COMMUNITY PROGRAMS- PARTICIPANT APPLICATION

Please select which program(s) you are applying for:

☐ Supported Retirement | Arc Choirs: ☐ M'n'M Singers OR ☐ Grace Notes

☐ Friday Fun Day | ☐ Petals with a Purpose | ☐ Cooking & Nutrition Class

☐ Triangle Self-Advocacy Network ☐ Durham County ☐ Orange County ☐ Wake County

☐ Community Connections Partnership Program ☐ Durham County ☐ Orange County ☐ Wake County

Legal Name:		Date of Birth:
Preferred Name:	Gender: ☐ Male ☐ Female ☐ Neutral/Fluid ☐ Unknown	

Ethnicity: ☐ African American ☐ Alaskan Native/Native American ☐ Asian ☐ Caucasian ☐ Hispanic
☐ Native Hawaiian/Pacific Islander ☐ Other___________________________________

Address:		County:
City:	State:	Zip:
Phone:	Cell Phone:	Email:

Why do you want to participate in the above selected activity(s)?

What kinds of leisure/recreational activities do you enjoy? Do you have any hobbies or special interest? This box must be completed if applying for the Community Connections Partner Program

Primary Language Spoken if other than English:

How do you best communicate?
☐ Verbal ☐ Limited Verbal ☐ Sign Language ☐ Combination verbal/sign language ☐ Gestures
If vocabulary is limited, what phrases and/or words do you use regularly?

Describe any special accommodations needed:

Diagnosis(es) (check all that apply):

☐ Intellectual/Developmental Disabilities ☐ Cerebral Palsy ☐ Down Syndrome

☐ Autism Spectrum Disorder ☐ Traumatic Brain Injury ☐ Other

Secondary Diagnosis or other significant conditions:

Precautions/Allergies:

Medications: (include name, dosage, frequency, purpose):	
Physician:	Phone:
Practice Name:	

Other Information/Services Received:

Living Situation:

Immediate Family and/or significant others living in the home (Names/Relationships):

Legal Guardian Name:		
Address (if different from participant):		County:
City:	State:	Zip:
Phone:	Cell Phone:	Email:

Emergency Contact and Additional Contact:

1. Name:		Relationship: ☐Parent ☐ Guardian ☐ Other
Address:		
City:	State:	Zip:
Phone:	Cell Phone:	Email:
2. Name:		Relationship: ☐Parent ☐ Guardian ☐ Other
Address:		
City:	State:	Zip:
Phone:	Cell Phone:	Email:

Program Fees:

Invoices and Arc Membership should be sent to (please check the one box that applies): ☐ Me at the address on the front of this form OR		
☐ Name:		Relationship: ☐Parent ☐ Guardian ☐ Other
Address:		
City:	State:	Zip:
Phone:	Cell Phone:	Email:
If payment of fees would be a hardship, please describe your circumstances below. Scholarships may be available.		

Transportation:

It is the responsibility of the participant to coordinate their own transportation. Please list the person who will provide transportation to the above Community Programs and/or your public transportation provider.		
☐ Name:	Relationship: ☐Parent ☐ Guardian ☐ Other	
Phone:	Cell Phone:	Email:
☐ Public Transportation Provider Name (Taxi, Bus, Uber, etc.):	Contact Name (if applicable):	
Office Phone:	Cell Phone:	

PROGRAM COMMITMENT & FINANCIAL OBLIGATION: I understand that by joining a Community Program I am agreeing to participate in the activity on the designated day(s)/time and am also responsible for paying any fees associated with that activity. Becoming a member of The Arc of the Triangle is also required and membership must be maintained annually. Membership is $15 for self-advocates.

PRIVACY STATEMENT: Your privacy is important to us. The information you provide about yourself, family members or friends is for The Arc of the Triangle's information only. We do not share this information with outside parties.

Signature	Date

Comments/Notes: (office use only)

Program: Admission Date: (office use only)	Discharge Date: (office Use Only

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Return this application to: Michelle Foy at mfoy@arctriangle.org or fax 919-832-5446