

Dear _____,

Thank-you for your interest in CareTrak. We, along with other agencies, are excited to offer this important service to those citizens who can benefit from this program.

The equipment provided in this project is the property of the Sheriff's Office, and is available on loan to qualified clients. There is a \$200.00 **one-time activation fee** for those who qualify for the system; this money is used to help cover the locator bracelet that is placed on the individual client. In addition there is approximate \$9.00 fee every two months for a change of battery and bracelet.

If you are interested in participating in the Care Trak process please fill out the enclosed [DeKalb County Care Trak Application](#) .pdf and return to:

Sheriff's Care Trak
150 N. Main St.
Sycamore, IL 60178
or
FAX to 815-895-7235

After receiving the application, we will set up an appointment with you to move forward and make Care Trak operational for your family. If you have any questions please feel free to give me a call At 815 895 5829, or email me rscott@dekalbcounty.org

Respectfully,

Sheriff Roger Scott

RS/jw

DeKalb County Sheriff's Care Trak Application

Name: _____

Frequency # (to be assigned): _____

Date: _____ Date of Birth: _____

Diagnosis _____ Nickname: _____

Race _____ Height _____ Weight: _____

Sex _____ Hair Color: _____

Scars, Marks, Tattoos: _____

Address: _____

City _____

Caregiver/Parents _____

Home Phone: _____ Cell _____

Additional Emergency Contact: _____

Relationship to Client: _____

Phone #: _____

School District: _____ School: _____ Grade: _____

Clients work: _____ Phone: _____

Client's favorite location: _____

Last time missing, where was the client found: _____

Special Instructions (calming techniques, things to avoid):

**DeKalb County Care Trak
Application**

Client Name: _____ Frequency: _____

Law Enforcement Jurisdiction:
City/ Village of
Rural

CRITERIA

Diagnosis: _____

24 hour supervision provided	yes	no
History of wandering	yes	no
Difficulty in communication skills	yes	no

Additional Information:

MEDICAL

Physician: _____

Address: _____ City _____

Office Phone: _____ Fax: _____

Caregiver Signature: _____ Date: _____

(To be completed by Sheriff's Office)

Verify Jurisdiction: Yes ___ No ___

Law Enforcement Contacted: _____ **Date** _____

Law Enforcement Comment:

Sheriff's Office: **Approval** **Denial**

Reason for Denial: