

Client Number: \_\_\_\_\_ Frequency: \_\_\_\_\_ ID Number or Code \_\_\_\_\_



## ALBANY POLICE DEPARTMENT

### Project Lifesaver Program

201 Oglethorpe Blvd.

Albany, Ga. 31701

229-431-2100

### Client Personal Data Questionnaire

This form is designed for Custodial Care Givers to provide, in advance, certain information that will be useful to Search Teams, should the need arise. Providing the information in advance of the need will allow Search Management Personnel the necessary information to establish a more effective search response.

Resident: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

Date Transmitter Placed: \_\_\_\_\_  
Facility/Organization/Caregiver: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Servicer filling out this form: \_\_\_\_\_  
PL Servicer that places transmitter on: \_\_\_\_\_

### Resident's Personal Data

Birthday: \_\_\_\_\_ Sex: Male/Female Race: \_\_\_\_\_  
Nickname(s): \_\_\_\_\_  
Most recent address: \_\_\_\_\_  
Most recent place of work: \_\_\_\_\_  
Most recent occupation: \_\_\_\_\_  
Name of Spouse: \_\_\_\_\_ Living/deceased (circle)

### Family/Friend Information

Other persons the resident might contact (family, friends, etc.)

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Relationship to client: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Relationship to client: \_\_\_\_\_

Responsible Party Paying for client: \_\_\_\_\_

Diagnosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physical Description**

Height \_\_\_\_ft. \_\_\_\_in. Weight \_\_\_\_\_lbs. Build \_\_\_\_\_ Complexion \_\_\_\_\_

Hair color \_\_\_\_\_ Hair Style \_\_\_\_\_ Eye Color \_\_\_\_\_

Beard: Yes No Mustache: Yes No Balding: Yes No False Teeth: Yes No

Shape of facial features: Round/Square/Oval/Other \_\_\_\_\_

Distinguishing marks, scars, tattoos, etc. \_\_\_\_\_

General Appearance \_\_\_\_\_

Languages other than English understood? \_\_\_\_\_

Speak? Yes No Read? Yes No Write? Yes No

Wear glasses? Yes No Contacts? Yes No Sunglasses Yes No

If yes to any of the above what style: \_\_\_\_\_

Degree of vision without eyewear? None Poor Fair (circle one)

**Personal Data Questionnaire**

Wear a hearing aid? Yes No What style? \_\_\_\_\_

If yes, what type of hearing without Aid? None/Poor/Fair (circle one)

**Health/Psychological Condition**

Any known physical handicaps? \_\_\_\_\_

Any known medical problems? \_\_\_\_\_

Medications taken regularly? \_\_\_\_\_

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

Consequences of NOT taking medications? \_\_\_\_\_

Attending Physician \_\_\_\_\_ Phone No. \_\_\_\_\_

Any Psychological Problems? Yes/No Nature \_\_\_\_\_

If Alzheimer's disease has been diagnosed, Answer the following:

1. Remains oriented to Time and Person? Yes No  
Explain \_\_\_\_\_
2. Recognizes familiar persons and faces? Yes No  
Explain \_\_\_\_\_
3. Able to travel to familiar locations? Yes No  
Explain \_\_\_\_\_
4. Has decreased knowledge of current events or tend to re-live events in his/her life? Yes No  
Explain \_\_\_\_\_
5. Sometimes clothe himself/herself improperly? Yes No  
Example: Putting shoes on the wrong feet, adding underwear over clothing?  
Explain if necessary \_\_\_\_\_
6. Remembers his/her own name and the names of spouse and or children? Yes No  
Explain \_\_\_\_\_
7. Sleep patterns frequent or Sporadic?  
Explain \_\_\_\_\_
8. Suffer from frequent personality and emotional changes? Yes No  
Explain \_\_\_\_\_
9. Suffers from delusions (See Imaginary Visitors, Talk to his/her own reflection in the mirror, Imagine that their spouse is an imposter, etc?) Yes No  
Explain \_\_\_\_\_
10. Communication ability? None Poor Fair Good Excellent

Personal Articles Normally Carried by the Resident:

Tobacco Products: Yes No Type \_\_\_\_\_ Brand \_\_\_\_\_

Candy/Gum: Yes No Brand \_\_\_\_\_

Matches: Yes No Lighter: Yes No Type \_\_\_\_\_

Food Items: \_\_\_\_\_

Facial tissue or other pocket/purse items: \_\_\_\_\_

Approximate Cash on Hand? \$ \_\_\_\_\_

Where Normally Carried \_\_\_\_\_

Handbag, Purse or Wallet:

