Drumheller And Region Transition Society

Application for Service

Applicant's Name:_____

Phone #: _____

Application Completed By (if different from above): _____

Phone #: _____

Date: _____

Type of Service/Program Requested: **Program Start Date/Desired Duration**

_____Connections for Independent Living _____/_____
(Independent setting in the community with daily living skills support)

_____Career Development _____/_____
(Employment supports-Gainful Employment / Contracts / Volunteer)

_____Transitional Services _____/_____
(For individuals under 18 years old, transitioning into community opportunities, employment, independent supports or residential supports)

_____Residential Services _____/_____
(Supported living in a group setting in the community with daily living skills support)

_____Approved Support Home _____/_____
(Supported living with a family in the community)

_____Respite Services _____/_____
(Provides a break and change for support in home life)

_____Other_____ _____/_____

Desired Start Date:_____

Personal Information

Full Legal Name of Applicant:_____

Mailing Address:_____

Phone # Work: _____ Home: _____

Religious Affiliation:_____

Sex Male:_____ Female:_____

Date of Birth:_____Place of Birth:_____

Marital Status:_____

Length of Residence in Canada:_____ Alberta:_____

Language Spoken (please also note if applicant has any knowledge of sign language):
_____and/or understood_____

Social Insurance #:_____

Health Care #:_____

Blue Cross # (or other, please specify:_____

Band #:_____Treaty #:_____

Service Requirements:

What is the nature of the applicant's impairment/disability?

_____

_____

_____

_____

Are you receiving support from any other agencies?

_____

_____

Is there a need for support from another agency?

_____

_____

Legal Status:

Independent Adult Yes:_____ No_____ (if no, please complete the following)

Guardianship: Public_____ Private:_____

Name: _____

Address:_____

Phone #- Work:_____ Home:_____

Relationship to Applicant:_____

Alternate Contact:_____

Guardianship Order Areas:
_____ Where to live
_____ With whom to live and whom to consort
_____ Social activities
_____ Employment
_____ Educational, vocational, or other training
_____ Licenses, permits or any other consent/authorization required
_____ Legal matters (except financial)
_____ Health care
_____ Daily living routines

Trusteeship:

Public:_____ File:_____

Private:_____ Informal:_____

Name of Trustee:_____

Address:_____

Phone #- Work:_____ Home: _____

Relationship to Applicant:_____

Financial Position:

_____ Employed
_____ Social Assistance
_____ Assured Income for the Severely Handicapped (AISH)
_____ PDD funding for staff support
_____ No Income
_____ Other:_____

Medical Information:

Name of Doctor:_____
Address:_____
Phone Number:_____ Date of Last Appointment:_____

Name of Medical Specialist:_____
Address:_____
Phone Number:_____ Date of Last Appointment:_____

Name of Dentist:_____
Address:_____
Phone Number:_____ Date of Last Appointment:_____

Name of Optometrist:_____
Address:_____
Phone Number:_____ Date of Last Appointment:_____

Current Medications:

Medication	Dosage	Purpose	Side Effects	Last Review Date

Does Applicant self-administer medication (if any) or require support?

_____
_____

Medical Information (continued) :
Who arranges and accompanies the individual to the doctor's appointments?

_____

_____

List all known/ suspected allergies (drug, food, etc.), type of reaction and recommended method of treatment:

_____

_____

_____

_____

Epilepsy: Yes_____ No_____
Seizures: None_____ Controlled_____ Uncontrolled_____
Age of Onset:_____

Describe: Physical signs, frequency duration, after effects, recommended method of treatment.

_____

_____

_____

Can applicant sense onset of seizures? Yes_____ No_____
Comments:

_____

_____

Please describe any present on-going medical conditions:

_____

_____

_____

Please list any major accidents, operations, serious illnesses, and recent hospitalization(s) the applicant has had:

_____ Date:_____
_____ Date:_____
_____ Date:_____
_____ Date:_____

Please attach record or provide dates of immunizations received (i.e. Hep B, DTPP):

_____

Does the applicant have a history of measles, mumps, chicken pox, and/or rubella?

