



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 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.

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 may 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"/> <b>Guardian</b>		<input type="checkbox"/> <b>Conservator</b>		Name:			
Address:			City:		State:		Zip:
Home Phone:				Work Phone			
Cell:				E-mail:			
<input type="checkbox"/> <b>Payee</b>		Name:					
Address:			City:		State:		Zip:
Home Phone:				Work Phone			
Cell:				E-mail:			
<input type="checkbox"/> <b>Own Guardian</b>				<input type="checkbox"/> <b>Ward of the State</b>			

### Medical Information

<b>Primary Physician:</b>			Phone Number				
Address:			City:		State:		Zip:
<b>Dentist:</b>			Phone Number				
Address:			City:		State:		Zip:
<b>1. Specialist:</b>			Type:			Phone:	
Address:			City:		State:		Zip:
<b>2. Specialist:</b>			Type:			Phone:	
Address:			City:		State:		Zip:
<b>3. Specialist:</b>			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)				
<b>SRS Assistance</b>		<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		<b>Name of Agency:</b>					
<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 <b>Agency Name:</b>	
<input type="checkbox"/>	Attending School <b>School Name:</b>	<b>School District:</b>
<input type="checkbox"/>	Competitive Employment Employer:	
<input type="checkbox"/>	None	<input type="checkbox"/> Other Specify:

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

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

<b>Completed by:</b>	<b>Date Completed:</b>
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