## The Arc of St. Lucie County, Inc.
## Job Access Reverse Commute Application

The **Job Access Reverse Commute (JARC)** provides transportation to/from work and vocational training for those who qualify. Participants must fall within 0% to 150% of the Federal Poverty Level Guidelines and/or be disabled. A minimum of 24 hours notice is required for any changes in transportation. Initial information obtained in this document, and subsequent information obtained upon annual review will be subject to verification. In the event that the individual requires emergency care, information contained in this document must be provided to EMS and/or hospital as needed.

**Instructions**: Complete all sections. If a section does not apply to the individual, indicate it as N/A for not applicable. If information is not available or is unknown indicate it as UNK.

**Preferred Start Date:** ____________________

| | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|---|---|
| **Days you need Transportation (please check)** | | | | | | | |
| **PU/DO Time (put am/pm)** | | | | | | | |
| **Work Clock In/Out Times (put am/pm)** | | | | | | | |

**Notes:** ____________________

____________________

____________________

____________________

**Pick Up:**

Address ____________________ Florida ____________________

Street City State Zip Code

**Drop Off:**

Address ____________________ Florida ____________________

Street City State Zip Code

**Source of referral:** ____________________

**Name** **Contact Information**

**Participant's Name** ____________________

Last First Middle

Address ____________________ Florida ____________________

Street City State Zip Code

Telephone ____________ Alternate Number ________ DOB ____________

Social Security Number: Sex Race ____________

Legally Competent Yes ☐ No ☐

Disabled Yes ☐ No ☐

If yes, list disability: ____________________

**Emergency Contacts:**

Name Address Relationship Contact Phone #'s

____________________

____________________

____________________

**Allergies (medication, food, insects)** Yes ☐ No ☐

If yes, please specify ______________________________

| **Please list any/all Behavior(s)/Characteristics:** |
| --- |
| |
| **Please list any/all Medical Issues:** |
| |

**Current Medications (Prescription/Non Prescription):**

| Name/Dosage | Frequency | Physician | Purpose | List known side effects to consumer below. Refer to Medication Side Effect Worksheet for potential effects. |
| --- | --- | --- | --- | --- |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Primary Physician:** ______________________________

Name Address Phone

**Please list the names and incomes of all people living in your house:**

| Name | Gross Income | per | | | |
| --- | --- | --- | --- | --- | --- |
| | | per | ☐ Week | ☐ 2 Weeks | ☐ Month |
| | | per | ☐ Week | ☐ 2 Weeks | ☐ Month |
| | | per | ☐ Week | ☐ 2 Weeks | ☐ Month |
| | | per | ☐ Week | ☐ 2 Weeks | ☐ Month |
| | | per | ☐ Week | ☐ 2 Weeks | ☐ Month |

Total Gross Income for the household: ____________ per ☐ Week ☐ 2 Weeks ☐ Month

**PARTICIPANT'S EMPLOYMENT/VOLUNTEER HISTORY**

Employer ____________ Address ____________ Phone ____________

Nature of Work/Occupation ______________________________

Employment Dates ____________ Hours/ week ________ Paid ________ Volunteer ________

Comments: ______________________________

Employer ____________ Address ____________ Phone ____________

Nature of Work/Occupation ______________________________

Employment Dates ____________ Hours/ week ________ Paid ________ Volunteer ________

Comments: ______________________________

I hereby give my consent to The Arc of St. Lucie County, or persons operating in its authorized behalf, the unqualified right and permission to take photographs, slides or motion pictures of myself, my son or daughter for the purpose of reproductions, publication, and illustration in advertising and publicity media.

______________________________ ____________________

Applicant/Guardian/Parent Signature Date

In the event that medical treatment or other emergency services should be required, I do hereby consent for The Arc to obtain the required emergency medical procedures necessary for my health and welfare or for the health and welfare of myself/son/daughter. I agree to pay all costs and fees contingent on any emergency medical care and/or treatment for myself/my child. This consent will be effective the date it is signed and continue while the participant is enrolled in an Arc program.

Applicant/Guardian/Parent Signature Date

I have completed and understand the application for the JARC program. I wish to enroll in The Arc's JARC program. I understand it is my obligation to notify the Arc within 24 hours for any changes regarding my transportation to/from the program. I have informed The Arc of all health, physical and emotional problems of the participant and agree to update information as changes occur.

Applicant/Guardian/Parent Signature Date

I am aware that any omissions, falsifications, misstatements, or misrepresentations on the above information I have given may disqualify me or cause my termination from the JARC program. I certify that to the best of my knowledge and belief that all of the information contained herein is true, correct, complete, and made in good faith.

Applicant/Guardian/Parent Signature Date

Signature of Office Personnel Date Application was received