_____

_____

_____

Medical Information (continued):
Please list any other medical/ physical limitations and/ or concerns which may have an impact on services being requested:

Hearing Impairment: Yes_____ No_____ If yes, please describe nature of impairment:

Vision Impairment: Yes_____ No_____ If yes, please describe nature of impairment:

Speech Impairment: Yes_____ No_____ If yes, please describe nature of impairment:

Family/Personal Support System:

Family Support: (include siblings and/or client's children, if applicable):

Name	Relationship	Degree/frequency	Address	Phone

Personal Support:

Name	Relationship	Degree/frequency	Address	Phone

Applicant's History:

Residential History:
Please list places of residence since the birth of the applicant, including the name of any institutions. Please begin with current situation:

Where _____ When (from _____ to _____)

Has the individual lived with roommates? Please describe the living arrangement (was it a positive or negative experience)? Why?

Has the individual lived alone? Was this a positive or negative experience? Please describe:

Educational/Training History:
Please list educational/training /day programs which the applicant has attended in the past five years. Please begin with the current or most recent situation:

Where _____ When (from _____ to _____)

Employment History:
Please list any position held by the applicant over the past 5 years. Please begin with the current or most recent situation:

Assessments:
Please indicate (or attach) dates of assessments, results, who completed them, and where they were done over the past two years. Please include any psychological, educational, vocational, physiotherapy/occupational therapy, psychiatric or functional assessments. Please attach any available documentation to the end of this application. Verification of the information provided in this section may be requested.

Mobility:

Walk unaided: Yes_____ No_____
Please comment on any mobility difficulties and/or restrictions and describe the nature of support required, including the use of any assistive devices.

Sitting Ability:

Please describe any special needs or limitations.

Communication Skills:

Please describe communication abilities (e.g. gestures, vocalizations, signs, clear speech, etc.) as well as any special equipment used and/or needed.

Independent Living Skills:

Please comment on abilities and need for assistance in the areas of personal care, homemaking, transportation, and handling of finances/budgeting.

Social Skills:

Describe applicant's general attitude and motivation.

Describe applicant's interaction with others.

Describe applicant's ability to express feelings/ emotions.

Describe any characteristic traits, activities, idiosyncratic behavior patterns which may affect the applicant's relationship with other individuals in the community.

Leisure and Recreation:

Describe activities/interests the applicant currently enjoys in his/her leisure time.

Describe the extent of choices experienced by the individual.

What activities/interests would the applicant like to develop and/or participate in, given the opportunity?

What additional assistance/ support would the applicant require to become involved in these leisure activities?

Behavioral:

Describe any behaviors for the individual, frequency, duration and intensity.

When are the behaviors most likely to occur? Least likely?

Where are the behaviors most likely to occur? Least likely?

With whom are the behaviors most likely to occur? Least likely?

What activity is most likely to produce the behavior? Least likely?

Personal Goals:
What are the individual's top three goals that you want staff support with? Personal, health, behavioral, work related?

_____
_____
_____
_____
_____
_____
_____
_____

Additional Information:

Please comment on any additional or relevant information. (attach any additional information)

_____
_____
_____
_____

Do you have the ability to obtain basic room furniture? Yes_____ No_____
If not, we can provide you with resources.

