



**Beacon Programs
Adult Enrollment Form**



Participant Information

1. Last Name _____ 2. First Name _____
3. Gender Male Female 4. Birth Date (optional) (month/day/year) _____
5. Street Address (number and street) _____ Apt # ___ Zip Code _____
6. Ethnicity American Indian Asian (Non-Hispanic) Black (Non-Hispanic)
Hispanic/Latino Pacific Islander White (Non-Hispanic)
Other
7. Primary Language _____

Emergency Contact Information

Persons authorized by you to be contacted in case of emergency.

8. Emergency Contact Name: _____
Relationship _____
Home Phone Number _____
Cell Phone Number _____
9. Emergency Contact Name: _____
Relationship _____
Home Phone Number _____
Cell Phone Number _____

Health History

10. Are you or any member of your household covered by Medicaid, Child Health Plus, Family Plus or private medical insurance? Yes No
- If no, do you want to be contacted with information about public health insurance programs? Yes No

Please list any allergies or health issues that we should be made aware of in case of emergency:

Certification Statement

I, the undersigned, certify that all information on this form is true and correct. I understand that my statements are subject to verification. I agree and accept that I will abide by all applicable rules and regulations of the program.

Applicant Signature _____ Date _____
Intake Officer Signature _____ Date _____