



# **PROJECT LIFESAVER**

of

# **ISANTI COUNTY**

## **STANDARD OPERATING PROCEDURE**



## **I. ENROLLMENT**

Transmitters will be placed with clients only at the request of a legally responsible party, ie:

1. Spouse
2. Family member having legal, primary caregiver responsibility.
3. Assisted living or nursing home administrator requiring transmitter for client to reside at the facility.
4. Father or Mother, if client is a minor.

In the event there is no spouse, and there is disagreement on placement, no placement will be done until requested by the family member having legal authority via power of attorney, or court order naming him/her as the responsible caregiver. This will apply in the case of minors with no parent available.

Caregivers will be provided with instructions and emergency contact phone numbers.

Caregivers will be provided with a tester and given instructions on its use and proper procedures to test the transmitter daily; and record the results on the monthly inspection sheet.

The caregivers will be given a contract, and the terms and agreements will be explained. The contract must be signed and filed at the Isanti County Sheriff's Office.

## **II. SERVICING**

- 1. All transmitter batteries and bands are to be changed every 30 days, or 60 days depending on the type of transmitter used (or if caregiver notifies agency of a dead battery). They will be replaced by a new battery and band, by either:
  - a. an agency member, or**
  - b. a volunteer, trained and supervised by an agency member.****
- 2. The caregiver will be contacted 3-4 days prior to the anticipated battery and band change date to arrange date and time for the change to occur.
  - a. If unable to contact caregiver, a message will be left requesting a call back.**
  - b. If no contact is made within 4 days past the anticipated change date, member will notify the agency program liaison officer.****
- 3. Completed Monthly Inspection sheets will be collected and a new sheet given to the caregiver. The completed Monthly Inspection sheet is to be turned in to the agency program liaison officer within 3 business days of the service visit.**
- 4. The transmitter will be inspected visually and the frequency will be verified during each service visit.**

# CAREGIVER INSTRUCTIONS

## Emergency Phone: **911**

1. Check the transmitter everyday with the tester provided. If a problem exists or the transmitter isn't indicating transmission (no pulsing or steady burning red light), notify the Agency Liaison Officer as soon as possible, at the number below. Sign and date the tester sheet.
2. If the Client is missing, notify the Isanti County Sheriff's Office at 911 to report a missing person. Specify that the missing person is a Project Lifesaver client.
3. If you are not at home, give the correct telephone number where you can be reached.

### Non-Emergency Contact Numbers:

Sgt. Lisa Lovering  
Isanti County Sheriff's Office  
509 18<sup>th</sup> Ave SW  
Cambridge, MN 55008  
(763)689-2141 Dispatch  
(763)691-2416 Direct  
(763)689-3691 Fax

[Lisa.lovering@sheriff.co.isanti.mn.us](mailto:Lisa.lovering@sheriff.co.isanti.mn.us)



# PROJECT LIFESAVER of ISANTI COUNTY



## Program Contract

**If applicant is accepted into the Project Lifesaver Program, the following terms shall apply upon signing of the Project Lifesaver contract:**

I acknowledge that the information I have provided is true and accurate to the best of my knowledge. All information provided has been given voluntarily. I consent to the collection, use and disclosure of such information for the purposes of Project Lifesaver. Furthermore, I hereby represent and warrant that I have full power and authority as the duly authorized representative of the Applicant named below, to register and act on his/her behalf. A Power of Attorney and/or letters of Guardianship are attached, if necessary.

**THEREFORE, IN CONSIDERATION** of the mutual promises and obligations contained herein, the sufficiency of which is acknowledged, the parties agree as follows, each to their respective obligations:

1. I understand that when I enroll an Applicant in Project Lifesaver, that it does not replace the need for constant supervised care of the person. I am, and remain, primarily responsible for supervised care, and take full responsibility for protecting this person from wandering. I also understand that I, or a family member, must be present in the home with the Applicant at all times.
2. I understand that Project Lifesaver equipment is designed to be an additional aid to help locate a missing person and that there is no warranty, representation or guarantee that a person will be found because they are wearing a Project Lifesaver bracelet. Project Lifesaver equipment is designed to provide Law Enforcement personnel with an additional technology in attempting to locate the Applicant. I also acknowledge that this is an experimental program for aiding in the search and rescue of persons suffering from diminished mental capacity or other disability.
3. In order for Project Lifesaver to work, I have a responsibility to obey the instructions of the Program, follow all training, and make certain that the person that I enroll is wearing the Project Lifesaver transmitter bracelet. If the bracelet has been removed or is defective, I will call Project Lifesaver of Isanti County immediately.
4. When I notice that the enrolled Applicant has wandered off, I must immediately call the emergency number supplied by Project Lifesaver and report the Applicant as a missing person. Project Lifesaver teams will respond to search. I understand and acknowledge that the Project Lifesaver device cannot predict or report that the Applicant has wandered off. It is solely as an aid for emergency personnel when notified that the Applicant is missing.