Description \_\_\_\_\_ Type \_\_\_\_\_ Color \_\_\_\_\_

Jewelry (Please describe) \_\_\_\_\_

Watch? \_\_\_\_\_ Type \_\_\_\_\_ Color \_\_\_\_\_ Description \_\_\_\_\_

**Equipment**

Cane or /Walker \_\_\_\_\_ Hunting/Fishing, Etc. \_\_\_\_\_ (circle one or describe)

Other: \_\_\_\_\_

**Experience**

Ever go out alone? Yes No Where \_\_\_\_\_  
Familiar with area? Yes No How recently \_\_\_\_\_ Days/Months/Years  
If not local, what other areas are known to Resident? \_\_\_\_\_

Taken outdoor classes? Yes No Where? \_\_\_\_\_ When? \_\_\_\_\_

Taken first-aid training? Yes No Where? \_\_\_\_\_ When? \_\_\_\_\_

Involved in Scouting? Yes No Explain \_\_\_\_\_

Military Experience? Yes No Where? \_\_\_\_\_ When? \_\_\_\_\_

Outdoor Experience? Yes No \_\_\_\_\_

Camping Experience? Yes No \_\_\_\_\_ Day or Night \_\_\_\_\_

Ever been lost before? Yes No Where? \_\_\_\_\_

When \_\_\_\_\_ Time of Day \_\_\_\_\_

Location found \_\_\_\_\_

Actions taken \_\_\_\_\_

General Athletic Interest/Abilities \_\_\_\_\_

**Personality Habits**

Smoke? Yes No How often \_\_\_\_\_ what \_\_\_\_\_ Brand \_\_\_\_\_

Drink Alcohol? Yes No    What Type? \_\_\_\_\_ Brand \_\_\_\_\_  
 Use Illicit Drugs? Yes No    How often \_\_\_\_\_ Type \_\_\_\_\_  
 Evidence of Leadership Yes No    Explain \_\_\_\_\_  
 Any trouble with the law? Yes No    Explain \_\_\_\_\_  
 Religious? Yes No    What faith \_\_\_\_\_  
 Received mail recently? Yes No    From Whom \_\_\_\_\_  
 Afraid of Dogs? Yes No    The dark? Yes No    Noises? Yes No  
 Horses? Yes No    People? Yes No    Other (explain) \_\_\_\_\_  
 Talks to strangers? Yes No  
 Dangerous to self/others Yes No

Outgoing or Quiet \_\_\_\_\_ Likes Groups or being alone? \_\_\_\_\_

What does Resident value most? \_\_\_\_\_

Which family member is resident closest to? \_\_\_\_\_ Relationship \_\_\_\_\_

Where was Resident born and raised? \_\_\_\_\_

Reactions to hurt or pain? (Cry, shout, etc.?) \_\_\_\_\_

**PROJECT LIFESAVER  
LOST SUBJECT PROFILE**

INCD. NAME	DATE	TIME	INCD. CMDR.
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**PERSONAL**

NAME	NICKNAME	AGE	RACE	SEX
HOME ADDRESS		CITY	STATE	
NAMES OF FAMILY OR NEAREST RELATIVES				

**PHYSICAL DESCRIPTION**

HEIGHT	WEIGHT	COMPLEXION	HAIR COLOR
HAIR STYLE	FACIAL HAIR		EYE COLOR
DISTINGUISHING MARKS			

## CLOTHING

<input type="checkbox"/>	SHIRT	(description)	
<input type="checkbox"/>	DRESS	(description)	
<input type="checkbox"/>	SWEATER	(description)	
<input type="checkbox"/>	PANTS	(description)	
<input type="checkbox"/>	COAT	(description)	
<input type="checkbox"/>	HAT	(description)	
<input type="checkbox"/>	SHOES	SIZE	SOLE STYLE TREAD PATTERN

### PERSONAL ITEMS IN POSSESSION

<input type="checkbox"/>	WALLET/PURSE
<input type="checkbox"/>	JEWELRY
<input type="checkbox"/>	TOBACCO
<input type="checkbox"/>	CANDY/GUM
<input type="checkbox"/>	EYE GLASSES
<input type="checkbox"/>	KNIFE/TOOLS
<input type="checkbox"/>	CANE STICK
<input type="checkbox"/>	OTHER

### ADDITIONAL NOTES OR PICTURE

### PHYSICAL/MENTAL CONDITION

PHYSICAL	
MENTAL	
MEDICATION	
ALCOHOL	
ILLICIT DRUGS	
NOTES	

Additional Information:

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# *Project Lifesaver Program Contract*

If applicant is accepted into the Project Lifesaver Program, the following terms shall apply as agreed to upon the signing of the Project Lifesaver 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 Applicant named below, to register and act on his/her behalf. My Power of Attorney and/or Power of Personal Care is attached, if needed.

