Application Package – Children's Disability Services

Form Completed By: _____ Date: _____

Child's Information

Full Name: _____

Gender: _____ Date of Birth: _____(Day/Month/Year)

Primary Language: _____ Other Languages: _____

Is this child Indigenous? Yes No

Current School: _____ Grade: _____ Aide: Yes No

Comments: _____

Family Information

☐ Biological
☐ Foster
☐ Private Guardianship
☐ Other
☐ Adopted

Parent/Guardian Name(s): _____ _____

Street Address or Land Description: _____

Mailing Address: _____

Home Phone: _____ Work: _____

Cell: ( ) _____ ( ) _____

E-Mail: _____

Siblings:

Name	Age

What Services are you applying for?

- ☐ Group Respite
- ☐ In-home Respite
- ☐ Behavioural Development Support
- ☐ Community Aid Support
- ☐ Triple P
- ☐ Other

Funding Source

☐ FSCD ID Number: _____ Expiry Date: _____

Case Worker: _____

☐ Supports for Permanency

☐ CFS

☐ Other, please describe _____

What do you need support for/help with? _____

_____

_____

_____

How do you want supports to look? _____

_____

_____

_____

Communication

How does your child communicate?

- ☐ Verbal
- ☐ Non-verbal
- ☐ Vocalizations
- ☐ Facial Gestures
- ☐ Body Language
- ☐ Sign Language
- ☐ Lip read
- ☐ Communication device (electronic or manual)

What do we need to know to communicate with your child and how do they communicate with others?

Please describe: _____

_____

_____

_____

Medical Information

Medical Diagnosis: Please list all medical diagnosis or conditions (e.g., Down's Syndrome, Schizophrenia, ADHD, Heart Disease, Asthma, etc.)

_____

_____

_____

Current Medications:

Medication	Dosage	Administration Times	Purpose

Allergies: List all your allergies (drug, food, environmental, etc.)

Allergic To:	Reaction: What happens to your child?	Prescribed Treatment: What needs to be done to help your child?

CONCERNING ADVERSE BEHAVIOURS

Please check all that apply and provide further information below in comments. Note: providing information in this section does not preclude service delivery

- ☐ Has your child ever had a behavior support plan or individual program plan to address concerning behaviour?
- ☐ Have you had to restrict access to activities, events, people or possessions because of concerning behaviour?
- ☐ Has a formal risk assessment ever been completed in regard to concerning behaviour?
- ☐ Does your child take medication to assist with their mental health or concerning behaviour?
- ☐ Does your child have any physical/mental health or behavioural concerns that may cause risk, impact service delivery or impact the health or safety of them, staff or others?
- ☐ Has there been police or legal involvement due to concerning behaviours?
- ☐ Will your child require one to one care at any time? Yes No
- ☐ Does your child have any behaviour that we should be aware of (running away, aggression, etc.)?

Comments: _____

_____

_____

_____

_____

_____

Social and Leisure

What are some activities that your child enjoys? _____

_____

_____

_____

What do you want us to know about your child? _____

_____

_____

ADDENDUMS

Check off and complete all applicable addendums:

Seizure	☐ Yes	☐ No
Hearing Impairment	☐ Yes	☐ No
Vision Impairment	☐ Yes	☐ No
Speech Impairment	☐ Yes	☐ No
Mobility Impairment	☐ Yes	☐ No
Specialized Medical Procedures	☐ Yes	☐ No
Personal Care/Dietary	☐ Yes	☐ No
Employment Supports (for teens)	☐ Yes	☐ No

I _____ certify that the information provided in this application package on behalf of the named applicant _____ is a true and complete disclosure of information relating to the physical/mental health and behavioural concerns of the applicant that may: create risk, impact service delivery, or impact the health and safety of the applicant, staff or others.

