



## 2024 Participant Information Form

**It is mandatory that this form be filled in/updated each year and turned in to the SOAR office whether the participant is a member or non-member.**

*Please print legibly, and send completed form to*

**SOAR Fox Cities, Inc., 211 E. Franklin St., Suite A, Appleton, WI 54911  
or email to [leah@soarfoxcities.com](mailto:leah@soarfoxcities.com)**

### Participant Information

Group/Apartment/Foster/Adult Home Name, if any: \_\_\_\_\_

**Participant's Full Legal Name:** \_\_\_\_\_

Nickname (ex: Bob, Bobby, Rob), if any: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

County: \_\_\_\_\_

Place(s) of Employment: \_\_\_\_\_

Phone/s: \_\_\_\_\_

Primary Phone: \_\_\_\_\_

Participant Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Participant Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender (Circle One):

Male

Female

Prefer to self-describe: \_\_\_\_\_

Prefer not to answer

School attending (if applicable): \_\_\_\_\_

**EMERGENCY CONTACT – PERSON TO BE CONTACTED  
FIRST IN AN EMERGENCY:**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

\*Phone (Day): \_\_\_\_\_

(Evening): \_\_\_\_\_

*SOAR Fox Cities, Inc. and its Programs are not responsible for accidents or injuries that may occur to participants or attendees during activities. SOAR Fox Cities, Inc., its employees and volunteers are not liable for any and all claims demands, losses, damages, actions, rights of actions of whatever kind or nature arising out of, in consequence of, or on account of any injuries or incidents which may occur due to participation in a SOAR activity.*

Living Situation (check one):

\_\_\_ lives independently

\_\_\_ lives with parent/sibling/relative. Their name/s & phone are: \_\_\_\_\_

\_\_\_ foster home. Name & phone: \_\_\_\_\_

\_\_\_ adult family home. Name & phone: \_\_\_\_\_

\_\_\_ apartment program. Name & phone: \_\_\_\_\_

\_\_\_ group home. Name & phone: \_\_\_\_\_

\_\_\_ other: \_\_\_\_\_

**CANCELLATION CONTACT-PERSON TO BE  
CONTACTED WHEN A SOAR ACTIVITY IS  
CANCELLED:**

Name: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Phone: \_\_\_\_\_

Do you prefer: e-mail OR phone (circle one)

Caregiver or Support Staff name and phone\*: \_\_\_\_\_

Email: \_\_\_\_\_

### Guardian & Payee Information

\_\_\_ I am my own guardian

\_\_\_ I have Long-Term Care Funds (please circle one):

IRIS    Lakeland Care    CLTS

Community Care    Inlusa

\_\_\_ My guardian is: \_\_\_\_\_  
(address) \_\_\_\_\_

\_\_\_ My Payee/Fiscal Agent/Care Manager/Consultant's

(name) \_\_\_\_\_

(e-mail) \_\_\_\_\_

(phone) \_\_\_\_\_

email & phone are: \_\_\_\_\_

**Continue on other side →**

## **MEDICAL CONDITIONS**

*Check/circle all that apply*

- ☐ Autism Spectrum Disorder
- ☐ Brain Injury
- ☐ Down Syndrome
- ☐ Fragile X Syndrome

- ☐ Hearing/Vision Impaired
- ☐ Intellectual Disability
- ☐ Mental Health
- ☐ Prader Willie's
- ☐ Physically disabled  
\*Uses wheelchair, walker, other: \_\_\_\_\_

- ☐ Other :
- ☐ Seizure Disorder  
type:  
aura:  
other:  
\_\_\_\_\_vagal nerve stim.  
Magnet location: \_\_\_\_\_

*Please note assistance or other accommodations needed, including an interpreter if necessary.*

## **Is there anything we should know about the person's:**

- ☐ Speech/Communication
- ☐ Chewing/Swallowing
- ☐ Toileting/Incontinence
- ☐ Wandering/Eloping

## **Please list any ALLERGIES—Non Food and/or Food Related: -**

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**NOTE:** If this person has severe diet restrictions, we recommend that you send a bag lunch along.

**BEHAVIOR PROGRAM** Please indicate if there is a behavior procedure you wish SOAR staff to follow or attach the behavior sheet if you have one.

**RESPONSIVENESS** Does participant respond independently to emergency situations (fire alarms/drills)? Yes \_\_\_ No \_\_\_

**SOCIAL APPROPRIATENESS/INTERACTIONS WITH OTHERS** Is there anything SOAR staff should know about personal interactions?

**For agency funding/reporting purposes, the following information is needed.  
No names/identifying information is ever shared. Choose one in each column**

Race (Choose one)	Ethnicity (Choose one if applicable)	Gender Identity (Choose those applicable)	Individual's income level range (not Family) (Choose one)
White/Caucasian	Hispanic	Female	<\$12,144
Black/African-American	Hmong	Male	\$12,145-\$15,792
Asian		Trans-male	\$15,793-\$20,040
American Indian/Alaskan Native		Trans-female	\$20,041-\$24,288
Native Hawaiian/Pacific Islander		Non-Binary	>\$24,288
Multiple Races		Other:	



\_\_\_ **YES! I want to receive fundraising communication from SOAR Fox Cities!** (complete or circle one)  
Send via email: \_\_\_\_\_ **OR send via postal mail only.**

*A Partner Organization of United Way Fox Cities. Supported by the Community Foundation for the Fox Valley Region, individuals and corporate donors.*