Vilas County Project Lifesaver Program Application

Vilas County Sheriff's Department: 715 479 4441
Vilas County Emergency Management: 715 479 3690

APPLICANT INFORMATION: (Individual who has Alzheimer's disease, Autism, or related disease)

FULL LEGAL NAME:	**NICKNAME:**

What is Applicant's specific diagnosis?

When was the Applicant diagnosed?

D.O.B.	**CURRENT AGE:**	**HEIGHT:**	**WEIGHT:**	**EYE COLOR:**	**HAIR COLOR**

Describe any other distinguishing physical characteristics:

How long has this individual been living at this address?

MEDICAL INFORMATION

Is there any prior history of applicant becoming lost or wandering from Home? If yes, please describe the event (s) in detail with dates. (attach additional paper if needed):

Please list the name, address and phone number of the physician who diagnosed the Applicant:	**Describe any other health related problems of applicant:**

FAMILY/CAREGIVER INFORMATION

Are you the Parent of, or Guardian of or do you have durable power of attorney for health care that has been activated for the Individual you are seeking to enroll in Project Lifesaver? **YES:** **NO:**

NAME:	RELATIONSHIP TO APPLICANT:

HOME ADDRESS:	HOME PHONE #:	CELL PHONE #:

FAX #:	EMAIL ADDRESS:	EMPLOYER:

EMPLOYER ADDRESS:	WORK PHONE#:	WORK EMAIL ADDRESS:

ADDITIONAL EMERGENCY CONTACT INFORAMTION

NAME:	RELATIONSHIP TO APPLICANT:

HOME ADDRESS:	HOME PHONE #:	CELL PHONE #:

FAX #:	EMAIL ADDRESS:	EMPLOYER:

EMPLOYER ADDRESS:	WORK PHONE#:	WORK EMAIL ADDRESS:

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

A physician's supporting signature is required for acceptance into the Project Lifesaver Program. If you are unable to get your physician's signature before submitting this application, you may submit this application and provide your physician's signature within 60 days of application submittal. Failure to submit the physician's supporting signature within 60 days of the filing of the application will result in the application being rejected.

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

Please fax or mail this application form and the Liability Release to either of the following offices. After receiving this application, we will contact you to set up an appointment with the appropriate selection committee.

Vilas County Sheriff's Department
Patrick Schmidt, Chief Deputy
330 Court Street
Eagle River, WI 54521
715 479 4441 (phone)
715 479 6039 (fax)

Vilas County Emergency Management
Sherri Congleton, Director
330 Court Street
Eagle River, WI 54521
715 479 3690 (phone)
715 479 6039 (fax)

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Liability Release

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

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

I UNDERSTAND that should the Applicant be accepted into Vilas County Project Lifesaver, it does not replace the need for others to continue to provide constant supervised care of the Applicant.

I AGREE to assume all responsibilities associated with program participation and ongoing bracelet device maintenance as stated to me in the program contract.

I UNDERSTAND that while Vilas County Project Lifesaver utilizes a global tracking device that aids in locating individuals who wear a bracelet device, there may be times and circumstances when an individual cannot be located due to reasons including but not limited to device malfunction.

I UNDERSTAND that all information I have provided in this application will be shared between the Vilas County Sheriff's Department, and other appropriate agencies, as well as the emergency response agencies in the town where the Applicant resides, and I understand that none of the information I have provided or may provide in the future can be considered confidential or protected.

I UNDERSTAND that Vilas County Project Lifesaver is a program sponsored by the Vilas County Sheriff's Department and that the Vilas County Sheriff's Department will work in collaboration with other area agencies. **SHOULD THE APPLICANT BE ACCEPTED INTO THE VILAS COUNTY PROJECT LIFESAVER PROGRAM, THE APPLICANT AND CAREGIVER AND ALL HIS/HER AGENTS AGREE TO RELEASE AND HOLD EACH AGENCY AND ALL THEIR RESPECTIVE PERSONNEL, DIRECTORS AND VOLUNTEERS HARMLESS FROM ANY AND ALL CLAIMS OR LIABILITY AND/OR DAMAGE, AND WAIVE ANY AND ALL RIGHTS TO SEEK RECOURSE FOR ANY LOSS OR INJURY THAT MAY OCCUR AS A RESULT OF PARTICIPATION IN THE VILAS COUNTY PROJECT LIFESAVER PROGRAM**.

THIS AGREEMENT IS BINDING UPON THE APPLICANT'S HEIRS, EXECUTORS, ADMINISTRATORS, ASSIGNS, AND CAREGIVERS.

I HAVE READ THE VILAS COUNTY PROJECT LIFESAVER CLIENT CONTRACT AND AGREE TO ALL TERMS SET FORTH THERIN. FURTHERMORE, I HEREBY REPRESENT AND WARRANT THAT I HAVE FULL POWER AND AUTHORITY AS THE DULY AUTHORIZED REPRESENTATIVE OF THE APPLICANT NAMED ABOVE, TO REGISTER AND ACT ON HIS/HER BEHALF.

I have attached a copy of applicable Letters of Guardianship or Power of Attorney document.

____

Name

____

Signature   Date