APPLICATION FOR SERVICE

This application form provides CommunityAIM with the background information deemed necessary to assess the particular need of each applicant. All information within this document is considered confidential and shall not be released to any other organization unless written consent is obtained by the applicant or legal guardian.

Please be as accurate as possible to all questions in this document. Ensure that all pertinent information is provided in regards to your child as you are held responsible for any situations that may arise with your child that information was not provided (if there is not enough room on the document please write on back of application or attach a separate page to the document)

There may be parts of this application which are not applicable to the service being requested or the individual that is applying for services. Therefore please disregard any requests for information you feel are not applicable.

Please note that once services start all services provided require a 60 day cancellation notice (some exceptions apply) and all applicants are not permitted to hire any staff of any CommunityAIM site on a private hire basis. If this act is discovered the applicant may be held responsible for any lost revenue to CommunityAIM in doing so.

By signing below you acknowledge that you have read the above information and you acknowledge that by signing below you are responsible for all information that you provide.

____ ________________

Signature of parent/guardian/Individual filling out form Date

CommunityAIM

APPLICATION FOR SERVICE

Individual Profile Date (today's): ________________________

Name of individual: First ______________middle________________last____________

Address: ____________________________ Town/City ___________________________

Postal Code: _____________________ e-mail: ________________________________

Phone (home): ______________ Work: ________________ Cell: ________________

Gender: ___________________________ Birth Date: ____________________________

School attending: ___________________Grade/Program/Grade graduated:__________

Language Spoken: __________________and/or understood______________________

Native Status: _________ Treaty # _____________ Band: ________________________

Birth Certificate # ________________________________

Alberta Health Care # __________________________________

Do you have health insurance (ie Blue Cross) Yes No

If yes with whom? ____________________________________
Policy # ____

In case of an emergency an ambulance will be called it is the full responsibility of the parent/guardian and/or individual for the cost if not covered by insurance /AADL /AISH. Please initial that you have read and understand

Parent/Guardian/Caregiver contact information
(If address/information is same as applicant please leave blank)

Name(s) ____

Address: ___________________________________Town/City: ___________________

Postal Code: _________________________________

Phone (home) __________________ Work: _________________ Cell: ______________

Email: ____

Emergency Contacts

Emergency Contact Person (#1): ____

Phone #: _______________________ relationship to individual ____________________

Emergency Contact Person (#2): ____

Phone #: _______________________relationship to individual ____________________

Programs to which applicant is wanting support services

In – Home respite

Out-of-home respite

Community Access

In-home 24hr respite (overnight)

Out-of-home 24hr respite (overnight)

Recreation/Socialization program

Transitional planning

Life skills training

Out of Home Placement

Employment Preperation

Employment Placement

PLEASE NOTE:
In regards to In – Home Respite, Out of Home Respite, and Community Access CommunityAim prefers that set days during the week are decided on to assist with consistency and same staff longevity.

Community Access: We have multiple options – please be specific in the “Additional” section on what type of services you are looking for. Currently we provide:

1. weekly group options such as bowling, floor hockey, Library trips, and special events.
2. 1:1 support at Community organizations ie Girl Guides, Gymnastics, etc
3. Group Learning programs ie cooking/Healthy eating, computer use, Money Management.

Out of Home Respite: Currently we provide the following options:

1. 1:1 support within the community doing pre planned activities.
2. Partaking in set days of the week in group type activities within the community

Out of Home 24hr respite: Currently we provide this on a booking system on a first come first get mandate.

Are there time lines when you/applicant wish to see services implemented?
____
____

Legal Status

Legal Guardianship: Public ( ) Private (Biological) ( ) Partial ( ) Plenary (court order) ( )
Name and address of guardian(s) ____
Phone number: ____

Financial Status

Funding Sources: FSCD, PDD, Enhancement, Intervention, Band, and Private
Name of funding source:________________Workers name: _______________________
Phone #_____________ FSCD # and/or PDD # and/or Individuals billing #: __________

Funding amounts: Agreements can have several support services please list all services/amounts you are asking for us to support. Please be specific and list the service off of your agreement and the amounts for agency in your agreement or provide a copy of your agreement.

Name of service: (ie. respite, community access etc) : ___________________________
Amount of hours/days _____________per ______(circle) (week/month/year)
Amount per hour: ______________________

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Name of service: (ie. respite, community access etc) : ___________________________
Amount of hours/days _____________per ______(circle) (week/month/year)
Amount per hour: ______________________

ADAPTIVE EQUIPMENT (circle all that apply)

None Manual Wheelchair Electric Wheelchair Walker

Crutches Glasses Helmut Other: ____________________

TRANSFER ASSISTANCE:

None One Person (Partially Dependent) One Person (Fully Dependent)

PERSONAL CARE
Does the Individual need assistance with any of the following?

