The Arc
Capital Area

Education Program 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: _____

Relationship: _____

Address: _____
Street Address Unit #

_____
City State Zip Code

Phone #'s: _____
Cell

_____
Home

Email: _____

Employer: _____
Name

_____

Name: _____

Relationship: _____

Address: _____
Street Address Unit #

_____
City State Zip Code

Phone #'s: _____
Cell

_____
Home

Email: _____

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

Dieting/Eating	Comments
☐ Needs no assistance	
☐ Needs total assistance	
☐ Assist with cutting	
☐ Uses a straw	
☐ Difficulty swallowing liquids	
☐ Difficulty swallowing solids	
☐ Has a tongue thrust	
☐ Needs special utensils	

Walking and Equipment	Comments
☐ Walks alone well	
☐ Walks alone but not well	
☐ Walks with assistance from: ☐ An assistant ☐ Hand held walker ☐ Crutches or cane	
☐ Uses wheelchair and will bring to class ☐ Power ☐ Manual	
☐ Can transfer alone	
☐ Needs help to transfer. Type of transfer?	
☐ Cannot transfer at all	
☐ Pressure Ulcers/Sores	
☐ Braces ☐ AFO's ☐ SMO's Other braces (list) _____ Hand splints_____	
☐ Will wear braces or splints. If yes, what is his/her wearing schedule?	
☐ Contractures/Spasticity	
☐ Chronic Pain	
☐ Other equipment needed	

Vision and Hearing	Comments
☐ Normal Vision	
☐ Wears Glasses	
☐ Wears Contacts	
☐ Has partial vision	
☐ Is totally blind	
☐ Uses hearing aid	
☐ Has hearing impairment	
☐ Totally deaf	
☐ Wears hearing aid	
☐ Other	

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

Please describe special communication techniques/devices:

_____

_____

_____

Behavioral Concerns	Comments
☐ Hitting	
☐ Biting	
☐ Hallucinations	
☐ Obsessions/perseverations	
☐ Elopement risk	
☐ Overwhelmed frequently	
☐ Uses abusive language	
☐ Does not taking responsibility when he/she has made a mistake	
☐ Oppositional behavior	
☐ Does not respond well to redirection and consequences	
☐ Requires one to one supervision at all times	
☐ Likes to be alone	
☐ Over stimulated on community outings	
☐ 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: _____

Financially Responsible Party
(Who is responsible for financial plans for applicant)

Name: _____

Address: _____

*Phone Number:*_____

*Email Address:*_____

The Arc
Capital Area

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:

Name	Relationship	Phone Number

Allergies:

_____

_____

Current Medications:

Name	Dosage	Frequency

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