



**YORK- POQUOSON PROJECT LIFESAVER
YORK – POQUOSON SHERIFF’S OFFICE
PO BOX 99
YORKTOWN, VIRGINIA 23690**

CAREGIVER INSTRUCTIONS

As participants in the Project Lifesaver Program, you, the caregiver, have certain responsibilities. These include:

1. **DAILY**- Check the transmitter with the tester provided daily.
2. **MISSING**- If your loved one wanders away, **before you start any search**, notify us immediately by either calling 911 or (757) 890-3622 and state that it concerns a client that is in the York - Poquoson Project Lifesaver Program.
3. **IMPORTANT**- If your loved one moves to another location or enters the hospital – Take the wristband off and notify us at (757) 890-3622. We will pick up the wristband and place it back on your loved one on their return.
4. **MAINTENANCE**- For maintenance, or any other information, contact the York - Poquoson Sheriff's Office at (757) 890-3654, our office hours are Monday through Thursday 6:00am to 4:30pm. The after hours non-emergency number is (757) 890-3622.



YORK- POQUOSON PROJECT LIFESAVER
PO BOX 99
YORKTOWN, VIRGINIA 23690
PHONE: (757) 890-3639 FAX: (757) 890-2420

FREQUENCY 216.

SEARCH MANAGEMENT SECTION PERSONAL DATA QUESTIONNAIRE

This form is designed for *Custodial Caregivers* to provide, in advance, certain information that will be useful to Search Teams, should the need arise. Providing the information in advance of the need will allow Search Management Personnel to do their job faster, when needed.

Client: _____

Address: _____

City/State: _____ Zip: _____

Phone: _____

Client's Personal Data

Birth date: _____ Sex: _____ Race: _____ SS# _____

Nickname(s): _____

Most Recent Address: _____

Most Recent Place of Work: _____

Most Recent Occupation: _____

Name of Spouse: _____ Living/Deceased (circle)

Physical Description

Height: _____ ft., _____ in. Weight _____ lbs Build _____

Hair Color _____ Hair Style _____ Eye Color _____

Complexion _____ Beard Yes/No _____ Sideburns Yes/No
(circle one) (circle one)

Mustache Yes No _____ Balding Yes No _____ False Teeth Yes No
(circle one) (circle one) (circle one)

Shape of facial features: Round / Square / Oval / Other _____

Distinguishing Marks, Scars, Tattoos, etc., Describe: _____

General Appearance: _____

If Resident does not understand English, what Language is understood? _____

Do they speak the language Yes No or Can they write the language Yes No
(circle one) (circle one)

Does Resident Wear Glasses? Yes No Contacts? Yes No Sunglasses Yes No
(circle one) (circle one) (circle one)

If yes to any of the above what style: _____

If Resident wears glasses or corrective eyewear what degree of vision does he/she have without the eyewear? None / Poor / Fair (circle one)

Personal Data Questionnaire

Does Resident wear a hearing aid? _____ What style? _____

If yes, what type of hearing without aid? None / Poor / Fair (circle one)

Health/Psychological Condition

Any known physical handicaps? _____
(Describe please)

Any known medical problems? _____
(Describe please)

Medications taken regularly? _____

List any medication using correct name of drug and dosage being taken: _____

Consequences of **NOT** taking medications? _____

Attending Physician: _____ Telephone Number: () _____

Any Psychological Problems? Yes No Nature: _____

Personal Articles Normally Carried by the Resident

Tobacco Products: Yes No Type: _____ Brand: _____

Candy/Gum: Yes No Brand: _____

Matches: Yes No Lighter: Yes No Type: _____

Food Items: _____

Facial tissue or other pocket/purse items: Describe: _____

Approximate Amount of Cash on Hand: _____

Where Normally Carried: _____

(Please circle one) Handbag / Purse / Wallet Description _____ Type _____
Color _____

Jewelry (Please describe) _____

Watch _____ Type: _____ Color: _____ Description: _____
(circle one) wrist / pocket, etc

What does the client value the most? _____

Which family member is the client closest to? _____

What is their relationship? _____

Where was the client born and raised? _____

Has the client received any letters recently? Yes No From whom _____

Is the client afraid of dogs? Yes No Is the client afraid of the dark? Yes No Loud noises? Yes No

