RT AUTISM AWARENESS FOUNDATION, INC.

PROJECT LIFESAVER APPLICATION

General Instructions

Upon completion of this application, please print it out and U.S. Mail to; RT Autism Awareness Foundation, 329 Elton Hills Dr NW Rochester, MN. 55901

Upon receipt and review of this application, a member of the Rochester Police Department or Olmsted County Sheriff's Office, will make contact with you and arrange a time to meet with the applicant and their parents/caregivers to fit the Project Lifesaver Transmitter bracelet.

You will receive an invoice in the amount of $350.00 for the new application and first years' service, which will be monthly battery changes by the assigned police officer to the applicant. *Please be sure to clearly indicate who we should send the billing invoice in care of; i.e. Individual checks, Olmsted County Social Services, PossAbilities, etc.* Each month thereafter, your respected assigned police officer will make contact with you to change out the battery to assure it is a fresh battery. Parents/caregivers are also expected to test the battery each day to assure it is working. Each parent/caregiver will be given a batter tester and you will be shown how to test the applicant's battery each day.

Please also make available, a photo of the applicant. We ask that new photos be updated each fall of the applicant on the Project Lifesaver program to update our databank, so that in the invent a search is needed to find the applicant, that photo can be used to contribute in the search and assist the Project Lifesaver Team and other law enforcement agencies.

FOR FURTHER INFORMATION ON OLMSTED COUNTY PROJECT LIFESAVER, CONTACT:

James P Rechs – Executive Director
RT Autism Awareness Foundation, Inc.
329 Elton Hills Dr. NW
Rochester, MN 55901
Director@rtaaf.org
Telephone 507-226-7037

RT AUTISM AWARENESS FOUNDATION, INC.

PROJECT LIFESAVER ENROLLMENT APPLICATION

This application should be filled out by the **CAREGIVER** on behalf of the individual, i.e. "Applicant", who will be enrolled in the Project Lifesaver program.

We have divided the application into three sections – the first section requires information about you, [the **CAREGIVER],** the second section requires information about the individual being enrolled [the **APPLICANT]**, and the third section contains liability information and a release which we ask that you read carefully and sign.

As a reminder, all sections [minus those indicated otherwise], are to be filled out by the **CAREGIVER.**

APPLICANT'S NAME: _____
[Name of individual who this application is being made]

DATE TRANSMITTER PLACED IN SERVICE: _____

TRANSMITTER FREQUENCY #_____
[Section to be completed by Project Lifesaver Team Member]

SECTION 1: Caregiver Information

Caregiver's Name:	Relationship to Applicant:
Caregiver Address:	Caregiver's Email:
Caregiver's Home Phone:	Caregiver's Work Phone:
Caregiver's Cell Phone 1:	Secondary Cell Phone #:
Caregiver's Employer:	Employer Address:
Caregiver's Work Email:	Caregiver's Work Fax #:

SECTION 1 [CONTINUED]: FAMILY/MEMBER/CAREGIVER INFORMATION

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 telephone number of the individual who does and indicate his/her relationship to the Applicant:	**Yes**_____ **No**_____ **N/A**_____	
Name of Individual with Power of Attorney		
Address		
Home Telephone	Work Telephone	Cell Phone
Relationship to the Applicant		

SECONDARY EMERGENCY CONTACT INFORMATION		
Name:		
Relationship to Applicant:		
Address:		
Home Telephone	Work Telephone	Cell Phone
Home Email	Work Email	
Employer:		
Employer Address:		

INVOICE INFORMATION

Agency or Caregiver: _____
Contact Person: _____
Address: _____
City, State Zip Code: _____

SECTION II: APPLICANT INFORMATION

Full Legal Name:	Nickname:
Applicant's Address:	Year's/Months at this address:
Applicant's Employer:	Occupation:
Applicant's Employer Address:	Applicant's Employer's Telephone Number:
Applicant's Spouse's Name:	Living _____ Deceased_____
Applicant's Specific Diagnosis	Date of Diagnosis

List any medications taken regularly, using the correct name and dosage as well as prescribing person:

Consequences of NOT taking medications – Describe:

DIAGNOSING PHYSICIAN INFORMATION

Physician Name	Medical Facility
Telephone	Email
Physician Address, City, State	

Please describe any other health-related problems the Applicant has [attach additional pages if necessary]:

APPLICANT PHYSICAL MAKE-UP

Date of Birth:	Current Age:	Sex: Male_____ Female_____	
Height: _____FT _____In	Weight _____lbs.	Hair Color	Hair Style
Build:	Eye Color:	Complexion:	False Teeth ___Y___N
Facial Hair: ____Beard	____Sideburns	____Mustache	____Goatee ____None
Facial Shape: ____Round	____Oval	____Square	____Other
Other distinguishing physical characteristics [i.e. Tattoos, Birthmarks, Marks, Scars, etc.];			

SECTION II: APPLICATION INFORMATION CONTINUED:

Language:	Spoken Only: ____Y ____N	Written & Spoken ___Y ___N
Glasses ____Y ____N	Contacts ____Y ____N	Sunglasses ___Y ___N
If any of the above are worn, what style:		
What degree of vision does the applicant have without corrective lenses: ___None ___Poor ___Fair		
Hearing Aid: ____Y ____N	What Style:	
What degree of hearing does the applicant have without the hearing aids: ___None ___Poor ___Fair		
APPLICANT EXPERIENCE		
Is the applicant familiar with the area ____Y ____N	Length of time in the area ____Years ____Months ____Days	
If not local, what other areas are known to the applicant?		
Military Experience ____Y ____N	Where	When
Is there any past history of the Applicant becoming lost or wandering from home? ___Y ___N		
If "Yes," please describe where the applicant was found:		
If "Yes," please describe the event[s] in detail with dates [attach additional pages if necessary]:		
Does the applicant ever go out alone ____Y ____N	Does the applicant stay on trails or roadways ____Y ____N	
Is the Applicant drawn to water ____Y ____N	Does the Applicant know how to swim ____Y ____N	
APPLICANT FAMILY AND FRIENDS [Other people we may contact in an Emergency]		
Name & Relationship	Address	Telephone #'s Home Work Cell
Name & Relationship	Address	Telephone #'s Home Work Cell
Name & Relationship	Address	Telephone #'s Home Work Cell