Toileting Diapers/Pull ups Menstrual Care Eating Drinking

Dressing Specify: ____

COMMUNICATION

Receptive/Age Appropriate ____
Expressive/ Age Appropriate ____

RECREATIONAL INTERESTS

Individual enjoys: ____
____

Individual does NOT enjoy: ____
____

FOOD

Individual enjoys : ____
____

Individual does NOT enjoy: ____
____

SUPERVISION:

What level of Supervision does individual require? Ie: 1individual : 1 staff, 2 individuals : 1 staff, groups of 3-4 individuals with 1 staff are suitable

Outside/Playground ____

Inside: ____

Swimming: ____

Field Trips/ Community ____

Within employment (paid/unpaid) setting: ____________________________________

Is Individual a flight risk? Yes No

Medical

Disability Diagnosis (age of onset, cause, etc.) ___________________________________

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____

____

Family Physician:
Name: _________________________________
Address: _______________________________

____

Phone:__________________________________

Psychologist/Psychatrist/Other Specialist
Name: __________________________
Address:___________________________

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Phone: ___________________________

Name: _________________________________
Address: _______________________________

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Phone:__________________________________

Name: ____________________________
Address:___________________________

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Phone: ___________________________

Current Medical Conditions (ie colostomy/kidney dialysis/etc): _____________________

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Current Medications (dosage and methods of administration) _______________________

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Allergies Drug and Food (reaction and treatment) ________________________________

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Does the applicant have seizures? yes no

If yes, please describe: ____

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Please note an ambulance will be called if seizure lasts longer than 2 minutes unless advised differently by a medical doctor with medical documentation provided to CommunityAIM Initial that you have read and understand:

Does the applicant have any communicable diseases which staff should be aware of?
yes no If yes please specify: ______________________________________

____

Does the individual have Diabetes: Yes No Is individual on insulin Yes No
How often does individual need to check blood levels? ____________________________
Does individual need assistance: Yes No

Is there any physical/medical reason not already mentioned that individual should be excluded from any physical activity ie special Olympics/trampoline/etc : yes no
If Yes please explain: ____

____

BEHAVIOUR

Does the individual display any of the following behaviours? Please circle

None Swearing Hitting Biting Kicking Refusal Hair Pulling

Spitting Smearing Stripping

Please explain:

____

____

Are there certain noises or actions that are difficult for individual to be in close proximity too? Please explain - ____

____

Are there specific actions we should recognize to show us the individual is upset?

None Crying Withdrawal Refusal Yelling Pouting Swearing

Screaming Self Harm Aggression Faking injury or illness Overactive

Stimming

Please explain: ____

____

How do you suggest we handle the above behaviours?

Time out Removal Verbal Reminder Counting Redirection

Quiet Time

Please explain further: ____

____

____

What forms of intervention works for individual? ____________________________

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____

SPECIAL DIETARY NEEDS:

Does the individual have a G-tube? **Yes** **No**

If Yes G-Tube care outline is required.

Food preperations:

None Soft Diced Pureed Thickened Liquids

Please specify: ____

____

May **NOT** consume the following:

Dairy **Sugar** **Gluten** **Eggs** **Nuts**

Other:____

____

____

Support system (e.g family, friends)

Name: ___________________ Phone: ________________ Relationship: _______________

Name: ___________________ Phone:________________ Relationship: _______________

Name: ___________________ Phone:________________ Relationship: _______________

Please add any additional or relevant information (Please provide any further information that may be useful in determining program suitability in meeting your needs)

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How did you find out about us: ____

By signing below your acknowledge that all information in this document is accurate to your knowledge and that all information has been provided. Any information that comes to our attention after supports have been put in place and is found that the information was held from CommunityAIM intentionally will result in discontinuation of services.

Application completed by: ___________________________ Phone: ___________________

Signature: Date: ____________________

Relationship to applicant: ____

Release of Information

I ______________________________ parent/guardian of __________________________ give permission for the person(s) listed below to provide information to CommunityAIM and "Maitland House" when information is requested by the CommunityAIM and "Maitland House"

1. FSCD (Family Support for Children with Disabilities) this includes worker and the agency as a whole. This also includes permission for CommunityAim to request copy of FSCD agreement from FSCD. Initial _________
2. Family Doctor __________________________________ ph # ________________
3. PDD Initial_____
4. AISH Initial _____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

____ _______________________

Signature of parent(s) / guardian(s) /Individual Date

_________________________________ _______________________

Signature of witness Date