Project Lifesaver®
Program Contract

If applicant is accepted into the Project Lifesaver Program, the following terms shall apply as agreed to upon the 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, and 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. My Power of Attorney and/or Power of Personal Care is attached, if needed.

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 of 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 sure 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 immediately.

4. When I notice that the Applicant enrolled 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 used solely as an aid for emergency personnel when notified the Applicant is missing.

5. A monthly maintenance fee of up to $ 25 shall be paid to the member agency enrolling client

6. I understand that while Project Lifesaver is an electronic tracking device that assists in locating persons 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, Provincial or city Law Enforcement or Fire and Rescue Agencies (collectively the "Releases") involved liable for failure to locate the person using the system, and 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 among 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 or 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 confidentially to the Applicant's medical records by Project Lifesaver International or any of Project Lifesaver's member agencies which includes 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: Alzheimer's Alliance Tri-State. 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, 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.

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 involuntarily removed from the program. All property will then be returned to Project Lifesaver and 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 (PRINTED)

_____
CAREGIVERS SIGNATURE

_____
DATE

_____
(WITNESS)

_____
APPLICANTS NAME

_____
FOR PROJECT LIFESAVER

_____
(AFFILIATE NAME)

Participant Name: **Transmitter Frequency:**

Miller County– Project Lifesaver Letter of Agreement

The agreement outlined below describes the basic responsibilities of the Caregiver and Miller County - Project Lifesaver

1. Miller County - Project Lifesaver will furnish the following equipment to the client/ caregiver:
    a. Project Lifesaver Transmitter with assigned frequency number (#)
    b. Battery
    c. Transmitter armband
    d. Transmitter Tester
    e. Instruction Sheet
    f. Daily Check Sheet
2. Miller County - Project Lifesaver will provide monthly maintenance for the Transmitter Tester and battery and armband replacements for the Transmitter; the caregiver will provide signed Daily Check Sheets at the time of battery replacements each month.
3. It shall remain the responsibility of the caregiver to notify Miller County - Project Lifesaver if the Transmitter fails to operate properly, is damaged, or is found to be missing.
4. Any equipment purchased by the *Alzheimer's Alliance Texarkana Area, Inc*. remains the property of Miller County - Project Lifesaver, and it is expected that the caregiver will return any supplies and equipment provided as a scholarship to the *Alzheimer's Alliance Texarkana Area, Inc.* when it is no longer needed. A deposit of $__50__ for the equipment/supplies will be required when approved for the program. The full deposit will be refunded at the time the equipment is returned in working order. If the equipment is not returned a balance of $350 will be due.
5. Any equipment purchased by a caregiver for participation in the Project Lifesaver program belongs to the caregiver, however it is requested that any supplies and equipment be donated back to the Miller County – Project Lifesaver program so that others who cannot afford the costs will be able to benefit from Project Lifesaver.
6. If the equipment is damaged or lost, Miller County - Project Lifesaver will attempt to replace/ repair the equipment, and reimbursement shall be made for said equipment by the caregiver or the facility of residence.
7. If the Client is found to be missing, it is the responsibility of the caregiver to follow the Caregiver Instructions, call 911 to notify local authorities, and identify the client as a participant in Project Lifesaver.
8. The caregiver or Miller County - Project Lifesaver may withdraw the client from the Project Lifesaver Miller County program at any time.

Family / Facility Caregiver: **Date:**

Alzheimer's Alliance Staff: **Date:**

PROJECT LIFESAVER

CAREGIVER INSTRUCTIONS

1. Check the transmitter every day with the tester provided.

2. If a problem exists or the transmitter isn't indicating transmission (no pulsing or steady burning red light, notify us right away. Call the Alzheimer's Alliance office at (903) 223-8021.

3. Always remember to sign and date the Battery Check sheet.

4. If the client is missing, CALL 9-1-1.

    - Tell the dispatcher the missing person's name, that they are on Project Lifesaver and the last location they were seen and when.