_____ _____

Applicant/Guardian Date

SEIZURE – ADDENDUM

☐ Controlled ☐ Uncontrolled

Describe the seizures: type, physical signs, frequency, duration, triggers, after effects, prescribed treatment, etc.:

_____

_____

_____

_____

_____

_____

_____

HEARING IMPAIRMENT – ADDENDUM

List any communication aides used such as hearing aid, telephone device, amplification system, sign language, etc.:

_____

_____

_____

In what ways does the impairment affect day to day living (living in the community, transportation, self-care, etc.)? _____

_____

_____

Other relevant information:

_____

_____

VISION IMPAIRMENT – ADDENDUM

Check any sight aides used:

- ☐ Cane
- ☐ Magnifier
- ☐ Glasses
- ☐ Contact lenses
- ☐ Braille
- ☐ Other _____

In what ways does the impairment affect day to day living (e.g. community living, mobility, cooking, self-care, leisure, etc.)?_____

_____

Other relevant information: _____

_____

SPEECH IMPAIRMENT – ADDENDUM

Please describe the speech impairment: _____

_____

_____

In what way does the impairment affect day to day living (e.g. community living, self-care, relationships, etc.): _____

_____

Other relevant information: _____

_____

_____

_____

_____

MOBILITY IMPAIRMENT – ADDENDUM

Please describe any mobility impairments, special needs, or supports required: _____

_____

_____

Check any mobility aids or equipment used:

- ☐ Wheelchair
- ☐ Specialized seating
- ☐ Helmet
- ☐ Walker
- ☐ Splints (leg or hand)
- ☐ Foot orthotics
- ☐ Walking or standing frame
- ☐ Mechanical lift
- ☐ Braces
- ☐ Crutches
- ☐ Cane
- ☐ Specialized shoes
- ☐ Body Jacket or brace
- ☐ Other:_____

In what ways does the impairment affect day to day living? _____

_____

Other relevant information: _____

_____

SPECIALIZED MEDICAL PROCEDURES – ADDENDUM

Check any of the following that apply:

- ☐ Gastro Intestinal Tube
- ☐ Catheter
- ☐ Nebulizer
- ☐ C Pap Machine
- ☐ Chest Physiotherapy
- ☐ Suctioning Procedures
- ☐ Tracheostomy
- ☐ Physical Therapy exercises
- ☐ Other:_____

Please explain all of the above as they apply: _____

_____

_____

PERSONAL CARE AND DIETARY – ADDENDUM

Please describe any difficulties, special needs or supports required in the following areas:

Dressing: _____

_____

Bathing: _____

_____

Toileting: _____

_____

Hygiene: _____

_____

Dietary and eating: _____

_____

Comments: _____

_____

COMMUNITY SUPPORT: EMPLOYMENT SUPPORTS – ADDENDUM

Education and Training History

School	Location	Year(s) Attended

Additional History (if required): _____

_____

What learning was enjoyed the most at school? _____

_____

Describe any Career Counseling received: _____

_____

Describe any training for special skills (e.g. cooking, hair dressing, carpentry, etc.)?

_____

_____

Describe any workshops/conferences for learning (e.g. First Aid, Leadership, Communication, etc.):

_____

_____

Describe any work site training (e.g. work experience in school or at a business):

_____

_____

What further learning is desired: _____

Volunteer History

Location	Responsibilities	Dates

Is there a willingness to volunteer in order to build skills?

☐ Yes ☐ No

If yes, what would the areas of interest be? _____

_____

What should be avoided: _____

_____

Employment History

Employer	Position/Responsibilities	Dates

Why is work important at this time? _____

_____

What kind of work would be of interest? _____

_____

What could ASC help with?

- ☐ Career planning
- ☐ Resume writing
- ☐ Job searching
- ☐ Interviewing skills
- ☐ Training for specific skills
- ☐ Self-management skills (telling time, schedules, hygiene, dress, relating to others)
- ☐ Safety skills
- ☐ Job coaching
- ☐ Employer relations

Other relevant information: _____

_____

_____

_____