The Arc
Sedgwick County

According to SRS licensing requirements, this information must be completed mad returned **BEFORE** you can attend any activity (including the Y.E.S.S. Program) sponsored by The Arc.

Below are marked the forms your file needs at The Arc for this coming year. These forms are enclosed for you to complete.

☐ ***A Medical Examination*** **(Good for 2 years) – must be filled out and signed by a physician-** a recent medical form from another agency can be substituted

☐ ***General Information*** **(due annually) –** must be filled out as completely and accurately as possible.

☐ ***Consents*** **(due annually)** – Transportation, Publicity, and Appointment of Agent all to be signed by the Participant/guardian/ parent.

☐ ***HIPAA Acknowledgement of Receipt*** **(completed one time)** – Filled out and signed by the Participant if they are their own guardian/guardian/ parent for a child under 18.

☐ ***Membership*** **(due annually)** – you must be a member to participate in Arc programs. Membership runs January 1 – December 31.

All forms must be **Completed in Full** and returned to allow us to serve you or your client in **The Arc** Programs.

Return Forms As Soon As Possible To:

The Arc of Sedgwick County
2919 West Second St. N.
Wichita, KS 67203

If you have questions or need more information, call The Arc at 943-1191.

The Arc of Sedgwick County
Application and General Information

Personal Information

Participant's Name:			
Address:	City:	State:	Zip:
Home Phone:	DOB:	Race:	Sex:
Work Phone:	County Residence:		
Social Security #:	Medicaid #:		
Marital Status	Spouses Name		

Secondary Insurance

Name of policy holder:	Name of Company:	
Policy #:	Member #	Group #:
Member Services Number:		

Funding Status

BASIS Assessment Date:	Tier:
Do you currently have HCBS Funds? ☐ No ☐ Yes	If yes, list the date allocated:

Family Information

Father:			Mother:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Employer:			Employer:		
Home Phone:			Home Phone:		
Work Phone:			Work Phone:		
Cell:			Cell:		
E-mail:			E-mail:		

Emergency Contacts

1. Name:			2. Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Employer:			Employer:		
Home Phone:			Home Phone:		
Work Phone:			Work Phone:		
Cell:			Cell:		

Targeted Case Management Services

Service Coordinator:			Agency:
Address:			
City:	State:	Zip:	Phone number/extension:

Legal Status

☐ **Guardian** ☐ **Conservator**	Name:		
Address:	City:	State:	Zip:
Home Phone:	Work Phone		
Cell:	E-mail:		

☐ **Payee**	Name:		
Address:	City:	State:	Zip:
Home Phone:	Work Phone		
Cell:	E-mail:		

☐ **Own Guardian**	☐ **Ward of the State**

Medical Information

Primary Physician:	Phone Number		
Address:	City:	State:	Zip:
Dentist:	Phone Number		
Address:	City:	State:	Zip:
1. **Specialist**:	Type:	Phone:	
Address:	City:	State:	Zip:
2. **Specialist**:	Type:	Phone:	
Address:	City:	State:	Zip:
3. **Specialist**:	Type:	Phone:	
Address:	City:	State:	Zip:

Monthly Income

Necessary for United Way reports AND if requesting a scholarship.

☐ SSI Amount:	☐ SSDI Amount:	☐ Parents Combined Income: (if lives at home)		
SRS Assistance	☐ Food Stamps Amount:	☐ AFDC Amount:	☐ General Assistance Amount:	☐ Other Amount:

Living Arrangement

☐ With Family	☐ With Friend/Spouse	☐ Foster Care
☐ Other Please specify:		
☐ Residential Service **Name of Agency:**		
Address:	City:	State: Zip:
Residential Contact:	Phone Number:	

Current Day Activity

☐ Day/Habilitation Services **Agency Name:**			
Address:	City:	State:	Zip:
Day Services Contact:	Phone Number:		
☐ Attending School **School Name:**		**School District:**	
☐ Competitive Employment Employer:			
☐ None	☐ Other Specify:		

Please list adaptive equipment used by the Participant (wheelchair, braces, walkers, etc.)

Seizures? ☐Yes ☐No	Type	Known Causes
Allergies:		
Behavior Issues:		

Completed by:	**Date Completed:**