

FOUNTAIN POLICE DEPARTMENT HOME SAFE PROGRAM



Instructions:

Please fill out the application completely – information is required to issue an alert

Please include a recent picture of the participant – picture should be recent, large and clear

Please provide medical documentation of diagnosis – documentation is required to issue state and national alerts

Participant Information:

Last Name: _____ First: _____ MI: _____

Home Address: _____ Apt#: _____

School/Employer: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: _____ Race: _____ Date of Birth: _____ Height: _____

Weight: _____ Hair Color: _____ Eye Color: _____

Vehicle(s) Information:

Vehicle #1

Type: _____ Make: _____ Model: _____

Year: _____ Color: _____ License State: _____ License Plate: _____

Vehicle Identification Number: _____

Vehicle #2

Type: _____ Make: _____ Model: _____

Year: _____ Color: _____ License State: _____ License Plate: _____

Vehicle Identification Number: _____

Physicians Information:

Physicians Name: _____

Documented diagnosis: _____ (attach letter from Physician)

Co-existing medical condition(s): _____

Prescribed Medication(s): _____

Does the participant wear any of the following?

ID Bracelet

Medical Alert Jewelry

GPS tracker

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Primary Contact:

Relationship to participant: _____

Last Name: _____ First: _____ MI: _____

Sex: _____ Race: _____ Date of Birth: _____

Home Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Does the participant live with you? _____

If no, who provides care for the participant? _____

Care Provider's contact phone number(s): _____

Additional Emergency Contacts:

Name: _____ Relationship to participant: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name: _____ Relationship to participant: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name: _____ Relationship to participant: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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Participant Details

Diagnosis/Disability (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Autism/Asperger's Syndrome | <input type="checkbox"/> Blind/Low Vision |
| <input type="checkbox"/> Brain Injury/TBI | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Deaf/Low Hearing | <input type="checkbox"/> Diabetic |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Other Mental Disability | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Other Developmental Disability | <input type="checkbox"/> Dementia |

Communication Method (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Verbal | <input type="checkbox"/> Non-Verbal |
| <input type="checkbox"/> Speech Difficulty | <input type="checkbox"/> Assisted Communications Device |
| <input type="checkbox"/> Picture Exchange Communication System | <input type="checkbox"/> Sign Language (ASL) |
| <input type="checkbox"/> Deaf/Low Hearing | <input type="checkbox"/> Diabetic |
| <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Non-Communicative |
| <input type="checkbox"/> Language other than English: _____ | |

Special Considerations (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Combative | <input type="checkbox"/> Combative if restrained |
| <input type="checkbox"/> Fear of Officers or Uniformed Individuals | <input type="checkbox"/> Fear of dogs |
| <input type="checkbox"/> Hugs | <input type="checkbox"/> Light sensitive |
| <input type="checkbox"/> Noise sensitive | <input type="checkbox"/> Paranoid |
| <input type="checkbox"/> Repeats Phrases | <input type="checkbox"/> Run tendency |
| <input type="checkbox"/> Self-stimulatory behavior | <input type="checkbox"/> Sensitive to stimulation |
| <input type="checkbox"/> Touch sensitive | <input type="checkbox"/> Unresponsive to strangers |
| <input type="checkbox"/> Water Fixation (Attraction) | <input type="checkbox"/> Therapy dog/attached to family dog |

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1. If the registered person has a tendency to wander, please describe places he/she have been found recently or may choose to go:

2. Medical or psychological concerns relevant to police officers attempting to assist the registered person to remain safe and return home:

3. Suggestions for ways a police officer can approach and help the participant:

4. Regular behaviors, past locations and known routines that are significant to the participant:

5. Additional information you feel would be important for the police to know:

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Photograph

Include or attach a single photograph of the participant. The image should be of good contrast and show the subject in a well-lit condition:

Date of photograph: _____ Age in photograph: _____

ACKNOWLEDGEMENT

By participating in Fountain Police Department's Home Safe registration program, I understand and acknowledge that:

- The Fountain Police Department will collect and retain the listed information to respond to calls for service involving the person registered in order to promote effective interaction with him/her, and, if applicable, to return the person home or to another responsible person(s).
- The Fountain Police Department will not share or distribute personal information gathered by this form except as required by law and will use it solely for the purposes stated in this document.
- It is my responsibility to ensure the information submitted is current and accurate, and to notify the Fountain Police Department in writing of any changes.
- I may request that the information in this form be withdrawn at any time.
- The Fountain Police Department will provide an annual notice for information to remain on file in the registry. If the Fountain Police Department is unable to contact me at the address provided, I understand the information will be purged.
- By signing below, I certify that I have the authority to submit the listed information on behalf of the person to be registered. I understand the terms of this document and consent to the use of the information for the stated purposes.

Signature: _____ Date: _____

Print Name: _____

Email: _____

*****FOR OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE*****

Received by: _____ Date Received: _____ Time Received: _____

Entered by: _____ Date Entered: _____ Time Entered: _____