5. A maintenance fee of \$10.00 shall be payable at the time of service. Payment shall be made by check or cash.
6. I understand that while Project Lifesaver is an electronic tracking device that assists in locating person who wear the bracelet device, there may be unforeseen times or circumstances when individuals cannot be located, even while wearing the transmitter bracelet. I will not hold Project Lifesaver, or any of its employees or volunteers, County or city Law Enforcement, Fire and Rescue Agencies (collectively the "Releases") involved liable for failure to locate the person using the system. I hereby release all such Releases from any claim, cause of action, loss or damages arising from any inability or delay in locating the Applicant.
7. I understand that all information I have provided in this application may be shared amongst local Law Enforcement, Fire and Rescue, and other necessary agencies in the community where I reside. Therefore, I understand that none of the information I have provided (or will provide in the future) can be considered confidential, protected, or private, when used for the purposes of the Project Lifesaver Program (notwithstanding the provisions of the Personal Information Protection and Electronic Documents Act).
8. I specifically waive any rights to confidentiality of the Applicant's medical records by Project Lifesaver International, or any of Project Lifesaver's member agencies, which include dissemination of such information. I confirm that I have the authority by which to waive such rights.
9. I understand that Project Lifesaver is a program administered by: The Isanti County Sheriff's Office. I agree to release and hold each agency and all of their respective personnel, officers and volunteers harmless from any and all claims of liability and/or damage. I 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.
10. I understand that the transmitter and tester remain the property of Project Lifesaver, and when no longer being used by the Applicant to whom it was assigned, will be returned undamaged to Project Lifesaver to be assigned to another participant in the Program. I shall remain liable for any loss or damage to all such equipment, and for the replacement cost of all such equipment until returned to Project Lifesaver.
11. I understand that if I fail to use the tester device at least once per day and record the results on the supplied test result monthly inspection sheet; or if I fail to notify Project Lifesaver immediately when I discover the Applicant missing; or if I fail to notify Project Lifesaver if I test the transmitter device and find no signal indication; or if the Applicant refuses to wear or removes the device 3 (three) times, then the Applicant may be removed from the Program. All property will then be returned to Project Lifesaver. I will return to the original security measures which were in place prior to enrollment in Project Lifesaver, and without recourse to Project Lifesaver.

\_\_\_\_\_  
 CAREGIVERS NAME (PLEASE PRINT)

\_\_\_\_\_  
 CAREGIVERS SIGNATURE

\_\_\_\_\_  
 APPLICANT'S NAME

\_\_\_\_\_  
 WITNESS

\_\_\_\_\_  
 PROJECT LIFESAVER REPRESENTATIVE

\_\_\_\_\_  
 DATE



# PROJECT LIFESAVER of ISANTI COUNTY Program Application

Phone: (763) 689-2141

Applicant's Name: (Name of Individual for whom this application is being made)

## FAMILY/CAREGIVER INFORMATION

NAME:

RELATIONSHIP TO APPLICANT:

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

If not, please provide the name, address and phone number of who is, and their relationship to the Alzheimer's Individual, Autistic Person or person with other related disease.

HOME ADDRESS:

HOME PHONE #:

CELL PHONE #:

FAX#:

EMAIL ADDRESS:

EMPLOYER:

EMPLOYER ADDRESS:

WORK PHONE#:

WORK EMAIL ADDRESS:

## ADDITIONAL EMERGENCY CONTACT INFORMATION

NAME:

RELATIONSHIP TO APPLICANT:

HOME ADDRESS:

HOME PHONE #:

CELL PHONE #:

FAX#:

EMAIL ADDRESS:

EMPLOYER:

EMPLOYER ADDRESS:

WORK PHONE#:

WORK EMAIL ADDRESS:

## 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 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:

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.

\_\_\_\_\_  
Physician Name (printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

Please fax or mail this application form to the Sheriff's Office. After receiving this application, we will be in contact with you to set up an appointment.

Isanti County Sheriff's Office  
Project Lifesaver Program  
509 18<sup>th</sup> Ave SW  
Cambridge, MN 55008  
763-689-2141 (phone)  
763-689-3691 (fax)



# PROJECT LIFESAVER of ISANTI COUNTY

## Liability Release Information:

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 Project Lifesaver, that it does not replace the need for others to continue to provide constant supervised care for the Applicant.

I AGREE to assume all responsibilities associated with program participation, and ongoing bracelet device maintenance.

I UNDERSTAND that while 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 device malfunction or other reasons.

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

I UNDERSTAND that Project Lifesaver is a program sponsored by the Isanti County Sheriff's Office and will work in collaboration with other area agencies. I UNDERSTAND THAT 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 OR LIABILITY AND/OR DAMAGE. HE/SHE ALSO WAIVES ANY AND ALL RIGHTS TO SEEK RECOURSE FOR ANY LOSSES OR INJURY THAT MAY OCCUR AS A RESULT OF PARTICIPATING IN THE PROJECT LIFESAVER PROGRAM.

I HAVE READ THE PROJECT LIFESAVER PROGRAM STANDARD OPERATING PROCEDURE AND AGREE TO ALL TERMS AS STATED THEREIN.

