAL DATA

D.O.B.____________Current age_________Gender Male Female Race___________

Nicknames:____

Most recent place of work______________________Most recent occupation_______________

Name of spouse:________________________________Living or deceased__________________

Additional information:____

PHYSICAL DESCRIPTION

Height: (feet)_____(inches)_____Weight (pounds):________Hair color:___________Eye color________

Build:_____________Complextion:____________________Facial hair:__________________________

Distinguishing marks/scars/tattoos:____

Does the applicant wear glasses?_______Contacts?________Sunglasses____________________

If yes to any of the above, what style:

If the Applicant wears corrective eyewear, what degree of vision does he/she have without eyewear?
None_____Poor_____Fair_____

Health Information

Physician's name:__________________________Physician's phone number:______________________

Physician's address: ____

Any other health/medical related issues?____

Any known physical handicaps:____

Medications taken regulary?____

Consequences of **NOT** taking medications?____

Any mental health problems?________Nature?____

Does the Applicant remain oriented to person, place and time?_________

Explain:____

COMMUNICATION INFORMATION

Would the applicant respond if being called out by his/her name?_____________
Method of Communication: Augmentative/Speech Assistance Device_________
Verbal_________Non-verbal_______Sign Language________Written_________

What type of Augmentative/Speech Assistance Device does the Applicant use?___________

What type of Sign Language does the Applicant use?____

What language (s) does the applicant speak or understand?____________________________________

What does the Applicant call the family member or friend with whom they have the closest emotional attachment?

Name?_______________________________________Relationship_____________________________

BEHAVIORAL INFORMATION

Does the Applicant sometimes dress himself/herself improperly__________________
Explain how the applicant will/might react if approached by a uniformed officer.

Does the Applicant have a fear of: People______Dogs_______Noises________Shouting___________
Bright Lights______Other___________

Explain:____

Do you have any suggestions for approaching the applicant and/or de-escalation techniques?

Does the Applicant have regular sleep patterns?_________________
Explain:____

Please list any significant historical information that could be pertinent should the applicant wander (for example previous long term residence or long term employment):

When outside, does the Applicant mostly stay on paths or roadways?____________

PERSONAL ITEMS

Does the Applicant like to carry any personal items, sentimental items, toys, purse, etc:__________

Explain:____

Candy/gum/food Items?____

Approximate amount of money the applicant may have?__________Access to ATM___________

Access to bank?_______Which bank?____

Credit card/ATM Card?____

Description of jewelry/watch worn:____

Does the Applicant have a cell phone?_____Phone number?________________Carrier_____________

Cane, walker, scooter, wheel chair?____________________________

Pocket knife, survival tools, etc?:____

Other Items:____

PERSONALITY/HABITS/INTERESTS

Military experience: Yes______No_______When:_____________________Branch__________________

Hobbies/interests:____

Does the Applicant smoke or use smokeless tobacco products or vape?___________________________

Type:______________Brand:___________________________Matches or lighter:___________________

Drink alcohol?_____How often:_________________Type:_______________Brand_________________

General athletic interests/abilities:____

Demeanor: Outgoing___Quiet___ Prefers: Groups___Being alone___Talks to strangers?____________

Has the applicant ever been in trouble with the law?____

Explain:____

What does the Applicant value most?____

Where was the applicant born and raised?____

Is the applicant **DANGEROUS** to himself/herself or others?______________________________________
Does the Applicant suffer from frequent personality and/or emotional changes?___________________

Explain:____

Does the Applicant suffer from delusions (see imaginary visitors or friends, talk to his/her own reflection in the mirror, imagine that his/her spouse as an imposter, etc.)?______________________

Explain:____

Has the Applicant ever wandered before?__________When:___________Where___________________

Located by searchers OR returned by him/herself?____

Length of time missing?____

Location Found:____

Actions Taken____

Would the Applicant wander into the woods?_____________
When? Day_______Night________Both_____

Does the Applicant frequent/gravitate to water, playground, etc.:________
If yes, give locations:____

In the event the Applicant were to wander, please provide the names, addresses and phone numbers of people they may attempt to contact or a location they may travel towards.

