



**Arc of the Arts
Participant Application**
Please Print Clearly

Office Use Only

RECEIVED CONTACT TRIAL DAY SUMAC START

PERSONAL INFORMATION

Full Name: _____
 First Middle Last Nickname

Address: _____
 Street Address Unit # City State Zip Code

_____ Email Address Date of Birth

Phone #'s: _____
 Cell # Home #

Social Security#: _____ **Male** **Female** **DOB:** ___/___/___
 (Required if client wishes to be paid 20% comission for art work sold)

Appearance: _____
 Height Weight

_____ Hair Color Eye Color Ethnicity

PARENT/GUARDIAN/HOUSE STAFF INFORMATION

Is applicant own guardian? Yes No

Name: _____ **Name:** _____

Relationship: _____ **Relationship:** _____

Address: _____ **Address:** _____
 Street Address Unit # Street Address Unit #

_____ City State Zip Code City State Zip Code

Phone #'s: _____ **Phone #'s:** _____
 Cell Cell

_____ Home Home

Email: _____ **Email:** _____

Employer: _____ **Employer:** _____
 Name Name

_____ Phone #

EMERGENCY CONTACT INFORMATION

When no one can be reached at the above numbers, who should staff contact in case of emergency ? This person must be willing to help if guardian is not accessible.

Full Name: _____
First Middle Last Nickname

Address: _____
Street Address Unit # City State Zip Code

Phone #'s: _____
Cell Work Home

SERVICE CARE PROVIDER INFORMATION

Is the Applicant already a client of The Arc of the Capital Area? **Yes** **No**

If Yes, please list Arc of the Capital Area Case Manager: _____

Other Service Provider Agency _____

Case Manager: _____
Name Phone # Email

Mailing Address _____
Street Address Unit #

City State Zip Code

Name of Group Home/ Facility _____

House Manager: _____
Name Phone # Email

Mailing Address _____
Street Address Unit #

City State Zip Code

Name of additional support personal who will be coming to visit or assist client

1. _____
Name Phone # Email

2. _____
Name Phone # Email

3. _____
Name Phone # Email

MEDICAL INFORMATION

Medical Diagnosis: _____

Level of Need (LON) : _____

Physician:

Name Phone #

Dentist:

Name Phone #

**Psychologist/
Counselor:**

Name Phone #

Medication: Are any medication that will need to be taken while at Art class? **Yes** **No**
Please note that we will not be able to administer any medications. All medications must be self administered or administered by Guardian. If **YES**, please provide exact and complete details below.

Name of Medication	Dose	Time Taken

Are you allergic to any food, drugs, or anything else? **Yes** **No**

If yes, list all allergies:

Food allergy: _____

Drug allergy: _____

Other allergy: _____

Latex allergy: _____

Has the Artist ever had seizures? Yes No

If yes, check all that apply:

- Seizures stopped long ago and participant is OFF medication.
- Seizures are totally controlled but is still on medication. (This means no seizure in over a year.)
- Seizures are partially controlled on medication. Last seizure was _____
- Seizures are poorly controlled. Frequency _____

Type of seizure, *check all that apply*:

- Gran mal (falls down and moves around)
- Petit mal (staring spells)
- Other

Does client have a documented Service plan in the event a seizure occurs?

Describe symptoms of seizure:

Who is the Artist's neurologist? _____ Dr.'s Phone _____

Does the participant have a shunt? Yes No If yes, where is it located? _____

Has the participant ever had surgery? Yes No

If yes, please list including date and type of surgery:

Additional Comments: _____

Surgery	Date

Please disclose all known medical history and concerns. In this section, check all the problems that apply to the participant with explanation or any comments in the right column.

Problem	Comments
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Breathing Problems	
<input type="checkbox"/> Nebulizer or Mist Machine	
<input type="checkbox"/> Heart Problem	
<input type="checkbox"/> Kidney or Bladder Problem	
<input type="checkbox"/> Stomach or Intestinal Problem	
<input type="checkbox"/> Muscles	
<input type="checkbox"/> Bones	
<input type="checkbox"/> Joints	
<input type="checkbox"/> Skin (e.g. rashes, eczema, sunburn easily)	
<input type="checkbox"/> Raynaud's phenomenon	
<input type="checkbox"/> Dehydrates easily	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Frequently constipated	
<input type="checkbox"/> Frequent loose stool or diarrhea	
<input type="checkbox"/> Eczema	
<input type="checkbox"/> Frequent Skin Rashes	
Toileting	Comments
<input type="checkbox"/> Needs no help	
<input type="checkbox"/> Needs some help (describe)	
<input type="checkbox"/> Needs total assistance	
<input type="checkbox"/> Partially-trained (describe)	
<input type="checkbox"/> Help with transfer (describe)	
<input type="checkbox"/> Wears diapers	
<input type="checkbox"/> Has a catheter	
<input type="checkbox"/> Trouble with bowel movements	
<input type="checkbox"/> On a toileting schedule. Please describe.	
<input type="checkbox"/> Other:	