Afraid of horses? Yes No Afraid of people? Yes No Other? _____

What actions are taken when the client is hurt? (cry, shout, etc.) _____

Will the client talk to stranger? Yes No

Is the client DANGEROUS to him/her self or others? Yes No

If Alzheimer's Disease has been diagnosed, 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 deceased knowledge of current events or tend to re-live events in his/her life? Yes No Explain: _____

5. Does the Client sometimes clothe himself/herself improperly? Yes No Example: Putting shoes on the wrong feet, adding underwear over clothing? Explain if necessary: _____

6. Does the Client remember his/her own name and the names of spouse and or children? Yes No
Explain: _____
7. Are the Client's sleep patterns frequently? Yes No Explain: _____

8. Does the Client suffer from frequent personality and emotional changes? Yes No
Explain: _____
9. Does the Client suffer from delusions (see Imaginary Visitors, Talk to his/her own reflection in the mirror, Imagine that their spouse is an imposter, etc?) Yes No Explain: _____

10. How good is the Client's communication ability? None / Poor / Fair / Good / Excellent
(please circle one)

CARE GIVER/ BILLING INFORMATION

Name of Person filling out this form: _____

Facility/Organization (if any): _____

Address: _____

City / State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

BILLING ADDRESS: (IF DIFFERENT FROM ABOVE)

Name: _____

Address: _____

City / State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Family/Friend Information

Other persons the client may contact (family, friends, etc)

Name: _____ Address: _____
Phone: _____

ADDITIONAL INFORMATION:

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE BEEN THOROUGHLY BRIEFED BY A MEMBER OF YORK - POQUOSON PROJECT LIFESAVER. I UNDERSTAND THAT THE DUTIES OF THE PROJECT LIFESAVER PERSONNEL IS TO INSPECT THE EQUIPMENT AND TO PROVIDE A MAINTENANCE/LOG SHEET ON A MONTHLY BASIS, TO REPLACE EQUIPMENT IF NEEDED, AND TO SEARCH FOR THE PATIENT. I ALSO UNDERSTAND THAT THE EQUIPMENT BEING USED IS THE PROPERTY OF YORK - POQUOSON SHERIFF'S OFFICE PROJECT LIFESAVER PROGRAM AND UPON TERMINATION OF THE SERVICE, ALL EQUIPMENT IS TO BE RETURNED TO THE SHERIFF'S OFFICE. **THE COST IS \$10.00 PER MONTH.**

CARE GIVER

DATE

APPROVING DEPUTY

DATE TRANSMITTER PUT IN OPERATION

FREQUENCY

UPDATED 01/05/12

PROJECT LIFESAVER AGREEMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. PLEASE READ CAREFULLY BEFORE SIGNING. CONSULTATION WITH LEGAL COUNSEL IS ENCOURAGED.

THIS AGREEMENT is made this ____ day of _____, 201__, by and between the York – Poquoson Sheriff's Office (hereinafter "YPSO"), party of the first part, and _____ (hereinafter "RESPONSIBLE PARTY"), party of the second part, acting on behalf and for the benefit of _____ (hereinafter the "Designated User").

WHEREAS, the YPSO, is undertaking an experimental program using electronic signaling devices to aid in searching for persons who suffer from a medical condition which may cause them to become lost; and,

WHEREAS RESPONSIBLE PARTY desires to participate in this experimental program for the Designated User's and RESPONSIBLE PARTY'S benefit; and,

WHEREAS RESPONSIBLE PARTY has presented to the YPSO a physician's certificate confirming that the Designated User suffers from a medical condition which may cause such person to become lost; and,

WHEREAS, the YPSO is under no legal or other duty to provide such a program or to furnish the equipment and services here provided for, but is willing to provide such equipment and services to RESPONSIBLE PARTY and the Designated User upon the terms and conditions set forth below;

NOW, THEREFORE, WITNESSETH that in consideration of the mutual promises made herein, the above parties agree as follows:

1. The YPSO shall furnish a CARETRAK system to RESPONSIBLE PARTY for the exclusive use and benefit of the Designated User and RESPONSIBLE PARTY.
2. YPSO using CARETRAK equipment shall lead or conduct searches for the Designated User when such Designated User becomes lost in York County or the City of Poquoson.
3. RESPONSIBLE PARTY understands and agrees that the YPSO does NOT represent that it will lead or conduct searches for the Designated User whose last known location before being lost was outside York County and the City of Poquoson. YPSO in its discretion may provide CARETRAK frequency information to the law enforcement agency outside of York County and the City of Poquoson where the Designated User was last seen.
4. RESPONSIBLE PARTY shall immediately notify the YPSO of any address change of either the Designated User or RESPONSIBLE PARTY.

