Vulnerable Persons Registry Form

A recent photo of the individual is required to complete registration form.

Vulnerable Person ☐ New Registration ☐ Renewal

Diagnosis/Disability: _____

First Name:_____ Middle Name:_____

Last Name:_____

Nickname(s):_____

Gender: Male ☐ Female ☐ Decline to answer ☐ Date of Birth: _____

Street Address:_____Unit/Apt # _____

City:_____State:_____Postal Code: _____

Phone Number:_____Cell Phone Number: _____

Email address: _____

Employment / Educational Institute

Employer/School:_____

Street Address:_____Unit/Suite # _____

City:_____State:_____Postal Code: _____

Phone Number:_____ext. # _____

Physical Characteristics

Height:_____Weight:_____Build:_____Complexion:_____
Hair Color:_____Hair Style:_____Facial Hair: _____
Facial Hair Color:_____Eye Color:_____Glasses /Contacts: _____
Hearing Device:_____Communicates: Verbally_____Non-Verbally
Best Method to Communicate: _____
Marks/Scars/Tattoos/Piercings – location and description: _____
_____

Dominant Hand: (*please circle*) ☐ Left or Right ☐

Does the individual wear or carry any identification on them?
(*Please list*)

_____

Please list areas where the individual may wander to, including favorite places, parks, shops, friend's/family's houses and previous addresses. (*Please list*)

_____

_____

_____

Does the individual have a set daily routine - *Example: walks, visits coffee shops, etc*.?
(*Please list*)

_____

_____

What is the best method to approach this individual? Include de-escalation techniques if required:

_____

_____

_____

Please list any life threatening medical concerns and medication required:

_____

_____

Please provide any other relevant information:

_____

_____

If the person has access to a car please provide the following information:

Make/Model & Year of Vehicle: _____

Color of vehicle:_____Licence plate number_____State:_____

Registered Owner of the vehicle: _____

Family Physician

Name:_____Phone Number: _____

Street Address:_____Unit/Apt # _____

City:_____State: _____

Emergency Contact for Registrant: (if different from Legal Guardian below)

Name:_____Relationship:_____

Street Address:_____Unit/Apt # _____

City:_____State:_____Postal Code: _____

Phone Number:_____Cell Phone Number: _____

Email address: _____

This form must be completed by the Vulnerable Person's Legal Guardian

Registration form completed by: _____

Date of Birth:_____Relationship to Registrant: _____

Street Address:_____Unit/Apt # _____

City:_____State:_____Postal Code: _____

Phone Number:_____Cell Phone Number: _____

Email address: _____

As a person's Legal Guardian, you must also provide a copy of the paperwork establishing the guardianship.

Please read the following privacy policy and sign below:

Vulnerable Person Registry

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION AND PRIVACY POLICY

Through this form, the Fort Smith Police Department (FSPD) seeks to collect information that can identify you or a family member. Such identifying information may include your name, date of birth, e-mail, address, mailing address and other similar information ("personal data") when it is voluntarily submitted under HIPAA. You are not obligated to provide any information herein to the FSPD. You acknowledge that any information you provide above is on a voluntary basis.

FSPD may use your personal data to respond to requests you make of us and/or to interact with the person named.

FSPD may refer to your personal data to better understand your needs and how we can improve our services in relation to you and/or your family.

This information may be accessed by other police agencies through our records management system; however, consent must be provided for the use of such information.

By signing below, you authorize the FSPD to share this information with other emergency service agencies as needed. This information shall be used for emergency purposes only.

It is acknowledged that it is your responsibility to ensure that the information collected is current and valid. .

I authorize the FSPD's use or disclosure of the above named individual's health information as described herein. This authorization is intended to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), HIPPA regulations, and other state and federal laws and regulations that may create a right of privacy in the health information approved to be disclosed by this authorization. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the FSPD.

I hereby declare that the information provided in this document is true and correct to the best of my knowledge, and have read and accept the above.

Signature:_____ Date:_____

Submit Registration Form To:

Crisis Intervention Unit
Fort Smith Police Department
100 South 10th Street
Fort Smith, Arkansas 72901

OFFICE USE ONLY

Received and approved by: _____

Entered into Records Management System by: _____

Hazard for address recorded in C.A.D. by: _____

Date: _____