



According to SRS licensing requirements, this information must be completed and 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 or Special Olympics may 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/guardian/ parent.

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
Wichita, KS 67203**

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

Due to postal regulations for bulk mailings all envelopes must be the same weight. Blank sheets of paper have been added to some envelopes to meet the bulk mailing standards. Just ignore them. Thank you.



The Arc of Sedgwick County Application and General Information

Personal Information

Participant's Name:		Service Coordinator:			
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:		Social Security Number of policy holder:			
Policy #:		Member #		Group #:	

Funding Status

BASIS Assessment Date:		Tier:			
Do you currently have HCBS Funds?		<input type="checkbox"/> No	<input type="checkbox"/> 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

<input type="checkbox"/> Guardian		<input type="checkbox"/> Conservator		Name:			
Address:			City:		State:	Zip:	
Home Phone:				Work Phone			
Cell:			E-mail:				

<input type="checkbox"/> Payee		Name:				
Address:			City:		State:	Zip:
Home Phone:				Work Phone		
Cell:			E-mail:			

<input type="checkbox"/> Own Guardian		<input type="checkbox"/> Ward of the State			
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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.

<input type="checkbox"/> SSI Amount:		<input type="checkbox"/> SSDI Amount:		<input type="checkbox"/> Parents Combined Income: (if lives at home)	
SRS Assistance	<input type="checkbox"/> Food Stamps Amount:	<input type="checkbox"/> AFDC Amount:	<input type="checkbox"/> General Assistance Amount:		<input type="checkbox"/> Other Amount:

Living Arrangement

<input type="checkbox"/> With Family		<input type="checkbox"/> With Friend/Spouse		<input type="checkbox"/> Foster Care	
<input type="checkbox"/> Residential Service	Name of Agency:				
<input type="checkbox"/> Other Please specify:					

Residential History

Has the participant ever resided in any of the following?

State Mental Retardation Hospital?	<input type="checkbox"/> Winfield	<input type="checkbox"/> KNI	<input type="checkbox"/> Parsons		
State Mental Health Hospital?	<input type="checkbox"/> Larnard	<input type="checkbox"/> Osawatomie	<input type="checkbox"/> Topeka	<input type="checkbox"/> Rainbow Mental Health Facility	
Private ICF/MR	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Private Nursing Facility	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Current Day Activity

<input type="checkbox"/>	Day/Habilitation Services Agency Name:	
<input type="checkbox"/>	Attending School School Name:	School District:
<input type="checkbox"/>	Competitive Employment Employer:	
<input type="checkbox"/>	None	<input type="checkbox"/> Other Specify:

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

Seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type	Known Causes
Allergies:		
Behavior Issues:		

Completed by:	Date Completed:
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Appointment of Agent

I hereby appoint the Arc of Sedgwick County as my agent and representative for the purpose of authorizing and consenting to hospital care and/or medical care for the treatment of _____ for any
(Participant's Name)
illness or injury that may occur while such person is in the care or custody of The Arc between the dates of January 1, _____ and December 31, _____, while I am not immediately available to give such consent.

Signature of Participant/Parent/Guardian

Transportation Consent

This is my permission to the Arc of Sedgwick County to transport, under supervision _____
(Participant's Name)
to places deemed necessary for the interest of the participant and/or in times of medical emergency to the appropriate agency for the period of January 1, _____ through December 31, _____.

Signature of Participant/Parent/Guardian

Publicity Consent

I hereby give my permission to The Arc of Sedgwick County and/or United Way to allow the use of _____
(Participant's Name)
's name and/or use photographs, audio recording, or video tape of activities in which he/she participates in an appropriate manner during the period of January 1, _____ through December 31, _____.

Signature of Participant/Parent/Guardian