5. In the event the Designated User or RESPONSIBLE PARTY moves from the York County or the City of Poquoson, the RESPONSIBLE PARTY shall promptly return the CARETRAK equipment to the YPSO in good working condition.
6. In the event the Designated User becomes institutionalized for over thirty - (30) days, dies, or for any other reason no longer needs the CARETRAK equipment, RESPONSIBLE PARTY shall promptly return such equipment to the YPSO in good working condition.
7. In the event any CARETRAK equipment entrusted to RESPONSIBLE PARTY malfunctions, RESPONSIBLE PARTY shall immediately return such malfunctioned equipment to the YPSO for repair or replacement. If such equipment malfunction is determined by the YPSO to result from misuse or abuse then RESPONSIBLE PARTY shall reimburse the YPSO for all the costs of repair or replacement. The re-issue of CARETRAK equipment is contingent upon such reimbursement.
8. In the event any CARETRAK equipment entrusted to RESPONSIBLE PARTY is for whatever reason damaged, RESPONSIBLE PARTY shall immediately return such damaged equipment to the YPSO, and shall further reimburse the YPSO any costs of repair or replacement, as determined necessary by the YPSO. The re-issue of functioning CARETRAK equipment is contingent upon such reimbursement.
9. In the event any CARETRAK equipment entrusted to RESPONSIBLE PARTY is for whatever reason lost or stolen, RESPONSIBLE PARTY shall immediately report such loss, and shall further reimburse the YPSO all costs of replacement. The re-issue of new CARETRAK equipment is contingent upon such reimbursement.
10. The YPSO shall retain ownership of the CARETRAK equipment, and neither the Designated User nor RESPONSIBLE PARTY shall acquire any right of ownership in said equipment through possession.
11. This Agreement may be terminated for any reason at the option of either party upon thirty - (30) days written notice to the other party. Upon the termination of this Agreement, RESPONSIBLE PARTY shall return the CARETRAK equipment within ten (10) days in good working condition to the YPSO. If such equipment is damaged or not returned, RESPONSIBLE PARTY shall reimburse the YPSO the cost of repair or replacement.
12. RESPONSIBLE PARTY agrees to cause the Designated User to wear the CARETRAK equipment at all times and to regularly check to ensure that such equipment is functioning properly.

13. In the event the Designated User becomes lost, RESPONSIBLE PARTY shall immediately notify YPSO of such loss and provide all requested details regarding the circumstances of such loss, including but not limited to the last known whereabouts of the Designated User, the probable time of loss, the time when such loss was discovered, the whereabouts of RESPONSIBLE PARTY at the probable time of discovery of such loss, and contact information for any person other than RESPONSIBLE PARTY who had custody of the Designated User at the probable time of the loss.
14. RESPONSIBLE PARTY acknowledges that accepting CARETRAK equipment and associated services in no way constitutes a substitute for care, monitoring, attention, and oversight of the Designated User by RESPONSIBLE PARTY.
15. RESPONSIBLE PARTY specifically agrees and promises NOT TO RELY on the equipment or services provided herein for the safety, security, welfare, finding, or retrieval of the Designated User, and shall at all times regard the equipment and services provided herein as ancillary equipment and services which may or may not be effective in assisting with locating the Designated User.
16. RESPONSIBLE PARTY understands and agrees that the YPSO makes no warranties, guarantees, assurances, or promises of any kind regarding the quality or effectiveness of the CARETRAK equipment and associated services under this agreement.
17. RESPONSIBLE PARTY hereby absolves the YPSO, the COUNTY OF YORK, as well as all other divisions of the YORK COUNTY, including, but not limited to the York County Fire and Life Safety, Emergency Management Services, all employees, officers, agents, volunteers, and any other persons or entities of the County of York from any claim or cause of action arising out of the Designated User's and RESPONSIBLE PARTY'S acceptance and use of the CARETRAK equipment and associated services, and agrees to indemnify the YPSO and the COUNTY OF YORK and its employees, officers, agents, volunteers, and any other persons or entities associated with the same from and against any and all such claims or causes of action which may be brought against said indemnified parties either jointly or severally by the Designated User, RESPONSIBLE PARTY, other parties, or parties acting on their behalf relative to the CARETRAK equipment and/or services provided under this Agreement.

