Project Lifesaver Application

General Instructions

The Rochester Police Department/ Olmsted County Project Lifesaver Program is a joint program designed for the most vulnerable of our population who suffer from a cognitive disability who have a history of wandering. Wandering is a tendency for an individual to leave the safety of a responsible person's care or safe area and is not to be confused with intentionally running away due to anger or problem behaviors. The intended population for the program are people who have been diagnosed with Autism, Alzheimer's, Down Syndrome, Traumatic Brain Injury, and other Dementia related disorders.

Project Lifesaver is designed to be a worst case scenario option for when a person wanders off while under supervision. Caregivers must understand and agree that the locating technology used is not intended to take the place of responsible child care or caregiver practice. The wrist transmitter worn by the client remains property of the Rochester / Olmsted County Project Lifesaver Program. If at some point the client is no longer in need of the program or unable to remain part of the program, the transmitter will be returned so it can be utilized by another participant.

Please see below for program requirements. If approved, you will receive a follow up application requesting information, including detailed caregiver contact information, secondary contacts, further detailed description of the applicant, and billing information. The initial fee for the program is $375 which applies to the purchase of the Project Lifesaver transmitter. There is an annual maintenance fee of $150 which applies to the battery and band replacements made throughout the year. Transmitter lifespans are approximately 5 years and due to this, every 5 years, the plan will be to replace the transmitter-at a cost of $375.

Upon Completion of this application, please print it out and mail it to: RT Autism Awareness Foundation at 1130 7th St. NW Suite 208 Rochester, MN 55901.

The transmitter may be paid for by grant or waiver. If needed, please contact RTAAF for scholarship information.

General Client Requirements for Project Lifesaver:

- Lives within the City of Rochester or Olmsted County
- Diagnosed with a cognitive impairment or related diagnosis
- Willing to wear a wristband (on the wrist or ankle) at all time
- Has a history of wandering
- Has 24/7 supervision and isn't allowed to live alone or be left home alone without supervision.
- Willing to allow an officer/deputy to visit to change the transmitter battery every 30-60 days.

Caregiver information

Name:_____Relationship to Applicant:_____

Address:_____

Phone:_____

Email:_____

Client Information

Name: _____DOB: _____

Address: _____

Years lived at this address: _____

Medical Diagnosis (If more than one please list all which are applicable):

_____

_____

_____

Is the person verbal? Y ☐ N ☐ If yes, what language do they speak? _____

If limited speech, describe: _____

Is the person drawn to water? Y ☐ N ☐ Can the person swim? Y ☐ N ☐

Is the person able to dress themselves? Y ☐ N ☐

Does the person have physical disabilities? Y ☐ N☐ If yes, describe _____

_____

_____

Does the person have additional medical issues? Y ☐ N ☐ If yes, describe _____

_____

_____

Does the person attend any type of day programming? Y ☐ N ☐ If yes, describe

_____

Does the applicant have a social worker? Y ☐ N ☐ If yes, please fill the following:

Social worker name: _____ Social worker County: _____

Phone #: _____Email: _____

History of Wandering: Please describe each wandering episode on the following page(s):			
Date of Episode 1:		Time of Episode 1:	
Where did they wander from (home, school, community event, etc.)?			
Where were they found?			
How long were they missing?			
How were they found?			
Were there extreme weather conditions such as high or low temperatures, severe thunderstorms, snow storms?			
Were the police called to assist? YES ☐ No ☐			

Date of Episode 2:		Time of Episode 2:	
Where did they wander from (home, school, community event, etc.)?			
Where were they found?			

How long were they missing?
How were they found?
Were there extreme weather conditions such as high or low temperatures, severe thunderstorms, snow storms?
Were the police called to assist? YES ☐ No ☐

Date of Episode 3:		Time of Episode 3:	
Where did they wander from (home, school, community event, etc.)?			
Where were they found?			
How long were they missing?			
How were they found?			
Were there extreme weather conditions such as high or low temperatures, severe thunderstorms, snow storms?			
Were the police called to assist? YES ☐ No ☐			
Any additional Comments:			

This release authorizes the exchange of information between **RT Autism Awareness Foundation** and the **Olmsted County Sheriff's Office**, **Rochester Police Department**, and **Olmsted and Wabasha County** for the purpose of participating in and ensuring the effective operation of the **Project Lifesaver** program.

I, the undersigned, hereby authorize RT Autism Awareness Foundation to exchange information as specified below for the purpose of participation in the Project Lifesaver program:

Description of Information to Be Released:

- Autism or Medical Diagnosis (e.g., clinical diagnosis, healthcare reports)
- Behavioral Information (e.g., behavioral assessments, intervention strategies)
- Medical Information (e.g., health conditions, medication information)
- Emergency Contact Information (e.g., family members, caregivers)
- Billing Information and fiscal management party for grant and waivers
- Other (please specify): _____

Purpose of Release of Information:

The information will be used specifically for participation in Project Lifesaver. The information may also be used to coordinate services with first responders and other organizations involved in the safety and well-being of the participant.

- For participation in Project Lifesaver
- To provide emergency responders with necessary details
- To coordinate safety measures and support services
- Initial and Annual Billing for Project Lifesaver
- Other (please specify): _____

Parties Involved in Information Exchange:

- **RT Autism Awareness Foundation**
  Address:1130 1/2 7th St NW, Suite 208, Rochester, MN 55901
- **Olmsted County Sheriff's Office**
  Address: 101 4th St SE, Rochester, MN 55904
- **Rochester Police Department**
  Address:4001 West River Parkway NW, Suite 200. **Rochester**, MN 55901.
- **Olmsted County**
  Address: 2100 Campus Drive SE, Rochester, MN 55904

Expiration of Authorization:

This authorization is valid for the duration of the participant's enrollment in the Project Lifesaver program, or until the following date: _____. If no date is specified, this authorization will remain valid for the duration of use of the Project Lifesaver.

Right to Revoke:

I understand that I have the right to revoke this authorization at any time by submitting a written request to **RT Autism Awareness Foundation**. The revocation will not affect any actions taken

prior to the revocation.

Privacy and Confidentiality:

I understand that the information disclosed as a result of this authorization may no longer be protected by confidentiality provisions under applicable law. However, the recipient is bound by their own privacy and confidentiality policies to safeguard this information and use it solely for the purposes outlined in this release. **Olmsted County Sheriff's Office**, **Rochester Police Department**, and **Olmsted and Wabasha County** are bound by these policies.

Acknowledgment and Consent:

I acknowledge that I am voluntarily signing this form and that my refusal to sign it will not affect my eligibility to participate in the **Project Lifesaver** program or my eligibility for services provided by **RT Autism Awareness Foundation**. I certify that the information provided is accurate and consent to the exchange of information as outlined above with the **Olmsted County Sheriff's Office**, **Rochester Police Department**, and **Olmsted and Wabasha County** for the purposes of the **Project Lifesaver** program.

Client/Participant Signature:

Signature: _____
Date: _____
If the client/participant is unable to sign, the following information is required:

Authorized Representative's Name: _____

Relationship to Client/Participant: _____
Authorized Representative's Signature: _____
Date: _____