Clallam County. Sheriff's Office

PROJECT SAFER RESPONSE FORM

223 E. Fourth St., Suite 12
Port Angeles, WA 98362
Phone: (360) 417-2262

The more complete information disclosed will help in accomplishing the goals for "Project Safer". The information obtained in this document will be maintained as confidential and only disclosed to the extent necessary in aiding in the positive interactions with first responders. Medical information will be protected under State HIPPA laws.

This project is in collaboration between Port Angeles Police Department, Developmental Disabilities Administration, Clallam County Developmental Disabilities (Health and Human Services), along with other essential community members. We all want to ensure positive outcomes and interactions between all community members and first responders. This as a team effort.

Section 1: Client ID

RECENT DIGITAL PHOTOGRAPH

OPTIONS

1. Attach a photo here. ➡
2. Take a picture of the client and e-mail it at the same time you send the application.
3. Bring the client in to the Sheriff's Office and we will take the picture for you.

1.1 LEGAL NAME:				
1.2 NICKNAME	1.3 SEX	1.4 DATE OF BIRTH	AGE	1.5 RACE
	☐ Male ☐ Female ☐ Non-Binary			
1.6 PRIMARY DIAGNOSIS:				
1.7 PRIMARY **DE-ESCALATION** SUGGESTIONS (words to use; client interests; safe objects):				
1.8 PRIMARY CONTACT:			1.9 PHONE:	

Section 2: Client Information

2.1 WEIGHT	2.2 HEIGHT	2.3 HAIR COLOR	2.4 EYE COLOR	2.5 IDENTIFYING MARKS

2.6 STREET NUMBER	2.7 STREET NAME	2.8 CITY

2.9 How long has the client been living at this address?
2.10 VEHICLE LICENSES**:**

2.11 Does the client's diagnosis make him/her at-risk for wandering?	**Yes** ☐ **No** ☐

2.12 If **YES**, please explain:
2.13 Does the client have any mobility problems: **Yes** ☐ **No** ☐
2.14 If YES, please explain:
2.15 Please add additional information that may assist First Responders interact with the client: (attach a separate page if needed):

Section 3: Family Member / Primary Caregiver Information

3.1 FULL NAME	
3.2 RELATIONSHIP TO CLIENT	3.3 NAME CLIENT USES

3.4 STREET ADDRESS		
3.5 CITY	3.6 STATE	3.7 ZIPCODE
3.8 HOME PHONE	3.9 CELL PHONE	3.10 WORK PHONE

3.11 HOME E-MAIL	3.12 WORK E-MAIL

3.13 VEHICLE LICENSES:
3.14 OTHER RELEVANT INFORMATION:

Section 4: Family Member / Secondary Caregiver Information

4.1 FULL NAME		
4.2 RELATIONSHIP TO CLIENT	4.3 NAME CLIENT USES	
4.4 STREET ADDRESS		
4.5 CITY	4.6 STATE	4.7 ZIPCODE
4.8 HOME PHONE	4.9 CELL PHONE	4.10 WORK PHONE
4.11 HOME E-MAIL	4.12 WORK E-MAIL	
4.13 VEHICLE LICENSES:		
4.14 OTHER RELEVANT INFORMATION:		

Section 5: Health & Psychological Conditions

5.1 **MEDICAL CONDITIONS**	
5.4 **PSYCHOLOGICAL CONDITIONS**	
MEDICATIONS	
5.7 Medication:	5.8 Dosage:
5.9 Reason:	
510 Consequence of **NOT** taking this medication:	

Section 5: Health & Psychological Conditions (continued)

5.11 Medication:	5.12 Dosage:
5.13 Reason:	
5.14 Consequence of **NOT** taking this medication:	
5.15 Please add any other relevant health, educational, psychological information that may assist first responders:	

Section 6: Additional Family and Friends Contacts

6.1 Name:		6.2 Relationship:
6.3 Home Phone	6.4 Cell Phone	6.5 Other
6.6 Name:		6.7 Relationship:
6.8 Home Phone	6.9 Cell Phone	6.10 Other
6.11 Name:		6.12 Relationship:
6.13 Home Phone	6.14 Cell Phone	6.15 Contact

Section 7: Form Contact

7.1 Person Filling out Form:		7.2 Date:
7.3 Cell Phone:	7.4 Home Phone:	7.5 E-Mail: