Application Package – Adult Services

Form Completed By: ______________________________ Date: ________________________

Applicant Full Name: ____

Gender: ____

Date of Birth: ____
Day Month Year

Mailing Address/legal land description:
____

____

Home Phone #: _____________________________ Cell Phone #: _______________________

Email address: ____

What Services are you applying for?

- ☐ Overnight Staffed Residence (24hr)
- ☐ Supported Independent Living (hourly residential services)
- ☐ Approved Home
- ☐ Companion Supports
- ☐ Respite
- ☐ Employment
- ☐ Community Access

Funding Source

- ☐ Disabilities Services (PDD)
- ☐ Private fee for service
- ☐ Funded fee for service ________________________________
- ☐ Other please describe ________________________________

What do you need support for/help with? ______________________________________

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LEGAL STATUS

Guardianship

- ☐ Independent Adult
- ☐ Supported Decision Making Authorization
- ☐ Co-decision Making (court ordered)
- ☐ Guardianship Court Order
  - Private
  - Office of the Public Guardian

Name of Guardian/ Relationship to applicant: ____

Trusteeship

- ☐ Independent
- ☐ Private informal
- ☐ AISH Benefits Program
- ☐ AISH Funds Administrator
- ☐ Private Formal (court order)
- ☐ Office of the Public Trustee (court order)

Name of Trustee/ Relationship to applicant: ____

COMMUNICATION

How do you communicate?

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

Can you read?

- ☐ Yes
- ☐ No

Can you print, write, type/text?

- ☐ Yes
- ☐ No

What do we need to know to communicate with you?

____

____

____

____

____

MEDICAL

Medical Diagnosis

Please list all medical diagnosis and/or conditions (e.g. Down's Syndrome, Schizophrenia, ADHD, Heart Disease, Asthma, etc.)____

____

____

Medications

Do you self-administer your medications?

☐ Yes ☐ No

List Current Medications:

Medication	Dosage	Administration Times	Purpose

Allergies

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

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

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.

☐ Have you ever had a behavior support plan or individual program plan to address concerning behaviour?

☐ Have you had your access to activities, events, people or possessions restricted because of concerning behaviour?

☐ Has a formal risk assessment ever been completed in regard to concerning behaviour?

☐ Do you take medication to assist you with your mental health or concerning behaviour?

☐ Do you have any physical/mental health or behavioural concerns that may cause risk, impact service delivery or impact the health or safety of yourself, staff or others?

☐ Have you had police or legal involvement due to concerning behaviours?

Comments:

____

____

____

ADDENDUMS

Check off and complete all applicable addendums.

Employment Supports	☐ Yes	☐ No
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
Goals of Support	☐ 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

EMPLOYMENT SUPPORT – ADDENDUM

Education and Training History

School	Location	Year(s) Attended

Additional History (if required)

____

____

What learning was enjoyed most at school?

____

____

Describe any career counseling received

____

____

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

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____

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

What transportation is available to get to and from work or ASC services?

____

____

Other relevant Information:

____

____

SEIZURE – ADDENDUM

☐ Controlled ☐ Uncontrolled

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

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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: ____________________________________

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

____

Other relevant information: ____

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MOBILITY IMPAIRMENT – ADDENDUM

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

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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 PROCEDUREES – 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: ____

____

GOALS OF SUPPORT – ADDENDUM

What areas required support?

- ☐ Making/maintaining connections
- ☐ Getting to know the community
- ☐ Accessing the community businesses/resources
- ☐ Social skills
- ☐ Communication
- ☐ Establishing routines
- ☐ Scheduling time management
- ☐ Medications
- ☐ Medical appointments/support
- ☐ Home safety
- ☐ Home living
- ☐ Cleaning
- ☐ Laundry
- ☐ Meal planning
- ☐ Shopping
- ☐ Cooking
- ☐ Budgeting
- ☐ Personal hygiene

Other Goals: ______________________________