Dear Family of Applicant,

Project Lifesaver of Hamilton County started in 2009 following the public's need for a program to assist families with loved ones who have Autism, Down Syndrome, Dementia or Alzheimer's that may wonder away from home. The program has several police and fire agencies that assist in locating your loved one. All of the responding agencies as well as the Hamilton County Sheriff's Office are trained in search and rescue with the Project Lifesaver Equipment.

The program relies on proven technology and specially trained search and rescue teams. Project Lifesaver clients wear a wristband that emits a silent individualized tracking signal. When caregivers call 911 and report a loved one is missing, a search and rescue team responds to the area and starts searching with state-of-the-art tracking equipment. Since the use of this technology, search times have been reduced from hours and days to minutes. As of January 2010 there has been 100% success, with no reported serious injuries or deaths. Recovery time averages less than 30 minutes.

Our program is to assist families that have exhausted all other means of keeping their loved ones safe and from wandering. Please fill out the following application and return to:

Hamilton County Sheriff's Office
ATTN: Project Lifesaver of Hamilton County
18100 Cumberland Rd.
Noblesville, IN 46060

Should any questions arise, you can reach a Project Lifesaver of Hamilton County representative by calling 317-776-6PLS or via email at Project.Lifesaver@hamiltoncounty.in.gov. We look forward to speaking with you about placing your loved one on the program.

Sincerely,

Melissa Mitchell

Melissa Mitchell
President
Project Lifesaver of Hamilton County
18100 Cumberland Rd.
Noblesville, IN 46060
317-776-6PLS
Project.Lifesaver@hamiltoncounty.in.gov

Project Lifesaver of Hamilton County

Application Packet

Client's Name:				Age:
Date of Birth:		Nickname(s):		
Hgt:	Wgt:	Hair:	Eyes:	Hair Style:
Beard: Yes / No		Mustache: Yes / No	Glasses: Yes / No	Hearing Aid: Yes / No
Scars, Marks, & Tattoos:				
Address:				
City:		State:		Zip Code:
Home Phone:		Cell Phone:		

The following are Project Lifesaver of Hamilton County's guidelines for admittance into program:

1. Live within the county limits of Hamilton County, Indiana
2. Diagnosed as having Alzheimers, other dementia disorders, Autism, Down's Syndrome, traumatic brain injury, or other similar disorder
3. Known to wander away from caregivers
4. 24/7 supervision of client by family, friend, or caregiver

Is the client: Verbal / Non Verbal	Does the client know sign language? Yes / No
Does the client speak English? Yes / No	If no, what language:
Client's Medical Diagnosis:	

Please have applicant's physician sign below verifying that the applicant is or may be at risk for wandering as indicated by specific diagnosis listed above.

It is my opinion that _____ (name of applicant) is or may be at risk for wandering as indicated by specific diagnosis of _____.

Physician Name (printed):	Date:
Physician Signature:	Contact Number:

Does the client have any known physical handicaps?
Does the client have any known medical problems or allergies?

List any medications the client is currently taking (correct name of drug & dosage):

Consequences of *not* taking medications:

Client Behavior

Has the client ever wandered or become lost before? Yes / No (if yes, answer the following)

When: (Month & Year):	
Where was the client located?	
Was law enforcement called? Yes / No	If yes, what agency?

Does the client remain oriented to current date & time? Yes / No If no, explain:

Does the client recognize familiar persons and faces? Yes / No If no, explain:

Does the client remember their own name and the names of spouse and/or children? Yes / No
Explain:

Does the client suffer from frequent personality and emotional changes? Yes / No
Explain:

Does the client suffer from delusions? Yes / No If yes, explain:

Does the client need the use of a cane, walker, or wheelchair? Yes / No If yes, explain:

Is the client dangerous to themselves or others? Yes / No If yes, explain:

Other Facilities, Schools, or Treatment Centers

Please list other facilities, schools, or treatment centers in which the client frequently attends or visits. Attach additional pages if needed.

Business/School Name:		
Address:		
City:	State:	Zip Code:
Primary Contact:	Phone Number:	

Business/School Name:		
Address:		
City:	State:	Zip Code:
Primary Contact:	Phone Number:	

Business/School Name:		
Address:		
City:	State:	Zip Code:
Primary Contact:	Phone Number:	

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Primary Contact:	Phone Number:	

Business/School Name:		
Address:		
City:	State:	Zip Code:
Primary Contact:	Phone Number:	

HAMILTON COUNTY PROJECT LIFESAVER EST 2009

Family & Caregiver Information

Name:		Relationship to client:
Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:

Name:		Relationship to client:
Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:

Name:		Relationship to client:
Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:

Name:		Relationship to client:
Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:

Name:		Relationship to client:
Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:

Additional Information

Photograph:
Please submit 2 (two) recent photographs of client. Client needs to be wearing any clothing and/or accessory items that the client typically has on. At least one of the photographs needs to be a headshot. Photographs will not be returned, but kept in client's file.

House Floorplan:
Please draw floorplan of client's primary residence on attached grid paper. Basic floorplan needs to include: where the client's bedroom is located in relation to other rooms of the house, any known hiding places for the client, any specific areas client spends a majority of their time, and any doors or windows that have additional locks or other security measures taken to prevent client from leaving. If you have original floorplan of residence from the builder, feel free to attach a copy of that instead with above items labeled.

I understand that by filling out this form it does not guarantee acceptance of the client into the program. I understand that information provided in this application packet will be provided to the Hamilton County Sheriff's Office, other appropriate emergency response agencies, and other agencies as deemed necessary in locating the client or to provide appropriate care/treatment to the client. Lastly, I acknowledge all information provided in this packet is true, accurate, and complete to the best of my knowledge.

_____ _____
Caregiver's Printed Name Date

_____ _____
Caregiver's Signature Relationship to Client

Project Lifesaver of Hamilton County Mission Statement
The mission of Project Lifesaver of Hamilton County, Inc. is to provide Project Lifesaver Transmitters to individuals with a diagnosed medical disorder that causes them to wander and provide qualified search and rescue teams to respond when a client wanders regardless of the clients race, religion, age or sex as long as the individual meets the predetermined requirements of the program and resides within Hamilton County, IN.

Please mail completed applications to:
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