SECTION II [CONTINUED]: PERSONAL ARTICLES CARRIED BY APPLICANT

Tobacco: ____Y ____N	Type:	Brand:
Matches: ____Y ____N	Lighter: ____Y ____N	Type:
Candy or Gum: ____Y ____N	Brand:	
Food items often carried:		
Other items Applicant may carry:		
Does the applicant carry cash ____Y ____N	Wallet ____Y ____N	Purse ____Y ____N
Please describe any jewelry, watches, etc. worn by the applicant [including piercings];		
APPLICANT'S PERSONAL HABITS		
Smoke ____Y ____N	Drink ____Y ____N	Brand of Alcohol/If Any
Use of illicit drugs ____Y ____N	Type	
Hobbies/Interest		
Outgoing ____Y ____N	Quiet ____Y ____N	Likes Groups ____Y ____N	Being Alone ____Y ____N
Religious ____Y ____N	What religion	What Church
Is the Applicant Afraid of the following; ___Water ___People ____Dogs ____Dark ____Other [Describe]		
What action does the applicant take when hurt or injured [cries; shout, strong pain tolerance, etc.]		
Will the Applicant talk to strangers ____Y ____N ____Non-Verbal	Is Applicant dangerous to themselves or others ____Y ____N	

SECTION II [CONTINUED]: PLEASE ANSWER THE FOLLOWING QUESTIONS

Does the Applicant remain orientated with time: ____Y ____N
Please explain:
Does the applicant recognize familiar people and faces: ____Y ____N
Please explain:
Does the Applicant travel to familiar locations: ____Y ____N
Please explain:
Does the Applicant have decreased knowledge of current events or tend to relive events in his/her life: ____Y ____N
Please explain:
Does the Applicant sometimes cloth himself/herself improperly: ____Y ____N
Please explain:
Does the Applicant remember their name or the names of their spouse/relatives: ____Y ____N
Please explain:
Does the Applicant suffer from frequent personality/emotional changes: ____Y ____N
Please explain:
Does the Applicant suffer from delusions of any sort: ____Y ____N
Please explain:
Will the Applicant be afraid of any Emergency Lights/Sirens/Equipment: ____Y ____N
Please explain:
Does the Applicant have any sensory issues: ____Y ____N
Please explain:

How good is the Applicant's communication ability: _____None _____Poor _____Fair _____Good _____Excellent
How does the Applicant communicate: _____Verbal _____iPad _____Pictures _____Sign Language _____Other [please explain

SECTION III: LIABILITY INFORMATION AND RELEASE

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

I acknowledge that the information, I, the **Caregiver,** have provided in this application is true and accurate to the best of my knowledge.

I understand that acceptance into the Project Lifesaver Program does not replace the need for constant supervised care of the Applicant.

I understand that while Project Lifesaver utilizes electronic tracking technology that aids in locating individuals who wear the bracelet device, there may be times or circumstances when an individual cannot be located due to device malfunction or any other reason. I also agree to assume any/all responsibilities associated with the program participation and on-going unit maintenance.

I understand that all information I have provided in this application will be shared among the RT Autism Awareness Foundation, Inc., the Olmsted County Sheriff's Office, the Rochester Police Department, and other appropriate agencies, as well as the police department where the Applicant resides; and I understand that none of the information I have provided or provide in the future can be considered confidential or protected.

"Indemnified Person" means and includes each of the Olmsted County Sheriff's Office, Rochester Police Department, or any other participating governmental agencies, RT Autism Awareness Foundation, Inc., or any other participating organization and each of their respective directors, officers, employees, volunteers and agents.

I understand that Project Lifesaver is a program co-sponsored by RT Autism Awareness Foundation, Inc., Olmsted County Sheriff's Office and Rochester Police Department, which may work in collaboration with other private organizations and county agencies from time to time. Any of the co-sponsors can cancel its participation in the program at any time and for any reason. Accordingly, there is no guarantee of the long-term viability of the program; provided, however that RT Autism Awareness Foundation, Inc., the Olmsted County Sheriff's Office/Rochester Police Department is to give a one [1] year prior notice if it intends to terminate its participation in the program [the "One Year Notice Requirement"], unless the program does not receive sufficient funding, in which case the One Year Notice Requirement would not apply.

I understand that Project Lifesaver is a program sponsored by RT Autism Awareness Foundation, Inc., which works in collaboration with other area agencies; and should the Applicant be accepted into the Project Lifesaver Program, he/she agrees to release and hold each agency and all their respective personnel, directors, 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.

I understand that an initial fee of $350 applies to the purchase of the Project Lifesaver bracelet.

I understand that an annual maintenance fee of $150 applies for battery replacement and a member of the Olmsted County Sheriff's Office/Rochester Police Department Project Lifesaver Team must replace the battery each month during a set appointment.

I hereby represent and warrant that I have full power and authority as the duty authorized representative and **CAREGIVER** of the Applicant named in this application, to register and act on his/her behalf.

Caregiver's Printed Name:	
Caregiver Signature:	Date:
Project Lifesaver Representative:	Date