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Working with and for people with developmental disabilities and their families in Wake County.



PROJECT SEE (SUPPORTED EMPLOYMENT EXPERIENCES) PARTICIPANT APPLICATION

Name: _____

Address: _____

Phone: _____

Email _____

Birth Date: _____ Gender M F Soc. Sec. # _____
 (must be at least 16 years old)

Name of Applicant's Parents/Guardians: _____

Address (if different from applicant's): _____

Phone (Home): _____ (Work): _____

(Mobile): _____ Email: _____

In case of emergency, whom should we contact?

Name: _____ Relationship: _____

Phone (Home): _____ (Work/Other): _____

Are you currently in school? yes no If yes, School Name _____

Teacher's Name & Phone: _____

HEALTH INFORMATION:

Please check all boxes that apply:

- Seizures
- Frequent ear infections
- Visual Impairment
- Fever-related convulsion
- Difficulty eating
- Hearing Impairment
- Dental concerns
- Physical difficulties _____
- Other _____

Please list all medications and reason for use:

Please list all allergies & known reactions:

If you checked any of the above boxes, listed medications and/or allergies, please use this space to give any additional information that would be helpful to staff:

Please list and describe any fears/sensory issues that staff should know about:

Applicant's Primary Physician: _____

Address: _____

Phone: _____ Hospital Preference _____

Insurance Provider: _____ Policy/Group# _____

Name of Insured _____ Relationship _____

Secondary Insurance _____ Policy/Group# _____

Name of Insured _____ Relationship _____

I attest that the information provided here is accurate and willfully submit my application to be considered in the Project SEE program.

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

Signature of Applicant Date

Signature of Responsible Party/Relationship Date

Please complete both sides of this application!