OFFICE OF THE SHERIFF
COUNTY OF SALEM

ADMINISTRATIVE OFFICE

94 MARKET STREET
SALEM, NEW JERSEY 08079
PHONE (856) 935-7510 (EXT. 8375)
FAX (856) 935-8880

WARREN K. MABEY
UNDERSHERIFF

CHARLES M. MILLER
SHERIFF

CORRECTIONAL FACILITY

125 CEMETERY ROAD
WOODSTOWN, NEW JERSEY 08098
PHONE (856) 769-4300
FAX (856) 769-3578

RAYMOND C. SKRADZINSKI
WARDEN/UNDERSHERIFF

ANTHONY J. WRIGHT
DEPUTY WARDEN/UNDERSHERIFF

APPLICANT'S NAME: (Name of individual with Alzheimer's disease or a related dementia disorder)

FAMILY/CAREGIVER INFORMATION:

NAME:	RELATIONSHIP TO APPLICANT:

Do you have Power of Attorney for the individual you are seeking to enroll in Project Lifesaver?

If not, please provide the name, address and phone number of who is, and their relationship to the Alzheimer's disease individual.

HOME ADDRESS:	HOME PHONE #:	CELL PHONE #:

FAX NUMBER:	EMAIL ADDRESS:	NAME OF EMPLOYER:

EMPLOYER'S ADDRESS:	WORK PHONE #:	WORK FAX #:	WORK EMAIL ADDRESS:

ADDITIONAL EMERGENCY CONTACT INFORMATION:

NAME:	RELATIONSHIP TO APPLICANT:

HOME ADDRESS:	HOME PHONE #:	CELL PHONE #:

FAX NUMBER:	EMAIL ADDRESS:	NAME OF EMPLOYER:

EMPLOYER'S ADDRESS:	WORK PHONE #:	WORK FAX #:	WORK EMAIL ADDRESS:

APPLICANT INFORMATION: (Individual who has Alzheimer's disease or a related dementia disorder)

FULL LEGAL NAME:	NICKNAME: (If applicable)

Has this individual been diagnosed with Alzheimer's Disease or a related Dementia disorder?

When was the individual diagnosed?

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

DATE OF BIRTH:	CURRENT AGE:	SEX	RACE:	HEIGHT:	WEIGHT:	EYE COLOR:	HAIR COLOR:

Describe any other distinguishing physical characteristics:

How long has the individual been living at this address?

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):

FINANCIAL INFORMATION:

Are you able to afford to pay for the one-time equipment fee for the Project Lifesaver Unit ($275.00) ?

Are you able to afford to pay the cost of the monthly service fee (approx. $25.00 per month) ?

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 and accurate to the best of my knowledge.

I UNDERSTAND that should my relative be accepted into Project Lifesaver that it does not replace the need for individuals with Alzheimer's disease and/or related dementia disorder to have constant supervised care.

I UNDERSTAND that while Project Lifesaver is a mobile locater tracking system that aids in locating individuals who wear the bracelet device, there may be times and circumstances when an individual cannot be located due to device malfunction or any other reason. I also agree to assume any/all responsibilities associated with program participation and ongoing unit maintenance.

I UNDERSTAND that all information I have provided in this application will be shared among the Salem County Sheriff's Office, the Department of Health Human Services, Division of Senior Services, as well as the police department in the town where I reside, and I understand that none of the information I have provided or provide in the future can be considered confidential or protected.

I UNDERSTAND that Project Lifesaver is a program sponsored by the Salem County Sheriff's Office that will work in collaboration with the Department of Health Human Services, Division of Senior Services; AND 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, AND 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.

I HAVE READ THE PROJECT LIFESAVER PROGRAM FACT SHEET AND AGREE TO THOSE TERMS. 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:

SIGNATURE **Date:**