

**ACCREDITED SUPPORTIVE LIVING SERVICES
APPLICATION**

Name:	Telephone:
Address:	
Date of Birth:	Personal Health Care #:
Social Insurance #	Treaty #

General Information:

Has anyone told you that you have a disability? **Yes** **No**

If yes, what type of disability do you have? _____

Where does your money come from?

Work: AISH _____ Social Allowance _____ E.I. _____ Other _____

Have you ever worked before? **Yes** **No**

If yes, what kind of work have you done?

Are you presently employed? **Yes** **No**

If yes, what is your employer's name?

What are your job duties:

If no, do you wish to work? **Yes** **No**

What education do you have?

Health and Well-Being

Are you in good health?

Yes

No

If no, has your doctor told you that you have an illness?

Do you take medication?

Yes

No

If yes, what type?

Can you take your medication without someone helping you?

Yes

No

Emotions and Feelings

How do you usually feel from day to day?

I am happy _____ I can handle things okay _____ I often feel angry _____

I feel lonely _____ I often feel depressed _____ I feel worried or scared a lot _____

I wish I could handle things better _____

If you get mad, are you likely to injure other people? **Yes**

No

Maybe

Personal Habits

Do you use alcohol?

Yes

No

If yes, how often?

Every Day _____

Whenever I'm with my friends _____

A few times a week _____

Once a month _____

Once a week _____

Hardly ever _____

When you use alcohol or drugs, do any of these things happen?

People tell me I' m drunk _____ I miss work the next day _____
I get in fights _____ I get hurt _____
I get really sick _____ I can't remember what happened _____

Skills I Have Learned

Personal Hygiene:

Keeping clean, dressed neatly:

I do this best _____ I do this pretty good _____
I would like to learn to do this better _____

Preparing Meals:

Choosing what to eat, cooking meals:

I do this best _____ I do this pretty good _____
I would like to learn to do this better _____ I have never done this before _____

Buying Groceries:

Make a list, comparative shopping

I do this best _____ I do this pretty good _____
I would like to learn to do this better _____ I have never done this before _____

Household Skills

Doing laundry, vacuuming, dusting, washing dishes

I do this best _____ I do this pretty good _____
I can do some of this _____ I have never done this before _____
I would like to learn to do this better _____

Shopping:

Purchasing clothing, household items

I do this best _____ I do this pretty good _____
I can do some of this _____ I have never done this before _____
I would like to learn to do this better _____

Managing Money:

Using a bank, paying bills, writing cheques, budgeting

I do this best _____ I do this pretty good _____
I can do some of this _____ I have never done this before _____
I would like to learn to do this better _____

Living Situation:

Where are you living?

With a roommate _____ Room and Board _____
With my family _____ Group Home _____ Other _____

Would you like to look for other living arrangements?

Yes

No

If yes, check which type:

My Own Apartment _____

With a Roommate _____

Room and Board _____

Living with my Family _____

Group Home _____

Other _____

Time Available:

Are you willing to set time aside to see a worker in your home?

Yes

No

Every Day _____

A few times a week _____

Once a week _____

Every now and then _____

Only in Emergencies _____

Comments:

Signature

Date

Submit completed form to:

Accredited Supportive Living Services

Box 680

Grimshaw, AB T0H 1W0

Phone: (780) 332-4183

Fax: (780) 332-1553

E-mail: info@aslslimited.org

ACCREDITED SUPPORTIVE LIVING SERVICES
CLIENT EMPLOYMENT QUESTIONNAIRE

1. Where have you worked before?

2. What did you like and not like about each job?

3. Why do you want to work?

For money? _____ *For something to do?* _____

4. When can you work?

What time do you usually get out of bed? _____

What do you do afterwards? _____

Do you go out for coffee with friends? _____ *Daily?* _____

Do you eat meals at home or do you eat out a lot? _____

What kinds of activities or hobbies do you do? _____

When? _____

Do you have the same routine on the weekend? _____

If not, what do you do on the weekends? _____

What parts of your routine are you willing to change to have a job?

What parts of your routine are you not willing to give up?

After changing your routine, when are you willing to work?

Hours: _____

Shifts: _____

Days: _____

5. **Do you have any physical problems that might interfere with your job?**

6. **Are there any jobs or tasks that you have done in the past that you will not do again?**

7. **What are the things you like to do? Interests?**

- a)
- b)
- c)

8. **What do you think makes a good employer?**

9. **Are there any jobs that you would really like to do?**

10. **How much job support do you think you will need?**

11. **Do you feel you need a Community Support Worker with you at an interview?**

12. **Do you feel we need to role play an interview beforehand?**

13. **Do you have a current resume?**

**ACCREDITED SUPPORTIVE LIVING SERVICES
INDEPENDENT LIVING SERVICES
CLIENT INFORMATION**

Name:	Telephone #
Address:	
Date of Birth:	Alberta Health Care #
Social Insurance #	Treaty #
AISH/SAL:	Medical (YES/NO)

Guardian:	Telephone #
Address:	
Trustee:	Telephone #
Address:	
Parents:	Telephone #
Address:	
Nearest Relative:	Telephone #
Address:	

Doctor:	Telephone #
Dentist:	Telephone #
Optometrist:	Telephone #

HEALTH PROBLEMS:

OTHER INFORMATION:

**ACCREDITED SUPPORTIVE LIVING SERVICES
CLIENT ORIENTATION CHECKLIST**

Client Name: _____

Each item on the checklist should be dated and initialed by staff as covered. If an item is not applicable, indicate with a N/A in each, initial slot, and date it. Once the full orientation is complete, the original will be placed on the client's file.