Dieting/Eating	Comments
<input type="checkbox"/> Needs no assistance	
<input type="checkbox"/> Needs total assistance	
<input type="checkbox"/> Assist with cutting	
<input type="checkbox"/> Uses a straw	
<input type="checkbox"/> Difficulty swallowing liquids	
<input type="checkbox"/> Difficulty swallowing solids	
<input type="checkbox"/> Has a tongue thrust	
<input type="checkbox"/> Needs special utensils	
Walking and Equipment	Comments
<input type="checkbox"/> Walks alone well	
<input type="checkbox"/> Walks alone but not well	
<input type="checkbox"/> Walks with assistance from: <input type="checkbox"/> An assistant <input type="checkbox"/> Hand held walker <input type="checkbox"/> Crutches or cane	
<input type="checkbox"/> Uses wheelchair and will bring to class <input type="checkbox"/> Power <input type="checkbox"/> Manual	
<input type="checkbox"/> Can transfer alone	
<input type="checkbox"/> Needs help to transfer. Type of transfer?	
<input type="checkbox"/> Cannot transfer at all	
<input type="checkbox"/> Pressure Ulcers/Sores	
<input type="checkbox"/> Braces <input type="checkbox"/> AFO's <input type="checkbox"/> SMO's Other braces (list) _____ Hand splints _____	
<input type="checkbox"/> Will wear braces or splints. If yes, what is his/her wearing schedule?	
<input type="checkbox"/> Contractures/Spasticity	
<input type="checkbox"/> Chronic Pain	
<input type="checkbox"/> Other equipment needed	
Vision and Hearing	Comments
<input type="checkbox"/> Normal Vision	
<input type="checkbox"/> Wears Glasses	
<input type="checkbox"/> Wears Contacts	
<input type="checkbox"/> Has partial vision	
<input type="checkbox"/> Is totally blind	
<input type="checkbox"/> Uses hearing aid	
<input type="checkbox"/> Has hearing impairment	
<input type="checkbox"/> Totally deaf	
<input type="checkbox"/> Wears hearing aid	
<input type="checkbox"/> Other	

Communication	Comments
<input type="checkbox"/> No problems	
<input type="checkbox"/> Talks, but it is hard to understand	
<input type="checkbox"/> Understands, but cannot speak	
<input type="checkbox"/> Does not understand at age level	
<input type="checkbox"/> Uses sign language	
<input type="checkbox"/> Speaks only a few words	
<input type="checkbox"/> Has almost no communication	
<input type="checkbox"/> Writes notes to communicate	
<input type="checkbox"/> Uses other communication tools	

Please describe special communication techniques/devices:

Behavioral Concerns	Comments
<input type="checkbox"/> Hitting	
<input type="checkbox"/> Biting	
<input type="checkbox"/> Hallucinations	
<input type="checkbox"/> Obsessions/perseverations	
<input type="checkbox"/> Elopement risk	
<input type="checkbox"/> Overwhelmed frequently	
<input type="checkbox"/> Uses abusive language	
<input type="checkbox"/> Does not taking responsibility when he/she has made a mistake	
<input type="checkbox"/> Oppositional behavior	
<input type="checkbox"/> Does not respond well to redirection and consequences	
<input type="checkbox"/> Requires one to one supervision at all times	
<input type="checkbox"/> Likes to be alone	
<input type="checkbox"/> Over stimulated on community outings	
<input type="checkbox"/> Does not interact well with others	

Describe any successful behavioral interventions used for behavioral problems:

PERSONAL DATA

1. Does the participant have a job? Yes No If yes, where?

2. Does the participant attend school? Yes No If yes, where?

3. What are the participant hobbies? (Please list)

4. Please list any fears, concerns or problems the participant might have while at Art class.

5. Does participant require a personal attendant? Yes No If yes, please describe.

6. Will the Attendant be accompanying the participant? Yes No If yes, note name

7. Please list what activities the participant should not participate in by doctor or parent/guardian request:

8. Please designate days of week Artist would like to attend. Currently studio hours will be Monday through Friday 9:00 am – 2:00 pm. Arrival time is between 8:30 am- 9:00 am. Pick up time is between at 2:00 pm- 2:15pm

Monday (Digital Media Arts/ Visual Arts) Tuesday (Performing Arts/ Visual Arts)

Wednesday (Visual Arts) Thursday (Visual Arts) Friday (Visual Arts)

10. Please advise us if the applicant has a monetary income limit on artist commission checks with which the applicant would need to stay within to remain qualified for state/federal services.

Client monthly monetary income limit: _____



The Arc of the Capital Area
Emergency Medical Authorization

I hereby authorize The Arc of the Capital Area and give my consent for said provider and The Arc of the Capital Area Providers to seek emergency medical or dental care including hospitalization or surgical procedures as may be necessary on behalf of Participant _____ D.O.B. _____.

I further authorize the medical provider to bill me for the cost of such care.

Parent/Guardian Name: _____
First Middle Last

Phone #'s: _____
Cell Work Home

Insurance Company: _____

Policy Number: _____ Medicaid Number: _____

Name of Doctor: _____ Phone Number: _____

Emergency Contacts:

Table with 3 columns: Name, Relationship, Phone Number. Contains 3 empty rows for contact information.

Allergies:

Current Medications:

Table with 3 columns: Name, Dosage, Frequency. Contains 3 empty rows for medication information.

Special circumstances for participant, which require a call to 911 and immediate notification to family?

This authorization is valid unless revoked in writing by:

Participant / Parent / Legal Guardian's Printed Name

Participant / Parent / Legal Guardian's Signature

Date