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 an Applicant in Project Lifesaver, 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 fully responsibility of protecting this person from wandering. I also understand that I, or a family member, must be present in the home with the Applicant at all times.
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 Applicant. 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 has been removed or is defective; I will call Project Lifesaver immediately.
4. When I notice that the Applicant enrolled has wandered off, I must immediately call the emergency number supplied by Project Lifesaver and report the Applicant as a missing person. Project Lifesaver teams will respond to search. I understand and acknowledge that the Project Lifesaver device cannot predict or report that the Applicant has wandered off. It is used solely as an aid for emergency personnel when notified the Applicant is missing.
5. A monthly maintenance fee of \$ 15.00 shall be payable at the 1<sup>st</sup> day of each month or a one time annual fee of \$180.00 payable by the 30<sup>th</sup> day of January, by pre-authorized checking/credit card/cash. **This fee will be paid through the City of Albany Treasury Office located at 222 Pine Avenue - Suite 460 Albany, Georgia 31701 and will be paid to the Project Life Saver Account. I understand that if this monthly fee is not paid on or before the 1<sup>st</sup> day of each month, the transmitter bracelet will be collected by a member of the Albany Police Department.**
6. 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 or any of its employees or volunteers, Provincial 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 Applicant.

7. 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 shall provide in the future can be considered confidential or protected or private when used for the purposes of the Project Lifesaver Program, [notwithstanding the provisions of the Personal Information Protection and Electronic Documents Act].

8. I specifically waive any rights to confidentiality to the Applicant's medical records by Project Lifesaver International or any of Project Lifesaver's member agencies which includes dissemination of such information. I confirm that I have the authority by which to waive such rights.

9. I understand that Project Lifesaver is a program administered by: **Albany Police Department /Community Relations Unit**. 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.

10. I understand that the transmitter and tester remain the property of Project Lifesaver and when no longer being used by the Applicant to whom it was assigned will be returned undamaged to Project Lifesaver 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 all such equipment until returned to Project Lifesaver.

11. 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 immediately when I discover the Applicant missing, or if I fail to notify Project Lifesaver if I test the transmitter device and find no signal indication, or if the Applicant refuses to wear or removes the device 3 (three) times, then the Applicant may be involuntarily removed from the program. All property will then be returned to Project Lifesaver 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.

By signing below, I affirm that I have read and understand the contract including all waivers, releases, and liability limitations. It is my desire and intention to enter into this agreement and by affixing my signature below, I hereby agree to the terms and provisions of this contract.

\_\_\_\_\_  
CAREGIVERS SIGNATURE

\_\_\_\_\_  
CAREGIVERS NAME (PRINTED)

\_\_\_\_\_  
STREET ADDRESS/ PO BOX

\_\_\_\_\_  
CITY, STATE/ZIP

\_\_\_\_\_  
WITNESS (OR NOTARY) SIGNATURE

\_\_\_\_\_  
WITNESS (OR NOTARY) NAME PRINTED

\_\_\_\_\_  
STREET ADDRESS/PO BOX

\_\_\_\_\_  
CITY, STATE/ZIP

\_\_\_\_\_  
NOTARY COMMISSION EXPIRES

\_\_\_\_\_  
NOTARY IDENTIFICATION NUMBER



TELEPHONE NUMBER (CAREGIVER)

TELEPHONE NUMBER (NOTARY OR WITNESS)

PROJECT LIFESAVER REPRESENTATIVE

DATE

Sheet \_\_\_\_\_

Frequency \_\_\_\_\_

Client # \_\_\_\_\_

ID Code \_\_\_\_\_

### Project Lifesaver International Client Check Sheet

Client Name

Client City/Zip

Client Location (Address)

Contact Phone

Caregiver Contact

Caregiver Phone

Caregiver Relationship

Client Facility  House  Apt.  Duplex  Trailer  Hospital  Nursing Home  Asst. Living  Secured  Fenced

Day	Month	Time	Person Inspecting Equipment	Comments
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				

29				
30				
31				

	Transmitter	Battery	Case	"O" Ring	Band	Tester	Sheet
Install/New	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Replace/Modify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inspect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remove	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Visit1)

Signature \_\_\_\_\_ Caregiver Signature \_\_\_\_\_ Date \_\_\_\_\_ Responder \_\_\_\_\_ Date \_\_\_\_\_

Visit2)

Sheet \_\_\_\_\_ Caregiver Signature \_\_\_\_\_ Date \_\_\_\_\_ Client # \_\_\_\_\_ Responder Signature \_\_\_\_\_ ID Code \_\_\_\_\_ Date \_\_\_\_\_

