St. Louis Arc Participant Profile

Please complete both sides of this registration form.

Participant Name ____________________ Social Security Number ____________________

Home Phone ____________ Cell Phone ____________ Street Address ____________________

City ____________________ State ____________ Zip (We must have last 4 digits) ____________

Date of Birth ____________________ E-mail Address ____________________

1

Gender
- ☐ Male
- ☐ Female

Are you a St. Louis County Resident? ☐ Yes ☐ No

Do you receive Medicaid Waiver funds? ☐ Yes ☐ No

Are you an active St. Louis Regional Center client? ☐ Yes ☐ No

When did this disability manifest itself? ☐ Prior to age 19 ☐ Prior to age 22

2

Participant Lives:
- ☐ w/Family
- ☐ Independently
- ☐ Individual Supported Living
- ☐ Specialized Facility
- ☐ Nursing Home
- ☐ Habilitation Center
- ☐ Foster Home
- ☐ Group Home
- ☐ Other ____________________

3

Participant's Diagnosis:
- ☐ Mental Retardation
- ☐ Autism
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Learning Disability
- ☐ Head Injury
- ☐ Other ____________________

If "Other" diagnosis is checked, select the substantial functional limitations in two or more of the following areas of major life activities:
- ☐ Receptive-Expressive Language
- ☐ Capacity for Independent Living
- ☐ Self Direction or Economic Self Sufficiency
- ☐ Learning
- ☐ Self Care
- ☐ Mobility

4

Participant's Race:
- ☐ Caucasian
- ☐ African-American
- ☐ Bi-Racial
- ☐ Other ____________________
- ☐ Native American
- ☐ Hispanic
- ☐ Asian

5

Regional Center Service Coordinator Name: ____________________

Service Coordinator Phone: ____________________

6

Medical/Dietary Concerns/Accommodations Needed:

____

____

7

1st Contact Information: **Emergency Contact?** ☐ Yes ☐ No **If yes, please circle priority:** 1 2 3

Name ____________ Relationship ____________ (Area Code) Home Phone Number ____________

Address ____________ Work Phone Number ____________ Cell Phone Number ____________

City ____________ State ____________ ZIP ____________ E-mail ____________

2nd Contact Information: **Emergency Contact?** ☐ Yes ☐ No **If yes, please circle priority:** 1 2 3

Name ____________ Relationship ____________ (Area Code) Home Phone Number ____________

(Area Code) Cell Phone Number ____________ (Area Code) Work Phone Number ____________ E-mail ____________

Guardian (If registrant is own guardian, check here ☐) **Emergency Contact?** ☐ Yes ☐ No **If yes, please circle priority:** 1 2 3

Name ____________ Relationship ____________ (Area Code) Home Phone Number ____________

Address ____________ (Area Code) Work Phone Number ____________

City ____________ State ____________ ZIP ____________ (Area Code) Cell Phone Number ____________

E-mail ____________

Application Form - Neighborhood Experiences/Teens In Motion

Participant Name

Please choose only one activity from Box 1.

1

Neighborhood Experiences (ages 16 – 20)

Pick-up/Drop-off Locations: (select one)

- ☐ Arden Mead Youth Center (17 Selma Ave.)
- ☐ St. Louis Arc Office (1177 N Warson Rd.)

Teens In Motion (ages 13 – 15)

Will accept up to age 20 based on needs of participant

Pick-up/Drop-off Locations: (select one)

- ☐ Arden Mead Youth Center(17 Selma Ave.)
- ☐ St. Louis Arc Office (1177 N Warson Rd.)

2

Release and Agreement Statement

I hereby give permission to the physician selected by the program director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for the participant as named on this form at my expense. By signing, I give permission to the St. Louis Arc to release my personal information to the program leader. I do hereby indemnify said Association, its agents and employees, and agree to hold it and them harmless from any and all liability arising out of any injury, illness, or accident that might happen to the participant and from any damage the participant might cause to any person(s) or property while in the care of the Association or its agents of employees.

I have read the above, which I understand and agree to abide by.

Signature of Participant Date Signature of Parent/Guardian Date

3

Photo Release Statement

I hereby authorize the use of my name, photographs, and/or videotape for newspaper, radio, advertisement, promotional materials or publication/website of the St Louis Arc.

I have read the above, which I understand and agree to abide by.

Signature of Participant Date Signature of Parent/Guardian Date

Please return completed application within 7 business days of online registration.
Send by fax or e-mail to:

FAX #: 314-569-3645
E-mail: lmilton@slarc.org

No registrations will be accepted before February 21, 2014
Cancellations made before April 21, 2014 will receive a full refund

For use with online registration only.