

Dear Caregiver:

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](mailto:rscott@dekalbcounty.org)

Respectfully,

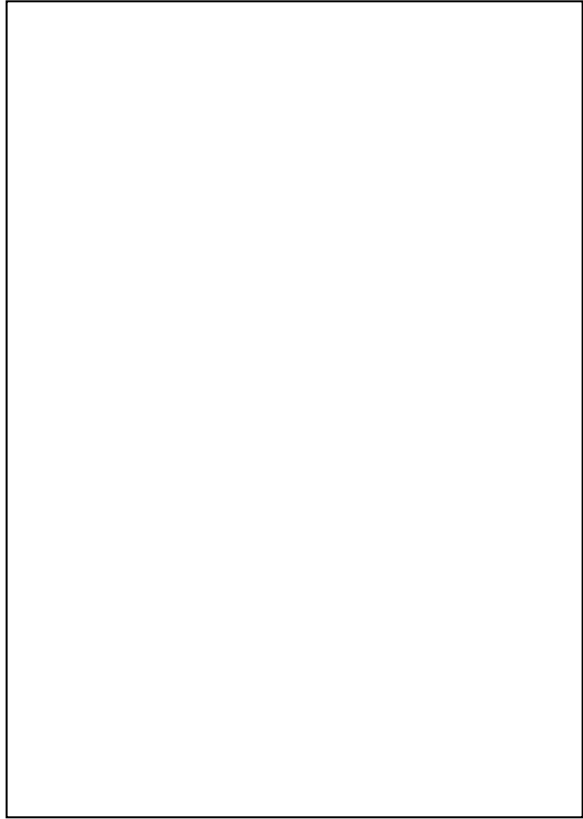
Sheriff Roger Scott

RS/jw

# DeKalb County Sheriff's Care Trak Application

Name \_\_\_\_\_

Frequency # (to be assigned:) \_\_\_\_\_



Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis \_\_\_\_\_ Nickname: \_\_\_\_\_

Height \_\_\_ft. \_\_\_ inches Weight: \_\_\_\_\_ lbs.

Race: \_\_\_\_\_ Other: \_\_\_\_\_

Sex \_\_\_M \_\_\_F 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: \_\_\_\_\_

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*(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:**