



Mesa Police Department
Resident Assistance Program



Resident:

Last Name: _____ First: _____ MI: _____

Sex: _____ Race: _____ DOB: _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Caretaker Email Address: _____

Ethnicity: _____ Height: _____ Weight: _____

Complexion: _____ Build: _____ Hand (L/R): _____

Hair: _____ Hair Style: _____ Eyes: _____

Occupation: _____ Employer: _____

Employer Address: _____

Primary Emergency Contact:

How Related: _____

Last Name: _____ First: _____ MI: _____

Sex: _____ Race: _____ DOB: _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Secondary Emergency Contact:

How Related: _____

Last Name: _____ First: _____ MI: _____

Sex: _____ Race: _____ DOB: _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Third Contact:

How Related: _____

Last Name: _____ First: _____ MI: _____

Sex: _____ Race: _____ DOB: _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Background Information about Resident

Diagnosis/Disability (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Blind/Low Vision |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Deaf/Low Hearing | <input type="checkbox"/> Diabetic |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Other Mental Disability | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Other Developmental Disability | |

Case Manager: _____

Preferred Care Facility: _____

Communication Method (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Verbal | <input type="checkbox"/> Non-Verbal |
| <input type="checkbox"/> Speech Difficulty | <input type="checkbox"/> Assisted Communication Device |
| <input type="checkbox"/> Picture Exchange Communication System | <input type="checkbox"/> Sign Language (ASL) |
| <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Non-Communicative |
| <input type="checkbox"/> Language other than English: _____ | |

Special Considerations (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Combative | <input type="checkbox"/> Combative if Restrained |
| <input type="checkbox"/> Disrobes or Prefers Nudity | <input type="checkbox"/> Fear of Dogs |
| <input type="checkbox"/> Hugs | <input type="checkbox"/> Light Sensitive |
| <input type="checkbox"/> Noise Sensitive | <input type="checkbox"/> Paranoid |
| <input type="checkbox"/> Repeats Phrases | <input type="checkbox"/> Run Tendency |
| <input type="checkbox"/> Self-Stimulatory Behavior | <input type="checkbox"/> Sensitive to Stimulation |
| <input type="checkbox"/> Touch Sensitive | <input type="checkbox"/> Unresponsive to Strangers |
| <input type="checkbox"/> Water Fixation (Attraction) | <input type="checkbox"/> Fear of Officers or Uniformed Individuals |

Additional Details

1. Medications the resident MUST take to avoid a medical emergency:
2. If the resident has a tendency to wander, please describe places the resident may choose to go:
3. List medical or psychological concerns that could help the resident remain safe and return home:
4. Suggestions for ways a police officer can approach and help the resident:
5. Regular behaviors and/or special interests:
6. Items the resident wears/possesses on a regular basis (medical devices, personal items, or objects):

Resident's Vehicle Information

If the resident can drive, please include the following information for their vehicles:

Type: _____ Make: _____ Model: _____

Year: _____ Color: _____

License State: _____ License Plate: _____

Vehicle Identification Number: _____

Photograph

You will need to submit a photograph once we verify this information with you. The image should be of good contrast and show the subject in well-lit conditions.

Date of Photograph: _____ Age in Photograph: _____

ACKNOWLEDGMENT

By participating in the Resident Assistance Program, I understand and acknowledge that:

- I am voluntarily offering the information to enroll in the Resident Assistance Program.
- The Mesa Police Department will collect and retain the listed information to respond to calls for service involving the resident in order to promote effective interaction with him/her, and, if applicable, to return the person home or to another responsible person(s).
- The Mesa Police Department will not share or distribute personal information gathered by this form except as required by law and will use it solely for the purposes stated in this document.
- It is my responsibility to ensure the information submitted is current and accurate, and to notify the Mesa Police Department in writing of any changes.
- Enrollment in the Resident Assistance Program is not considered an official police report.
- I may request to be withdrawn from the Resident Assistance Program at any time.
- The Mesa Police Department will retain the information for a period of one year, after which it will be purged from the system. Before it is purged, the Mesa Police Department will send a notice to me, at the address I provide, to determine if I want the information to remain on file for another one year. If the Mesa Police Department is unable to contact me at the address provided, I understand the information will be purged.
- By signing below, I certify that I have the authority to submit the listed information on behalf of myself or the resident, whichever applies. I understand the terms of this document and consent to the use of the information for the stated purposes.

Signature: _____ Date: _____

Print Name: _____

Relationship to Vulnerable Person: Self Other & Relationship