FURTHERMORE, I HEREBY REPRESENT AND WARRANT THAT I HAVE FULL POWER AND AUTHORITY AS THE DULY AUTHORIZED REPRESENTATIVE OF THE PARTICIPANT NAMED ABOVE, TO REGISTER AND ACT ON HIS/HER BEHALF.

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature





# PROJECT LIFESAVER of ISANTI COUNTY



Client Number: \_\_\_\_\_ Frequency: \_\_\_\_\_

## CLIENT PROFILE:

### Personal Data Questionnaire

This form is designed for Custodial Care Givers to provide additional information that may be useful to Search Teams, should the need arise. Providing this information in advance will allow the Search Management Personnel to establish a timely and effective search response.

Client Name:		Phone:	
Street address:		City:	State:
Facility/Organization:		Facility phone:	
Date transmitter placed:	Transmitter placed by:		

### CLIENT PERSONAL DATA

Sex: Male Female	DOB:	Race:	Nickname:
Most recent address:			
Most recent place of employment:			Occupation:
Married Separated Divorced Widowed	Name of spouse:		Living? Yes No
Name and location of ex-spouse (if applicable):			

### CONTACT INFORMATION (persons the client may contact)

Name:	Phone:
Address:	Relationship to client:
Name:	Phone:
Address:	Relationship to client:
Name:	Phone:
Address:	Relationship to client:

Responsible party paying for client: \_\_\_\_\_

PHYSICAL DESCRIPTORS				
Height:	Weight:	Eye Color:	Hair Color:	Hair Style:
Mustache: YES NO	Beard: YES NO	Balding: YES NO	False Teeth: YES NO	
Wears glasses: YES NO	Wears contacts: YES NO	Wears hearing aid: YES NO	If YES, which ear(s): LEFT RIGHT BOTH	
Does Client speak English: YES NO	If NO, what language does Client speak:			
Please list any distinguishing scars, marks or tattoos:				
Please describe any jewelry, watches, glasses, etc worn by the Client:				

HEALTH/PSYCHOLOGICAL CONDITION		
Does Client have any known physical impairments? If YES, please describe:	YES	NO
Does Client have any known psychological impairments? If YES, please describe:	YES	NO
Does Client take medication? If YES, please list exact name of drug and dosage taken:	YES	NO
Are there consequences if above medication is not taken as prescribed? If YES, please explain:	YES	NO
Attending Physician Name & Hospital/Clinic:	Physician Phone:	

If Client has been diagnosed with Alzheimer's or dementia, please answer the following:

1. Does the Client remain oriented to time and person? YES NO  
Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. Does the Client recognize familiar persons and faces? YES NO  
Explain: \_\_\_\_\_  
\_\_\_\_\_
3. Can the Client travel to familiar locations? YES NO  
Explain: \_\_\_\_\_  
\_\_\_\_\_
4. Does the Client have decreased knowledge of current events, or tends to relive events in his/her life? YES NO  
Explain: \_\_\_\_\_  
\_\_\_\_\_
5. Does the Client clothe himself/herself improperly at times? YES NO  
(example: putting shoes on wrong feet, adding underwear over clothing)  
Explain: \_\_\_\_\_  
\_\_\_\_\_
6. Does the Client remember his/her name and the names of spouse and/or children? YES NO
7. Does the Client suffer from frequent personality and emotional changes? YES NO  
Explain: \_\_\_\_\_  
\_\_\_\_\_
8. Does the Client suffer from delusional or imaginary experiences? YES NO  
Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. How good can the Client communicate? NONE POOR FAIR GOOD EXCELLENT
10. Does the Client have a cane, walker, or other mobility device? YES NO  
Please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PERSONALITY & HABITS		
Does Client smoke? YES NO	If YES, what Brand?	How often?
Does Client drink alcohol? YES NO	If YES, what type?	How often?
Does Client use illicit drugs? YES NO	If YES, what type?	How often?
Please list Client's hobbies & interests:		
Is Client: outgoing or quiet?	Prefers: groups or alone?	Is a: leader or a follower?
Spiritual? YES NO	If YES, what faith?	Church attended:
Any history of criminal activity? YES NO	If YES, explain:	
Where was the Client born and raised?		
What does the Client value most?		
Who is the Client closest to? What is their relationship to the Client?		
Will the Client talk to strangers? YES NO	Is Client a danger to self or others? YES NO	
Is the Client afraid of: the dark dogs horses people		

EXPERIENCE		
Is Client familiar with the area? YES NO	How long in the area?	
If not local, what other areas are known to the Client?		
Has Client ever taken outdoor classes? YES NO	Taken First Aid training? YES NO	
Involved in Scouting? YES NO	Military experience? YES NO	
Recreational outdoor experience? YES NO	Overnight camping? YES NO	
Has the Client ever been lost before? YES NO	If so, when and where?	
Was Client located by others or returned independently?		
Where was the Client found?		
Does the Client go out alone? YES NO	Stays on trails? YES NO	