By signing below, I, the RESPONSIBLE PARTY, affirm that I have read this Agreement in its entirety and understand all provisions thereof. I FURTHER UNDERSTAND THAT THIS IS AN IMPORTANT LEGAL DOCUMENT AND THAT IN SIGNING IT, I AM UNDERTAKING CERTAIN IMPORTANT LEGAL OBLIGATIONS. I FURTHER ACKNOWLEDGE THAT I HAVE BEEN GIVEN FULL OPPORTUNITY TO CONSULT WITH LEGAL COUNSEL OF MY CHOICE PRIOR TO SIGNING AND THAT ANY DECISION NOT TO SEEK LEGAL ADVICE HAS BEEN MY SOLE DECISION FREE OF ANY INFLUENCE BY ANY EMPLOYEE, DEPUTY, AGENT, OR VOLUNTEER OF YORK COUNTY. By affixing my signature below, I hereby agree to the terms and provisions of this Agreement.

Witness Signature

RESPONSIBLE PARTY

Printed Name of Witness

Witness Address: _____

Witness Telephone:() _____

Responsible Party Information:

Street Address:

Mailing Address:

Home Telephone:

Work Telephone:

Cellular Telephone:

Email:

Date of Birth:

SSN:

Designated User's Information:

Social Security No.:

Name of Attending Physician:

Attending Physician's Address:

Attending Physician's Telephone:

ACCEPTED: York – Poquoson Sheriff's Office

BY: _____

York Poquoson Williamsburg 911 Center

“HEADS UP” PROGRAM

The York Poquoson Williamsburg 911 Center has a special program to provide emergency response personnel with the knowledge of pre-existing conditions or situations present at emergency scenes, i.e., individual confined to a wheelchair, etc., while enroute to the scene. Providing them with this knowledge allows them to prepare for these conditions or situations and, if necessary, modify their plans to effect the most timely and positive outcome possible.

The program is called “Heads Up” to symbolize the effect the program has on emergency responders, causing them to be especially mindful of the special conditions or situations to which they have been alerted.

The special conditions/situations are entered into the existing Computer Aided Dispatch (C.A.D.) System via a special computer software program. The information is entered into the database according to the specific address. When an emergency is called into the York County 9-1-1 Emergency Communications Center from/for that address, the C.A.D. program will alert telecommunicators that there is special information for that address. The telecommunicators will then advise the emergency responder of the “Heads Up” information over the two-way radio.

The “Heads Up” program targets certain individuals:

- Individuals who are non-ambulatory (paralyzed, confined to beds, wheelchairs, or unable to walk without assistance)
- Individuals who are sensory impaired
- Individuals who are reliant on critical medical equipment (monitors, home dialysis units, etc.)
- Individuals who are mentally impaired or easily confused and disoriented and who require supervision and/or special assistance
- Individuals with special physical needs

The “Heads Up” program is available to all citizens in York County, the City of Williamsburg and the city of Poquoson. Information can be placed in the “Heads Up” program by a citizen completing the attached form and returning it to the York Poquoson Williamsburg 911 Center. Please contact the 911 center at 890-3621 if you have any questions. And if you have an emergency, dial 9-1-1 24 hours a day.

Name: _____
Last First Middle Nickname

Sex: _____ Age: _____ Height: _____ Approximate Weight: _____

DOB: _____

Street Address: _____
Number and Street Apt

City State Zip Code

Location: (Please give special directions to residence)

Telephone: _____
Home Work Other

Emergency Contact Persons:

1. _____

2. _____

3. _____

Special Medic Alert/Life Call Device:

Alarm Company: _____

Alarm Type: _____

Pre-Existing Medical Conditions:

Heart Disease Diabetes Respiratory Disease Other _____

Special Medical Problems: _____

Blood Type: _____

Special Needs:

Mobility Impaired

Needs: Cane Crutches Walker Wheelchair Bedridden

Other: _____

Visually Impaired:

Needs: TDD Signer

Other: _____

Mentally Impaired: Needs: _____

Does not speak/understand English Language Spoken: _____

Other Condition: _____

Needs: _____

Disclaimer: The "Heads Up" Program is designed to assist the York Poquoson Williamsburg 911 Center in rendering emergency services to its citizens. However, the department makes no warranties or guarantees of any kind and will not be responsible for power failures or breakdowns of computers or other equipment which may hinder the delivery of emergency services.

Signature

Date

Completed form can be mailed to:

**York Poquoson Williamsburg 911 Center
PO Box 532
Yorktown, VA 23690-0532**

For Office Use Only

Date Entered: _____

Remarks: _____