Please attach the following to this application:
Assessments - Supports Intensity Scale Report
- Psychiatric
- Behavioral
- Employment

Service plans
Behavioral plans
Individual Training Plans
Resume
An Original RCMP Criminal Record Search
Completed Release of Confidential Information form (attached)
Signed completed Disclose Form (attached)

Date:_____

Signature of Applicant:_____

Signature of Parent/ Guardian: _____
(If applicable)

	Not Applicable	Independent	Requires Prompts	Requires Assistance	Comment Please Describe
PERSONAL					
1) Toileting					
2) Washing face & hands					
3) Sponge bathing					
4) Bed bath					
5) Tub bath					
6) Shampooing hair					
7) Combing/brushing hair					
8) Brushing teeth					
9) Shaving (face, legs, etc.)					
10) Menstrual care					
11) Cutting nails (toe, finger)					
12) Dressing and undressing					
13) Wardrobe co-ordination					
14) Turning at night					
15) Getting day rest					
MEALS & RELATED SKILLS					
1) Eating and drinking assistance					
2) Special diet					
3) Food allergies					
4) Menu planning					
5) Meal preparation					
6) Grocery shopping					
HOMEMAKING					
1) Use of appliances					
2) Cleaning/maintenance of appliances					
3) Table setting					
4) After meal clean-up					
5) Bed making					
6) Sweeping/moping					
7) Scrubbing floors					
8) Dusting					
9) Vacuuming					
10) Doing laundry					
11) Ironing					
12) Cleaning washroom					
TRANSPORTATION					
1) Public transportation					
2) Special transportation					
3) Driving ability					
OTHER SKILLS					
1) Using telephone					
2) Knowledge of emergency procedure					
3) Time					
4) Number and amount					
5) Money					
6) Budgeting					
7) Use of bank					
8) Shopping					

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

DRUMHELLER AND REGION TRANSITION SOCIETY

I/We, _____ the undersigned

applicant and/or guardian of _____ of the

Town/City of _____ in the Province of _____

Do hereby grant permission for the release of confidential information of the above said person.

The information will be released:

From: _____ To: _____

_____ _____

_____ _____

The information to be released includes: _____

_____

Time Lines: _____

Dated at _____ Alberta, this _____ day of _____, 20__.

Signature of Applicant _____

And/or Guardian(s) _____

Requester's Signature _____

Drumheller And Region Transition Society

Drumheller and Region Transition Society ("DARTS")

Discloser by Referring Agencies

1.0 DARTS provides support service programs to assist Individuals with a developmental disability on referral from _____to live in the community.

2.0 In order to properly provide such services and to assess any risk of harm to Individuals in Service or DARTS staff, DARTS is prepared to undertake support services only upon the condition that _____ makes full discloser of all health or other information pertaining to the Individual currently in the possession of the _____ or acquired by _____ hereafter relevant to any of the following:

a) whether or not the Individual is fit to live in the community;

b) any history of violent, threatening, unlawful or suicidal behavior on the part of the Individual;

c) all available professional opinions regarding the Individual's inclination towards violent, threatening, unlawful or suicidal behavior;

d) any medical or other information regarding medication, therapy or other treatment that may assist in avoiding violent, threatening, unlawful or suicidal behavior on the part of the Individual;

e) any health or other information that might assist DARTS in providing support services to the Individual;

f) the identity of any other health care provider, custodian or affiliate of a custodian, including Alberta Health Services, which may have any of the above information in its possession.

3.0 It is a further condition precedent to DARTS providing such support services that;

a) _____obtain from the Individual or from the Individual's guardian all required consents to the disclosure of any of the above information

and to the use of such information for the purpose of providing support services to the Individual;

b) _____acknowledges in writing that it agrees to provide the above disclosure and warrants that it has made such disclosure.

4.0 _____ (the "Referring Agency") has referred _____ (the "Individual") to DARTS for the participation in DARTS's support service programs and agrees to comply with the above conditions. _____ further warrants and represents to DARTS that it has made full discloser to DARTS of all information of which it is aware respecting the Individual as required by the above conditions. _____ also undertakes to promptly provide DARTS with any additional similar information regarding the Individual which it receives or becomes aware of in the future while the Individual remains in DARTS support service programs.

DATED this _____ day of _____, 20 __.

_____
AUTHORIZED REPRESENTATIVE OF REFERRING AGENCY