**Responder Information:**

	Yes	No
1) Battery Working When Inspected/Changed	<input type="checkbox"/>	<input type="checkbox"/>
2) Transmitter Working When Inspected/Changed	<input type="checkbox"/>	<input type="checkbox"/>
3) Case Damaged Prior to Inspection/Change	<input type="checkbox"/>	<input type="checkbox"/>
4) Band Damaged Prior to Inspection/Change	<input type="checkbox"/>	<input type="checkbox"/>
5) Unauthorized Removal of Transmitter/Band	<input type="checkbox"/>	<input type="checkbox"/>
6) "O" Ring replaced	<input type="checkbox"/>	<input type="checkbox"/>

Client Condition since Last Visit:

**1) Personality or Behavior**

- |                                    |   |   |  |   |                                     |
|------------------------------------|---|---|--|---|-------------------------------------|
| <input type="checkbox"/> Change    | <input type="checkbox"/> Violent                            | <input type="checkbox"/> Aggressive             | <input type="checkbox"/> Agitated          | <input type="checkbox"/> Argumentative      | <input type="checkbox"/> Passive    |
| <input type="checkbox"/> No Change | <input type="checkbox"/> Paranoid                           | <input type="checkbox"/> Depressed              | <input type="checkbox"/> Withdrawn         | <input type="checkbox"/> Pleasant           | <input type="checkbox"/> Accusatory |
|                                    | <input type="checkbox"/> Mood Swings                        | <input type="checkbox"/> Fidgety                | <input type="checkbox"/> Hides Things      | <input type="checkbox"/> Disrobes in Public | <input type="checkbox"/> Assault    |
|                                    | <input type="checkbox"/> Theft                              | <input type="checkbox"/> Other Criminal Conduct | <input type="checkbox"/> Traffic Violation |   |                                     |
|                                    | <input type="checkbox"/> Other Inappropriate Behavior _____ |   |  |   |                                     |

**2) State of Mind**

- |                                    |   |   |                                   |
|------------------------------------|---|---|-----------------------------------|
| <input type="checkbox"/> Change    | <input type="checkbox"/> Memory Loss Short Term   | <input type="checkbox"/> Memory Loss Long Term            | <input type="checkbox"/> Confused |
| <input type="checkbox"/> No Change | <input type="checkbox"/> Cannot recognize friends | <input type="checkbox"/> Cannot recognize family members  |                                   |
|                                    | <input type="checkbox"/> Trouble Thinking         | <input type="checkbox"/> Cannot recognize familiar places |                                   |
|                                    | <input type="checkbox"/> Other _____              |   |                                   |

**3) Life State**

- |                                    |  |   |   |
|------------------------------------|--|---|---|
| <input type="checkbox"/> Change    | <input type="checkbox"/> Needs help dressing   | <input type="checkbox"/> Personal Hygiene Deteriorating | <input type="checkbox"/> Appetite declining |
| <input type="checkbox"/> No Change | <input type="checkbox"/> writing deteriorating | <input type="checkbox"/> Speech deteriorating           | <input type="checkbox"/> Stopped Eating     |
|                                    | <input type="checkbox"/> Not taking medicine   | <input type="checkbox"/> Declining potty habits         |   |
|                                    | <input type="checkbox"/> Cannot Travel alone   | <input type="checkbox"/> Cannot be left alone           | <input type="checkbox"/> Cannot navigate    |
|                                    | <input type="checkbox"/> Confused              | <input type="checkbox"/> Wanders                        | <input type="checkbox"/> Cannot drive       |
|                                    |  | <input type="checkbox"/> Trouble Thinking               | <input type="checkbox"/> Other _____        |

**4) Sleep**

- |                                 |   |   |   |              |
|---------------------------------|---|---|---|--------------|
| 0559)                           | Morning (0600-1159)                           | Afternoon(1200-1800)                        | Evening (1800-2359)                           | Night (2400- |
| <input type="checkbox"/> Change | <input type="checkbox"/> Morning to Afternoon | <input type="checkbox"/> Morning to Evening | <input type="checkbox"/> Morning to night     |              |
|                                 | <input type="checkbox"/> Afternoon to Evening | <input type="checkbox"/> Afternoon to Night | <input type="checkbox"/> Afternoon to Morning |              |

- No Change
- Evening to night
- evening to morning
- Evening to afternoon
- Night to morning
- night to afternoon
- night to evening
- Sleeps 2 hours
- sleeps 4 hours
- sleeps 6 hours

**5) Equipment**

- Client does not like to wear transmitter
- transmitter uncomfortable
- band/case chafing skin
- band/case irritating skin
- client removed band/transmitter
- client removed band/transmitter (hid/threw away transmitter)

Other Comments of Information:

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FORM:PLIclientchecksheet12-13-11