Name:______________________________________Name:______________________________________

Address:_____________________________________Address:____________________________________

Phone:______________________________________Phone:_____________________________________

Additional relevant information about the Applicant:

SECTION 2: AUTHORIZED REPRESENTATIVE/CAREGIVER INFORMATION

As the authorized representative, you will also serve as the **primary contact person.**

Name:____

Relationship to applicant:____

Address:____

Phone (home):__________________________Phone (cell):_______________________________________

Phone (Other):_____________________________Email:____

Employer:____

Employer address:____

Phone (work):__________________Fax number:_________________Work Email:_____________________

SECTION 3: SECONDARY EMERGENCY CONTACT INFORMATON

If an emergency arises and we are unable to reach the authorized representative, we will contact the individual you designate below. Also, please provide contact information for two additional people that we may contact in case of emergency.

Name:____

Relationship to Applicant:____

Address:____

Phone (home):_________________________Phone (cell):_____________________________________

Phone (other):____________________________Email:____

Employer:____

Employer address:____

Phone (work):_________________Fax number:________________Work email:____________________

ADDITONAL FRIENDS/FAMILY CONTACT INFORMATION

Name:____________________________________Name:___________________________________

Address:__________________________________Address:__________________________________

Phone(home):______________________________Phone (home):______________________________

Phone (cell):_______________________________Phone (cell):_______________________________

For administrative purposes only

Frequency Number________________Client #______________________

LIABILITY RELEASE INFORMATION

I ACKNOWLEDGE that the information I have provided in this application is true and accurate to the best of my knowledge.

I UNDERSTAND that should the Applicant be accepted into Project Lifesaver that it does not replace the need for individuals with Alzheimer's disease and/or related dementia disorder to have constant supervised care.

I UNDERSTAND that while Project Lifesaver is a mobile locater tracking system that aids in locating individuals who wear the bracelet device, there may be times and circumstances when an individual cannot be located due to devise malfunction or any other reason. I also agree to assume any/all responsibilities associated with program participation and ongoing unit maintenance.

I UNDERSTAND that all information I have provided in this application will be shared among the Salem County Sheriff's Office, the Department of Health, Human Services, Division of Senior Services as well as the police department in the town where I reside, and I understand that none of the information I have provided or provide in the future can be considered confidential or protected.

I UNDERSTAND that Project Lifesaver is a program sponsored by the Salem County Sheriff's Office that will work in collaboration with the Department of Health Human Services, Division of Senior Services; AND SHOULD THE APPLICANT BE ACCEPTED INTO THE PROJECT LIFESAVER PROGRAM, HE/SHE AGREES TO RELASE AND HOLD EACH AGENCY AND ALL THEIR RESPECTIVE PERSONNEL, DIRECTORS, AND VOLUNTEERS HARMLESS FROM ANY AND ALL CLAIMS OR LIABLITY AND /OR DAMAGE AND WAIVE ANY AND ALL RIGHTS TO SEEK RECOURSE FOR ANY LOSSES OR INJURY THAT MAY OCCUR AS A RESULT OF PARTICIATION IN THE PROJECT LIFESAVER PROGRAM.

I HAVE READ THE PROJECT LIFESAVER PROGRAM FACT SHEET AND AGREE TO THOSE TERMS. FURTHERMORE, I hereby represent and warrant that I have full power and authority as the duly authorized representative of the participant named above, to register and act on his/her behalf.

Name:____

Signature____**DATE:**__________________

PHYSICIAN'S STATEMENT

Patient Name____Date of Birth_______________________

Address:____

City/Town:________________________________State:____________________Zip:_________________

Caregiver's Name:______________________________ ____Relationship to Patient_________________

Phone (home):_________________________Phone (cell)_______________________________________

Physician's Name:____________________________Phone:_____________________________________

Specialty:____

Address:____

City/Town:________________________________State:____________________Zip:_________________

Comments:____

In order to qualify for the Project Lifesaver program, a medical diagnosis is required. Eligibility is restricted to the following: Alzheimer's disease or related dementia disorder, autism, Down syndrome, traumatic brain injuries or cognitive impairments that may cause wandering.

Diagnosis:____

Physician's Signature____Date:____________________