APPLICATION

The Arc.
For people with intellectual and developmental disabilities

12700 Hillcrest Road, Suite 200, Dallas, Texas 75230
214-634-9810 fax: 214-634-9815
dgill@arcdallas.org

We want to make The Arc's classes and activities a fun and enriching experience for you! This application was designed to ensure that all client students are receiving appropriate accommodations in the classroom or during an activity. While this may seem like a lot of information to fill out now, know that this application will only need to be filled out once a year. Additionally, please know that all of the information you provide is strictly confidential. No student will be turned away based on disability, behaviors or other areas of need. This form is only used to help us, help you!

Thank You for your cooperation!

Date: _____ Full Name: _____

Street:_____ City:_____ State: _____ Zip:_____

Home Phone: _____Cell Phone: _____

E-Mail: _____

Person filling out application: Self ____ Parent/Caregiver/Guardian _____Staff _____

Who do you live with? (check one) Parents _____Self __Group Home _____Other _____

Age: _____DOB: _____Gender: _____Height: _____Weight: _____

How would you like to be contacted regarding Arc classes and activities? (check one)
Home phone: _____Cell Phone: _____Email: _____Mail: _____

What kind of transportation will you be using to get to Arc classes and activities? (check one)
Self __Parents_____ Dart Bus ____ Dart Paratransit (# _____) Other: _____

Parent/Caregiver/Guardian Names: _____

Street:_____ City:_____ State: _____ Zip:_____

Work Phone: _____ Cell Phone: _____

Work Phone: _____ Cell Phone: _____

Other Emergency Contact Person:
(staff, relative, friend, etc.) _____

Call 911 or Parent/Contact first? _____

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Work Phone: _____ Cell Phone: _____

Who should be contacted for questions, emergency situation, etc. during class time?

Name and Phone Number: _____

Personal Information:

Tell us about yourself so we can plan appropriate activities for you...

Check any/all of the activities that you enjoy doing:
Board games _____Crafts _____Art _____Sports _____ Read _____
Listen to music ____Play video games ___Computer games ____ Other: _____

Reading (Please check where you are right now):
Cannot read ____ I know some words ____ Read independently ____

Writing (Please check where you are right now):
Cannot write ____ I can write simple words ____ Write independently _____

Are there things that bother you? (loud noises, change of routine, large crowds, etc.)

_____

_____

How would you describe your day-to-day behavior? (quiet, hyperactive, social, aggressive)

_____

Do you require one-on-one help with any of the following? (check all that apply)

Toileting _____Assistance in class _____Feeding _____Talking _____
Mobility (walking) _____Other _____

If yes, please describe in detail: _____

_____

_____

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Please include any other vital information about yourself that would help us, help you: _____

_____

_____

Please include any activity restrictions: _____

_____

Medical Information:

Do you take medications during the day? If so, what kind(s) of medications and what are the administration times?

Name: _____ Dosage: _____ Time: _____

Name: _____ Dosage: _____ Time: _____

Name: _____ Dosage: _____ Time: _____

_____

_____
Physician's Name Area of Specialization Phone

_____
Physician's Name Area of Specialization Phone

Do you have any allergies to food, animals, medicine, etc? If yes, please describe:

_____

If an emergency occurs and the circumstances permit, what hospital do you prefer?

_____

When deemed necessary by staff, may Aspirin or Tylenol (circle one) be given? _____

Please give us his/her Provider(s) (ex., Metrocare or Lifepath): _____

Please give us his/her Level of Need: _____ and their LCN Number: _____

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List Client disability/diagnosis: _____

Please circle if you have any of the following:

Asthma/Bronchitis	Emotional Problems	Cerebral Palsy
Heart Condition	Contact Lenses	Hepatitis
Seizure Disorder	Other: _____	

AUTHORIZATIONS for Individuals who are NOT their own Guardian:

FOR EMERGENCY TREATMENT:

I hereby authorize The Arc of Dallas staff and agents permission to (1) administer any treatment deemed necessary by a licensed physician or dentist; and (2) to transfer me to any hospital reasonably accessible.

I understand that this authorization is given to provide authority and power on the part of The Arc of Dallas employees or representatives to give specific consent to any diagnosis, treatment or hospital care, which, in the judgment of a licensed physician is deemed advisable.

Date _____ Signature _____

Date _____ Signature of Parent/Guardian _____

FOR TRANSPORTATION:

I, _____ am the (father, mother, guardian) of

_____. I give The Arc of Dallas staff, or representatives, my permission to transport my son/daughter to Arc authorized activities. I understand that The Arc of Dallas staff, or representatives, and their vehicles are covered by agency insurance.

Date _____ Signature _____

Date _____ Signature of Parent/Guardian _____

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FOR PHOTOGRAPHS:

I, _____ am the (father, mother, guardian) of

_____. I authorize The Arc of Dallas to

photograph: _____.

All photographs become the property of The Arc of Dallas and will be used exclusively for the programs and advocacy efforts of The Arc of Dallas.

Date _____ Signature _____

Date _____ Signature of Parent/Guardian _____

Payment Requirements:

The Arc of Dallas strives to keep all cost to our clients as low as feasibly possible. In order to do this The Arc of Dallas requires all payments to be made in full and at the time of registration. Non-payment may result in automatic withdrawal and denial to class or activity with outstanding balances subject to additional interest charges applied monthly yet not to exceed 15% per year. Therefore, it is your responsibility to understand that The Arc will conscientiously pay its vendors, local, state and federal agencies, employees, and staff in a prompt and timely manner.

A 30-day notice MUST be given for any change in class enrollment so that the class is staffed according to enrollment.

In general, your payment for any activity / class will be paid to The Arc of Dallas, 12700 Hillcrest, Suite 200, Dallas, TX 75230, by: (check all that apply)

_____ Cash or Check or _____ Credit Card

Payment Provided by:
_____ Self, Parent or Guardian
_____ HCS Provider
Provider Name _____
Case Manager: _____
Phone Number: _____
_____ Other (please explain): _____

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Individual(s) Responsible for Payment:

I understand and agree to the payment terms as stated above.

Date: _____ Signature: _____

Date: _____ Signature: _____