5. After calling 9-1-1, Call the Alzheimer's Alliance Tri-State Area office (903) 223-8021.

6. While law enforcement is responding, check obvious places around your home.

I agree and will perform the required Caregiver Instructions daily.

_____ _____

Signature Date

Alzheimer's Alliance
TRI-STATE AREA
ARKANSAS • OKLAHOMA • TEXAS

Health Insurance Portability and Accountability Act

HIPAA Privacy Notice

About this Notice

In this Privacy Notice, the word "Agency" means Alzheimer's Alliance Texarkana Area, Inc.

When you receive benefits from the Agency, that Agency may get health information about you. Health information includes any information that relates to (1) your past, present, or future physical or mental health or condition; or (2) providing health care to you.

This Notice tells you about your privacy rights, the Agency's duty to protect health information that identifies you, and how the Agency may use or disclose health information that identifies you without your written permission. This notice does not apply to health information that does not identify you or anyone else. Please share this Notice with everyone in your household who receives benefits from this Agency.

Your Privacy Rights

The law gives you the right to:

- look at or get a copy of the health information the Agency has about you, in most situations;
- ask the Agency to correct certain information, including certain health information, about you if you believe the information is wrong or incomplete. Most of the time, the Agency cannot change or delete information, even if it is incorrect. However, if the Agency decides it should make a change, it will add the correct information to the record and note the new information takes the place of the old information. The old information will remain in the record. If the Agency denies your request to change the information, you can have your written disagreement placed in your record;
- ask for a list of the times the Agency has disclosed health information about you;
- ask the Agency to limit the use or disclosure of health information about you more than the law requires. However, the laws does not make the Agency agree to do that;
- tell the Agency where and how to send messages that include health information about you, if you think sending the information about you to your usual address could put you in danger. You must put this request in writing, and you must be specific about where and how to contact you;
- ask for and get a paper copy of this notice from any Agency;
- withdraw permission you have given the Agency to use or disclose health information that identifies you, unless the Agency has already taken action based on your permission. You must withdraw your permission in writing.

An Agency's Duty to Protect Health Information that Identifies You

The law requires an Agency to protect the privacy of health information that identifies you. It also requires an Agency to give you this Notice of its legal duties and privacy practices.

- In most situations, the Agency may not use or disclose health information that identifies you without your written permission. This Notice explains when an Agency may use or disclose health information that identifies you without your permission.
- For all other uses and disclosures, the Agency must obtain your written permission, which you may withdraw at any time.
- If an Agency changes its privacy practices, it must notify you of the changes by mailing a new Privacy Notice to the most recent address you have given the Agency. The Agency will mail the new Privacy Notice within 60 days of the changes. The new practices will apply to all the health information the Agency has about you, regardless of when the Agency received or created the information.

Agency employees must protect the privacy of health information that identifies you as part of their jobs with the Agency. The Agency does not give employees access to health information unless they need it for a business reason. Business reasons for needing access to health information include making benefit decisions, paying bills, and planning for the care you need. The Agency will punish employees who do not protect the privacy of health information that identifies you.

If you have questions about this Notice or need more information about your privacy rights, you may contact the following:

- the Medicaid hotline at (800)252-8263

If you believe the Agency has violated your privacy rights, you may file a complaint by contacting the Medicaid hotline at (800)252-8263. You may also file a complaint with the:

- the U.S. Secretary of Health and Human Services by mail at 200 Independence Ave. S.W., Washington, D.C. 20201, or by telephone at (800)368-1019.
- The Texas Office of the Attorney General by mail at P.O. Box 12548, Austin, Texas, 78711-2548, or by telephone at (800)806-2092.

There will be no retaliation for filing a complaint.

Effective Date: This Notice takes effect on October 9, 2019, and stays in effect until it is replaced by another Notice.

