

# The Arc Van Service

**The Arc, Association for Retarded Citizens Wichita County, Inc.**  
3115 Buchanan Wichita Falls, Texas 76308 940/692-2303

**The Arc Van Service provides transportation to individuals with intellectual and developmental disabilities ages 18 and older. Each application must be approved. Individuals participating in this program must not live with their family, a caregiver or relative. You must be a member of The Arc or People First and live in Wichita County. Each participant is required to follow the rules for our van service, make a reservation for this service and pay \$1.00 for the transportation.**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ Phone \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_ Age \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Do you have a caseworker? If yes please state their name \_\_\_\_\_  
and work phone number \_\_\_\_\_.

Please list an emergency contact:

Name \_\_\_\_\_ Address \_\_\_\_\_  
Phone number \_\_\_\_\_.

Your social security number is \_\_\_\_\_.

Do you have medical insurance? If yes, list the policy number \_\_\_\_\_ and  
insurance company name \_\_\_\_\_.

Are you eligible for Medicaid benefits? If yes, please provide your number \_\_\_\_\_.  
Are you eligible for Medicare benefits? Please provide us your number \_\_\_\_\_.

What medication do you take? (Please print this information clearly)

Med#1 \_\_\_\_\_ Dosage \_\_\_\_\_

Specific time taken \_\_\_\_\_

Med # 2 \_\_\_\_\_ Dosage \_\_\_\_\_

Specific time taken \_\_\_\_\_

Med # 3 \_\_\_\_\_ Dosage \_\_\_\_\_

Specific time taken \_\_\_\_\_

Med # 4 \_\_\_\_\_ Dosage \_\_\_\_\_

Specific time taken \_\_\_\_\_

**Applicant** \_\_\_\_\_

**Please check the following if yes:**

Seizures \_\_\_\_\_      Wear glasses \_\_\_\_\_      Thyroid problems \_\_\_\_\_      Use a wheelchair \_\_\_\_\_  
Walker \_\_\_\_\_      Cane \_\_\_\_\_      Use only sign language \_\_\_\_\_  
Wear false teeth or dentures \_\_\_\_\_      Asthma \_\_\_\_\_      High blood pressure \_\_\_\_\_  
Wear a hearing aide \_\_ left ear \_\_ or right ear \_\_      Wear a pacemaker? \_\_\_\_\_  
Heart problem \_\_\_\_\_      Please explain \_\_\_\_\_.

**List foods any food allergies you have** \_\_\_\_\_.

**List any medications you are allergic to** \_\_\_\_\_.

**Describe any other medical information that would be beneficial in case of an emergency:**  
\_\_\_\_\_  
\_\_\_\_\_.

**Do you have a legal guardian? If yes, who? Name** \_\_\_\_\_  
**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **St** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Work #** \_\_\_\_\_ **Home #** \_\_\_\_\_

**Your primary doctor is** \_\_\_\_\_  
**Phone number** \_\_\_\_\_

**MEDICAL RELEASE**

**I/we** \_\_\_\_\_, hereby, give permission to request or approve any medical attention needed for myself to authorized staff or volunteers of The Arc or the emergency room staff of a local hospital or clinic.

\_\_\_\_\_  
**Signature of applicant** \_\_\_\_\_ **Date** \_\_\_\_\_  
\_\_\_\_\_  
**Guardian's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Applicant** \_\_\_\_\_