<i>Date</i>	<i>Form</i>	<i>Staff's Initials</i>	<i>Client's Initials</i>
_____	Application/Referral	_____	_____
_____	Client Information	_____	_____
_____	Medical Admission	_____	_____
_____	Informed Consent for the Administration of Medications (if applicable)	_____	_____
_____	Informed Consent to the Release of Information	_____	_____

<i>Date</i>	<i>Pertinent Assessments (List)</i>	<i>Staff's Initials</i>	<i>Client's Initials</i>
_____	Intake Summary	_____	_____
_____	Review Client Handbook	_____	_____
_____	Review any Health/Fire/Safety Procedures pertinent to Client's situation	_____	_____
_____	Introduction to Staff	_____	_____
_____	Introduction to other Client's as appropriate	_____	_____
_____	Tour of Facility	_____	_____
_____	Provide information on Personal Planning Process	_____	_____
_____	Arranging an informal opportunity for the CSW to get to know the Client as is necessary	_____	_____
_____	Provide copies of the Residential Procedures for Client finances	_____	_____
_____	Provide copies of the Residential procedures for emergency preparedness plan	_____	_____
_____	Provide information to clients and their parents/guardian on the cleaning and Maintenance schedules for the home	_____	_____

ORIENTATION COMPLETED

Date: _____

Client/Guardian: _____

CSW: _____

ACCREDITED SUPPORTIVE LIVING SERVICES
INFORMED CONSENT FOR OBSERVATION & TRAINING

I, _____, presently receiving services from Accredited Supportive Living Service's, hereby consent to:

_____ **Audio/Visual Recordings**

_____ **Photographs**

_____ **Observation**

For the following purposes:

_____ **Program Evaluation**

_____ **Research Studies**

_____ **Training Client/Staff**

_____ **Promotional Purposes**

I understand this information will be used for the above purposes only. This release covers the period from _____, to _____.

Signature

Witness

Signature of Parent/Guardian

Witness

Date

ACCREDITED SUPPORTIVE LIVING SERVICES
INFORMED CONSENT FOR THE ADMINISTRATION OF MEDICATION

I, _____, presently requesting and/or receiving services from Accredited Supportive Living Services, hereby consent to Community Support Workers:

1. Administering medication(s) according to appropriate schedules outlined by my doctor or doctors.

2. Distributing medication to myself as directed by doctors.

3. Monitoring medication while I am responsible for taking recommended medications.

This release covers the period from _____, to _____.

Signature

Witness

Signature of Parent/Guardian

Witness

Date

ACCREDITED SUPPORTIVE LIVING SERVICES
INFORMED CONSENT TO THE RELEASE OF INFORMATION

I, _____, presently requesting and/or receiving services from Accredited Supportive Living Services, hereby consent to the exchange of relevant information among the agencies/people below for the following purposes:

4. To allow for identification of appropriate community resources to meet my rehabilitation needs.
5. To facilitate implementation of rehabilitation programs on my behalf.
6. To facilitate implementation of Individual Program Plans on my behalf.
7. To allow on-going monitoring of program effectiveness.

I understand that such information will be exchanged by the appropriate personnel within the following agencies and that such information will be held in confidence. The agencies and people are:

1. _____
2. _____
3. _____
4. _____

This release covers the period from _____, to _____.

This release will be reviewed if new agencies/people are involved or upon my request if I no longer wish to have contact with a particular agency/person.

Signature

Witness

Signature of Parent/Guardian

Witness

Date

ACCREDITED SUPPORTIVE LIVING SERVICES
MEDICAL ADMISSION

To be completed by attending Physician

Date: _____

Applicant's Name: _____

Applicant's Address: _____

Applicant's Phone Number: _____

Name of Physician: _____

Physician's Address: _____

Physician's Phone Number: _____

Primary Diagnosis: _____

Present Medical Treatment

i.e. Drugs _____

Diet _____

Physiotherapy _____

Speech Therapy _____

Other _____

Specialist's Reports Please include any reports from any specialist you may have referred the patient to (i.e. sight, hearing, speech, psychology, dentist, etc.)

Physical Examination to include pertinent Specialist's reports.

Medical History

Please complete if a copy of medical history is not available.

1. *Cardiovascular and Blood Pressure*

2. *Ears/Eyes/Nose/Throat*

3. *Skin*

4. *Respiratory*

5. *Gastrointestinal*

6. *Genitourinary*

7. *Musculoskeletal*

8. *Neurological*

9. *Psychiatric*

10. *Metabolic*

11. *Other pertinent information*

12. *Hgb* _____ *Date:* _____
Urinalysis _____ *Date:* _____
Other (specify) _____ *Date:* _____

Doctor's Signature

Date