Signature of client's family caregiver date

Alzheimer's Alliance Texarkana Area, Inc.
100 Memory Lane
Texarkana, TX 75503
903-223-8021 www.akztrustate,org

Client # _____ **Frequency:** _____

Miller County – Project Lifesaver
100 Memory Lane
Texarkana, TX 75503
903-223-8021

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 the necessary information for a more effective search response.

Client: _____

Address _____

City _____ State AR Zip _____

Phone _____

Date Transmitter Placed: _____

Facility/ Organization: Alzheimer's Alliance Texarkana, Area, Inc. Phone 903-223-8021

Address: 100 Memory Lane, Texarkana, TX 75503

Name of person filling out this form: _____

Date _____

Client's Personal Data

Birthday _____ Sex _____ Race _____

Nickname(s) _____

Most recent address _____

Most recent place of work _____

Most recent Occupation _____

Name of Spouse _____ ☐ Living ☐ Deceased

Family/ Friend Information

Other persons the Client may contact (family, friends, etc.)

Name _____ Phone _____

Address _____

Name _____ Phone _____

Address _____

Name _____ Phone _____

Address _____

Physical Description

Height _____ Weight _____ Build _____

Hair Color _____ Hair Style _____ Eye Color _____

Complexion _____ Beard ☐ Yes ☐ No Sideburns ☐ Yes ☐ No

Mustache ☐ Yes ☐ No Balding ☐ Yes ☐ No False Teeth ☐ Yes ☐ No

Shape of facial features: ☐ ☐ Square ☐ Oval ☐ Other _____

Distinguishing Marks, Scars, Tattoos, etc. Describe _____

General Appearance _____

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

Spoken work only ☐ Yes ☐ No Written and Spoken ☐ Yes ☐ No

Does Client wear Glasses? ☐ Yes ☐ No Contacts ☐ Yes ☐ No Sunglasses ☐ Yes ☐ No

If yes to any of the above, What Style _____

If Client wears glasses or corrective eyewear, what degree of vision does he/ she have without the eyewear? ☐ None ☐ Poor ☐ Fair

Personal Data Questionnaire

Does Client wear a Hearing Aid? ☐ Yes ☐ No What Style _____

If yes, what type of Hearing without Aid? ☐ None ☐ Poor ☐ Fair

Health/ Psychological Condition

Any Known Physical Handicaps? (please describe) _____

Any Known Medical Problems? (please Describe) _____

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

Consequences of NOT taking medications? _____

Attending Physician _____ Telephone # _____

Any Psychological Problems ☐ Yes ☐ No Nature _____

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 decreased knowledge of current events or tend to re-live events in his/ her life? ☐ Yes ☐ No
   Explain _____
5. Does the Client sometimes clothe him/ herself improperly? ☐ Yes ☐ No
   Explain _____
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 regular? ☐ Yes ☐ No
   Explain _____
8. Does the Client suffer from frequent personality and emotional changes? ☐ Yes ☐ No
   Explain _____
9. Does the Client suffer from delusions? ☐ Yes ☐ No
   Explain _____
10. How good is the Clients communication ability? ☐ None ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Personal Articles Normally Carried by the Client

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: _____

Approximate Amount of Cash on Hand _____

Where Normally Carried _____

☐ Handbag ☐ Purse ☐ Wallet ☐ NONE

Description _____ Type _____ _____

Jewelry (please Describe) _____

Watch (☐ Wrist ☐ Pocket)

