PASSAIC COUNTY SHERIFF'S OFFICE

SHERIFF RICHARD H. BERDNIK

Community Policing Division
435 Hamburg Turnpike
Wayne, NJ 07470
(973) 389-5920
FAX: (973) 389-5948

ID #: _______________

WANDERING PROGRAM

ENROLLEMENT APPLICATION

Client Name: ______________________________

Nickname(s): ______________________________

Address: ______________________________

City: ______________________________ Zip Code: ______________

Home Phone: ______________________ Cell Phone: ______________________

Length of time residing at above address: ______________________________

Former Address(es) of Client: ______________________________

____

CLIENT DESCRIPTION

Date of Birth: ______________________ Current Age: __________ Sex: ☐ Male ☐ Female

Height: __________ft. __________in. Weight: ________________ Build: ________________

Hair Color: ________________ Hair Style: ________________ Eye Color: ________________

Race: ______________________ Complexion: ______________________

Distinguishing scars, marks, tattoos (describe): ______________________________

____

Is the Client a Veteran? ☐ Yes ☐ No

If the client does not understand English, indicate what language is understood: ________________

Glasses: ☐ Yes ☐ No Hearing Aid(s): ☐ Yes ☐ No Mobility Aids: ☐ Cane ☐ Walker

Does Client go out alone: ☐ Yes ☐ No Explain if "Yes": ______________________

CLIENT HEALTH

Diagnosis: ____ Diagnosed when: ________________________

Additional known medical issues: ____

____

Known psychological issues: ____

____

Known physical handicaps: ____

____

Medications (name, dosage and frequency): ____

____

Attending Physician: ______________________________ Phone Number: _________________________

WANDERING/ELOPEMENT HISTORY

Prior history of wandering: ☐ Yes ☐ No If "Yes", explain- including dates, locations and outcomes:

____

____

CLIENT HABITS/PERSONALITY

Uses tobacco products: ☐ Yes ☐ No Carries matches: ☐ Yes ☐ No Carries lighter: ☐ Yes ☐ No

Uses alcohol: ☐ Yes ☐ No If "Yes," type and frequency: ____________________________________

Carries cash: ☐ Yes ☐ No If "Yes," amount and where carried: _______________________________

Interests/hobbies: ____

☐ Outgoing or ☐ Quiet Talks to strangers: ☐ Yes ☐ No Danger to Self or Others: ☐ Yes ☐ No

Client's fears (dogs, cats, people, noises, darkness, etc.): ____

Client's actions when hurt or frightened (cry, shout, hide, etc.): _____________________________________

____

Client has access to a vehicle: ☐ Yes ☐ No If "Yes," plate number of vehicle(s): ____________________

INDIVIDUALS CLIENT MAY CONTACT IF LOST/WANDERING

Name: ____ Relationship to Client: __________________________

Address: ___________________________________ Cell: ____________________

Name: ____ Relationship to Client: __________________________

Address: ___________________________________ Cell: ____________________

Name: ____ Relationship to Client: __________________________

Address: ___________________________________Cell: _____________________

CAREGIVER(S)

Name: ____ Relationship to Client: __________________________

Address: ____

Home Phone: __________________ Cell Phone: _______________ E-mail: ____________________________

Employer Name: ____

Employer Address: ____

Work Phone: _________________________________ E-mail: ____

Name: ____ Relationship to Client: __________________________

Address: ____

Home Phone: __________________ Cell Phone: _______________ E-mail: ____________________________

Employer Name: ____

Employer Address: ____

Work Phone: _________________________________ E-mail: ____

SCHOOL/MANAGED CARE FACILITY

Facility/School Name: ____

Address: ____

Contact Person: __________________________ Phone: ___________________ Fax: ______________________

POWER OF ATTORNEY

Complete if an individual has power of attorney for the client. Enclose a copy of the power of attorney with the application.

Name: ____ Relationship to Client: _____________________________

Address: ____

Home Phone: ______________________ Cell Phone: _________________ E-mail: _____________________________

LIABILITY INFORMATION/RELEASE

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

I, (caregiver name) ____, acknowledge that the information I have provided in this application is true and accurate. I understand that acceptance into the Passaic County Sheriff's Office Project Lifesaver Program **does not replace the need for constant supervised care of the client**.

(A) I, (caregiver name) ___________________________ attest that (client name) ____________________________ is personally supervised by me and/or by another **responsible adult, 24 hours a day, 7 days a week**.

(B) I, (caregiver name) ___________________________ attest that (client name) ____________________________ **is not left unsupervised at any time**.

If both statements (A) and (B) above are NOT TRUE, the potential client is ineligible for enrollment in the Wandering Program. If any portion of the caregiver(s) responses are inaccurate, the client will no longer be eligible for participation in the Wandering Program.

I understand that while AngelSense utilizes a GPS technology that aids in locating individuals who wear the device, there may be times when an individual cannot be located due to device malfunction or other unforeseen circumstances. I agree to assume any/all responsibility associated with participation in the Passaic County Sheriff's Office Wandering Program.

I understand that the information I have provided in this application will be shared within the Passaic County Sheriff's Office and with other search and rescue agencies/organizations. I understand that none of the information I have provided, or will provide in the future, will be considered confidential or protected.

I also understand that the Wandering Program is sponsored by the Passaic County Sheriff's Office and works in collaboration with other area agencies. Should the client be accepted into the Wandering Program, he/she agrees to release and hold the County of Passaic, the Passaic County Sheriff's Office and each agency and their respective personnel harmless for 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 their participation in the Passaic County Sheriff's Office Wandering Program.

I have read the Project Lifesaver "Fact Sheet" and agree to its terms and conditions. I represent the client and proclaim that I have full power and authority as the duly authorized representative of the applicant to register and act on his/her behalf.

Print Caregiver Name: ____

Caregiver Signature: ____ Date: __________________________