



Drumheller And Region Transition Society

Application for Service

Name: _____

Home phone #: _____ Cell: _____

Email _____

Application Completed By (if different from above): _____

Home phone #: _____ Cell: _____

Email _____

Date: _____

Please check program requested:

____ **Connections for Independent Living** (Independent setting in the community-supports with daily living skills /community access)

____ **Residential Services** (Group home setting in the community-supports with daily living skills/community access)

____ **Approved Support Home** (Supported living with a family in the community)

____ **Respite Services** (Supports to provide a break and/or change in home life)

____ **Career Development** (Employment supports-gainful employment / contracts / volunteer)

____ **Transitional Services** (For individuals under 18 years old, transitioning to adult employment, living supports)

____ **Other** _____

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?

Do you have the ability to obtain basic room furniture? Yes _____ No _____
(If applying for residence) If not, we can provide you with resources.

Personal Information

Full Legal Name of Applicant: _____

Mailing Address: _____

Phone # Work: _____ Home: _____

Date of Birth: _____ Place of Birth: _____

Gender Male: _____ Female: _____ Marital Status: _____

Length of Residence in Canada: _____ Alberta: _____

Language Spoken (please also note if applicant has any knowledge of sign language):
_____ and/or understood _____

Do you have a religious affiliation: _____?

Social Insurance #: _____

Health Care #: _____ Blue Cross # _____

Band #: _____ Treaty #: _____

Legal Status:

Personal matters:

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

Guardian: Public _____ Private: _____

Name: _____

Address: _____

Phone # Work: _____ Home: _____ Cell: _____

Relationship to Applicant: _____

Guardianship Order Areas:

- | | |
|--|--|
| _____ health care | _____ educational, vocational, or other training |
| _____ where and with whom to live | _____ employment |
| _____ with whom to associate | _____ legal matters (except financial) |
| _____ participation in social activities | _____ personal matters as follows _____ |

Financial matters:

Trustee: Public: _____ Private: _____ Informal: _____

Name of Trustee: _____

Address: _____

Phone # Work: _____ Home: _____

Relationship to Applicant: _____

Financial Position:

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

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:

<u>Medication</u>	<u>Dosage</u>	<u>Purpose</u>	<u>Side Effects</u>	<u>Last Review Date</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

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:

Please describe any present on-going medical conditions:

Epilepsy: Yes____ No____ Age of Onset: ____ Seizures: None___ Controlled___ Uncontrolled___

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

Can applicant sense onset of seizures? Yes____ No____ Comments: _____

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

_____ Date: _____
_____ 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?

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:

Mobility: Walk unaided: Yes____ No____ Sitting ability (any special needs or limitations)
Please comment on any mobility difficulties and/or restrictions and describe the nature of support required, including the use of any assistive devices.

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/unique traits, activities, distinctive behavior patterns which may affect the applicant’s relationship with other individuals in the community.

Behavioural: Describe any behaviours for the individual, frequency, duration, and intensity.

When and where are the behaviours most likely to occur? Least likely?

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

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

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 _____ Started/Ended _____

Employment History:

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

Leisure and Recreation: Describe activities/interests the applicant currently enjoys in his/her leisure time.

What activities/interests would the applicant like to develop or participate in? What additional assistance/support would the applicant require to become involved in these leisure activities?

Describe the extent of choices experienced by the individual.

Do you have a religious affiliation? _____

Family/Personal Support System: include client's children (if applicable), family members, friends, etc.:

<u>Name</u>	<u>Relationship</u>	<u>Degree/frequency</u>	<u>Address</u>	<u>Phone</u>

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)

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, physio/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.

Please include copies of the following: Any Assessments – such as psychiatric, behavioural, Employment, school, service plans, behavioural plans, training plans, resume.

Required with this application are: an Original RCMP Criminal Record Search (CPIC), a completed Release of Confidential Information form (attached) Signed completed Discloser Form (if applicable)

Signature of Applicant: _____ Date: _____

Signature of Parent/Guardian: _____
(If applicable)