



## **PROJECT LIFESAVER & Clarkstown Police Dept Enrollment Application/ Client Profile**

This **Project Lifesaver** application is designed for Custodial Caregivers. By submitting this application, you will be considered for participation in the **Project Lifesaver Program**.

This application should be filled out by a **FAMILY, FRIEND, CAREGIVER or GUARDIAN** on behalf of the client, who will be enrolled in the **Project Lifesaver Program**. You may be sent additional materials to complete.

### **Client's**

**Name:** \_\_\_\_\_  
(Name of individual for whom this application is being made)

Client's Diagnosis: \_\_\_\_\_

Transmitter Frequency: \_\_\_\_\_ Tests at: \_\_\_\_\_

Date Transmitter Placed: \_\_\_\_\_

Unit Member completing form: \_\_\_\_\_

**Client's Photo:**  
(Attach at right)

**attach photo(s) here**  
(Any size will do)

**CLIENT DATA**

Client

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
\_\_\_\_\_

How long has the client been living at this address? \_\_\_\_\_

Client's Former Addresses:

\_\_\_\_\_  
\_\_\_\_\_

**CLIENT DESCRIPTION**

Date of Birth: \_\_\_\_\_ Current Age: \_\_\_\_\_ Gender: M \_\_\_ F \_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Build: \_\_\_\_\_ Race: \_\_\_\_\_

Hair Color: \_\_\_\_\_ Hair Style: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Complexion: (circle):            Fair            Medium            Dark

Does the client wear:            Glasses            Contacts            Hearing Aids

If "Yes," are they worn full-time?

Explain \_\_\_\_\_

**Circle** all that apply: Beard Moustache Bald Wig Cane Walker Limp

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

Other distinguishing physical characteristics (birth mark, mole, scar, tattoo, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the client's primary language English? Yes No

If "No," what language? \_\_\_\_\_

**CLIENT INFORMATION**

Client's verbal/non-verbal skills (circle): None   Poor   Fair   Good

Explain: \_\_\_\_\_  
\_\_\_\_\_

If verbal, can the client communicate his/her name, address phone number, etc?

Yes   No

Explain: \_\_\_\_\_  
\_\_\_\_\_

Does the client use an augmentative communication device?   Yes   No

If "Yes," what device, and how proficient is the client in communicating with others?

Explain: \_\_\_\_\_  
\_\_\_\_\_

Client's likes, dislikes and pre-occupations: \_\_\_\_\_  
\_\_\_\_\_

List articles/items normally carried by client: \_\_\_\_\_  
\_\_\_\_\_

Is the client familiar with the area?   Yes   No   How recent (months/years): \_\_\_\_\_

If "No," what area(s) are known/familiar to the client? \_\_\_\_\_  
\_\_\_\_\_

**MEDICAL/PSYCHOLOGICAL INFORMATION**

Does the client have any known medical problems?   Yes   No

Explain \_\_\_\_\_  
\_\_\_\_\_

Does the client have any known psychological problems?   Yes   No

Explain \_\_\_\_\_  
\_\_\_\_\_

(Attach additional pages if necessary).

Current Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Attach additional pages if necessary).

Client's Physician: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
\_\_\_\_\_

### **WANDERING HISTORY**

Is there any prior history of the client becoming "lost or wandering?" Yes No

If "Yes," describe the event(s) in detail with dates. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Location found: \_\_\_\_\_

By whom: \_\_\_\_\_

Actions taken: \_\_\_\_\_

(Attach additional pages if necessary).

Were law enforcement authorities notified or involved? Yes No

Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Attach additional pages if necessary).

### **HABITS/PERSONALITY**

Does the client smoke? Yes No Comments: \_\_\_\_\_

Does the client use alcohol? Yes No How often/type? \_\_\_\_\_

Does the client use (illicit) drugs? Yes No Type? \_\_\_\_\_

Does the client have access to any weapons (guns etc...) \_\_\_\_\_

Does the client have fears (dogs, cats, people, noises darkness, etc.)? \_\_\_\_\_

Will the client talk to strangers? \_\_\_\_\_

Is the client a danger to self or others? \_\_\_\_\_

List client's hobbies/interests: \_\_\_\_\_

Is there any additional information you would like to provide regarding the client?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Attach additional pages if necessary).

**FAMILY/FRIEND/CAREGIVER INFORMATION**

Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Address: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

\_\_\_\_\_ Cell Phone: \_\_\_\_\_

\_\_\_\_\_ Work Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Fax: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Unit Member**

\_\_\_\_\_  
**Date**