

Caretrak  
707 W. Southside Dr.  
Decatur, IL 62521  
217-424-2743

**Application**

Client Name: first, middle, last: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_

Person filling out this form: \_\_\_\_\_

Date of Birth: \_\_\_\_-\_\_\_\_-\_\_\_\_\_ Sex: Male Female Race: \_\_\_\_\_ Cell\_\_\_\_-\_\_\_\_-\_\_\_\_

Care Giver Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: (if different) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone(s): (Hm) \_\_\_\_-\_\_\_\_-\_\_\_\_\_ (Wk) \_\_\_\_-\_\_\_\_-\_\_\_\_\_ (Cell) \_\_\_\_-\_\_\_\_-\_\_\_\_

Explain why you believe involvement in the CARETRAK Program would be beneficial:

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*Carettrak Program Contract*

If applicant is accepted into the CARETRAK Program, the following terms shall apply as agreed to upon the signing of the CARETRAK contract:

This contract is entered into this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, between \_\_\_\_\_ ("Applicant"), \_\_\_\_\_ ("Caregiver"), and the Decatur Police Department, collectively, the "Parties", upon Caregiver's request, on Applicant's behalf, to participate in the CARETRAK Program.

Caregiver and Applicant acknowledge that the information provided is true and accurate to the best of their knowledge. All information provided has been given voluntarily, and Caregiver and Applicant consent to the collection, use and disclosure of such information for the purposes of CARETRAK. Furthermore, Caregiver hereby represents and warrants that he/she has full power and authority as the duly authorized representative of Applicant, to register and act on his/her behalf. Caregiver's Power of Attorney and/or Power of Personal Care is attached.

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. Caregiver understands that enrollment of Applicant in CARETRAK, does not replace the need for constant supervised care of applicant. Caregiver is, and remains, primarily responsible for supervised care and takes full responsibility of protecting Applicant from wandering. Caregiver also acknowledges that he/she, or a family member, must be present in the home with the Applicant at all times.
2. Caregiver and Applicant acknowledge that CARETRAK equipment is designed to be an additional aid to help locate missing persons and that there is no warranty, representation or guarantee that Applicant will be found because he/she is wearing a CARETRAK bracelet. CARETRAK equipment is designed to provide law enforcement personnel with an additional technology in attempting to locate the Applicant.
4. In order to be eligible for this program, the Caregiver acknowledges that the Applicant suffers from a disorder that may prohibit him or her from communicating personal information, such as who she or he is, or where he or she lives. Caregiver also acknowledges that Applicant shall not operate a motor vehicle while participating in this program, and that Caregiver and/or family have a responsibility to take reasonable measures to ensure that the Applicant does not have access to motor vehicle keys.

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4. In order for CARETRAK to work, Caregiver and family acknowledge his/her/their responsibility to obey the instructions of the Program, follow all training, and make sure that Applicant is wearing the CARETRAK transmitter bracelet. If it has been removed or is defective; Caregiver agrees to call CARETRAK immediately.
5. When Caregiver or family notice that the Applicant enrolled has wandered off, caregiver or family must immediately call the emergency number supplied by CARETRAK and report the Applicant as a missing person. Caregiver acknowledges that the CARETRAK device cannot predict or report that the Applicant has wandered off and that it is used solely as an aid for emergency personnel when notified the Applicant is missing.
6. Caregiver acknowledges that, while CARETRAK is an electronic tracking device that assists in locating persons who wear the bracelet device, there may be circumstances when individuals cannot be located even while wearing the transmitter bracelet. Caregiver and family hereby release and waive any and all claims, demands, suits, and causes of action against CARETRAK and its employees, and volunteers, as well as City or County Law Enforcement or Fire and Rescue Agencies for failure to locate the person using the system, and hereby release all such agencies, employees and volunteers from any claim, cause of action, loss or damages arising from any inability or delay in locating the Applicant.
7. Caregiver acknowledges that all information provided in this application may be shared among Local Law Enforcement, Fire and Rescue, and other necessary agencies in the community. Therefore, caregiver acknowledges that none of the information provided now or in the future can be considered confidential, protected, or private when used for the limited purposes of the CARETRAK Program, [notwithstanding the provisions of the Personal Information Protection and Electronic Documents Act].
8. Caregiver specifically asserts that he/she has full authority to waive any rights to confidentiality to the Applicant's medical records, and hereby waives any and all such rights.
9. Caregiver acknowledges that CARETRAK is a program administered by the Decatur CARETRAK Program, in cooperation with the Decatur Police Department. Caregiver releases, holds harmless, and agrees to indemnify and defend each participating Agency, their respective personnel, officers and volunteers, from any and all claims of liability and/or damage, and waives any and all rights to seek recourse for any losses or injury that may occur as a result of participation in the CARETRAK Program.
10. Caregiver acknowledges that the transmitter and tester remain the property of CARETRAK and when no longer being used by the Applicant will be returned undamaged to CARETRAK to be assigned to another participant in the Program. Caregiver shall remain liable for any loss or damage to all such equipment and for the replacement cost of all such equipment until returned to CARETRAK.

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11. Caregiver acknowledges that he/she or family member shall use the tester device at least once per day and record the results on the supplied test result monthly inspection sheet. Caregiver acknowledges that he/she or family member shall notify CARETRAK immediately when Applicant is first discovered missing. Caregiver acknowledges that he/she, or family fail shall immediately notify CARETRAK in the event the transmitter device is tested and no signal indication found. Caregiver acknowledges that if the Applicant refuses to wear or removes the device 3 (three) times, then the Applicant may be involuntarily removed from the program. Caregiver acknowledges that any failure to follow any the requirements of this contract may result in the Applicant being involuntarily removed from the program, in which event Caregiver acknowledges that all CARE TRAK property will be returned to CARETRAK, and without recourse to CARETRAK.

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Applicant/client

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Caregiver name (printed)

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Caregiver signature

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Date

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## Physician Referral to CARETRAK

Physician name: \_\_\_\_\_

Physician address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby certify that I have been the physician for the above CARETRAK applicant for:  
(months/years).

I hereby certify that to the best of my knowledge, the applicant does not have any communicable disease that requires any safety precautions by CARETRAK Staff.

I understand that the CARETRAK program provides assistance with locating participants that suffer from a disorder that may prohibit them from communicating personal information to others, or those that if lost and not located in a timely manner could be in danger. CARETRAK participants require constant supervision and must have someone responsible for their care giving.

As the physician for the above CARETRAK applicant and with an understanding of the CARETRAK Program,  
I certify the above and recommend the applicant for inclusion in the CARETRAK program.

Physician Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_