Type _____ Color _____ Description _____

Equipment

☐ Cane ☐ Walker Hunting/ Fishing, Etc.(describe) _____

Other _____

Experience

Familiar with area ☐ Yes ☐ No How recently _____

If not local, what other areas are known to Client? _____

Taken Outdoor Classes? ☐ Yes ☐ No Where _____ When _____

Taken First aid Training? ☐ Yes ☐ No Where _____ When _____

Involved in Scouting? ☐ Yes ☐ No Explain _____

Military Experience? ☐ Yes ☐ No Where _____ When _____

Recreational Outdoor Experience ☐ Yes ☐ No Explain _____

Overnight Camping Experience ☐ Yes ☐ No Explain _____

Ever been lost before ☐ Yes ☐ No Where _____ When _____

Located by Searchers or walk out by his/ herself? _____

Actions Taken _____

Ever go out alone? ☐ Yes ☐ No Where

General Athletic Interest/ Abilities _____

Personality/ Habits

Smoke ☐ Yes ☐ No How Often _____ What _____ Brand

Drink Alcohol ☐ Yes ☐ No Type _____ Brand _____

Use Illicit Drugs ☐ Yes ☐ No How Often Type

Hobbies/ Interests _____

☐ Outgoing ☐ Quiet Likes Being ☐ in Groups ☐ Alone

Evidence of Leadership ☐ Yes ☐ No Explain _____

Ever been in trouble with the law? ☐ Yes ☐ No Explain _____

Religious ☐ Yes ☐ No What Faith? _____

What Does Client Value Most _____

Which family member is Client closest to? _____ Relationship _____

Where was Client born and raised? _____

Has Client received any letters recently? ☐ Yes ☐ No From Whom _____

Is Client afraid of ☐ Dogs ☐ Dark ☐ Noises ☐ Horses ☐ People ☐ Other

Explain:

What actions taken when hurt? (Cry, shout, etc.) _____

Will Client talk to Strangers ☐ Yes ☐

Is the Client DANGEROUS to him/ herself or others? ☐ Yes ☐ No

Explain _____

Additional Information

_____

_____

_____

_____

_____

See Attached Photo: _____

Miller County – Project Lifesaver is facilitated by a partnership between the Miller County Sheriff's Department and the Alzheimer's Alliance Texarkana

Alzheimer's Alliance
TRI-STATE AREA
ARKANSAS • OKLAHOMA • TEXAS

MILLER COUNTY - PROJECT LIFESAVER PROGRAM

Release from Liability

I give my permission for _____(participant's name) to participate in the *Miller County - Project Lifesaver Program*. I acknowledge that I have chosen this agency to provide these services, and I knowingly and voluntarily assume all risk of liability that may arise there from. I also acknowledge that the *Miller County – Project Lifesaver Program* has made no representation to me regarding these services nor does it exercise any control over the manner or method by which the Agency delivers the services. Therefore, on behalf of myself and the above-named client, I covenant not to sue the *Miller County– Project Lifesaver Program* or any of its agents, employees, or representatives. I hereby **WAIVE** and **RELEASE** them from any and all claims for personal injury or damage that may arise during the course of this program that I have chosen.

Authorization for Release of Information

I _____ caregiver/ legal guardian/family member of _____ hereby authorize the participating Agencies of the *Miller County– Project Lifesaver Program* to release information concerning my records, medical history or other pertinent information in order to discuss and assist in securing appropriate services to meet my needs in the least restrictive or least limiting manner. I understand that all information presented is confidential. This release is valid during the time of service authorization. I understand that I may revoke, at any time, this authorization for release of information by writing the *Miller County – Project Lifesaver.* I further understand that upon revocation of this release of information services authorized for any and all programs offered through the *Miller County – Project Lifesaver* will be immediately discontinued.

_____ **4-2-24**

Signature of Project Life Saver Participants' Caregiver/Guardian/Family Member Date

Miller County - Project Lifesaver
Daily Check Sheet

Client Name _____ Month of _____

Began: _____ Frequency _____

Date	Caregiver initials/ signature	Time
1		
2		
3		
4		
5		
6		
7		
8		
9		
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11		
12		
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29		
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31		

60 Day Battery Life

Please note date of battery change, then bring or fax to Alzheimer's Alliance 903-334-8217

By signing/ initialing this sheet, you are certifying that you checked the condtion of the transmitter bracelet. you also certify that you checked the transmission of the signal using the transmitter tester.