ABILITY DEVELOPMENT SERVICES
by BEA FISHER

P.O. Box 296
3514 – 51 Avenue
Lloydminster, Alberta/Saskatchewan
Canada S9V 0Y2

Phone: 780-875-3633
Fax: 780-875-6513

APPLICATION FOR SERVICE

Service Applying For:	❑ Residential ❑ Community Access ❑ Employment

Duration of Service:	❑ Short Term 1 – 5 years ❑ Long Term 6 – 10 years ❑ Over 10 years

PERSONAL INFORMATION:				
Full Name:			❑ Male	❑ Female
Address			Postal Code:	
Phone #:	Home:	Work:	Cell:	
Email:				
Date of Birth:		Religion:		
Health Care #:		SIN #:		
Treaty #:		Band #		
Marital Status:	❑ Single	❑ Married	❑ Common-law	
Language Spoken/Understood:				

Guardian:	❑ Mother	❑ Father	❑ Public	❑ Own Guardian	❑ Other
Name					
Address			Postal Code:		
Phone #:	Home:	Work:	Cell:		
Email:					

Trustee:	❑ Mother	❑ Father	❑ Public	❑ Own Trustee	❑ Other
Name					
Address			Postal Code:		
Phone #:	Home:	Work:	Cell:		
Email:					

Next of Kin:	❑ Spouse	❑ Parent	❑ Sibling	❑ Guardian	❑ Other
Name					
Address			Postal Code:		
Phone #:	Home:	Work:	Cell:		
Email:					

PDD/CLSD Worker:			
Address		Postal Code:	
Phone Number(s):			

AISH/SAID Worker:			
Address		Postal Code:	
Phone Number(s):			

Emergency Contact:			
Name			
Address		Postal Code:	
Phone #:	Home:	Work:	Cell:

Family History:			
Mother's Name:		❑ Living	❑ Deceased
Date of Birth:		Phone #:	
Address		Postal Code:	

Father's Name:		❑ Living	❑ Deceased
Date of Birth:		Phone #:	
Address		Postal Code:	

Sibling's Name:		❑ Living	❑ Deceased
Date of Birth:		Phone #:	
Address		Postal Code:	

Sibling's Name:		❑ Living	❑ Deceased
Date of Birth:		Phone #:	
Address		Postal Code:	

Sibling's Name:		❑ Living	❑ Deceased
Date of Birth:		Phone #:	
Address		Postal Code:	

Sibling's Name:		❑ Living	❑ Deceased
Date of Birth:		Phone #:	
Address		Postal Code:	

Describe current level of family involvement:

MEDICAL INFORMATION:			
Family Doctor:		Phone #:	
Dentist:		Phone #:	
Optometrist:		Phone #:	
Psychiatrist:		Phone #:	
Physiotherapist:		Phone #:	
Occupational Therapist:		Phone #:	
Specialist:		Phone #:	
Specialist:		Phone #:	
Other:		Phone #:	

Diagnosis and Description of Disability:

Please Describe any Other Medical Conditions, i.e. Epilepsy, Diabetes:

Diagnosis and Description of Disability:

Is Individual Subject to Convulsion?	❑ Yes	❑ No			
Type of Seizure:		Frequency of Seizure:		Duration:	
Behavior After:					

Please list any special Dietary needs:

Physical Aids:	❑ Wheelchair	❑ Cane	❑ Walker	❑ Brace

Communication:	❑ Verbal	❑ Non-Verbal
If Non-verbal, please indicate method of communication:		

Past serious illness or surgery(s):

Medications (Include name, use, dosage and time administered)		
Is assistance required to administer medications:	❑ Yes	❑ No

Allergies:	❑ Yes	❑ No	If yes, please list.

Past Family Medical History of Importance:

Record of Immunization:	Date	Record of Immunization:	Date
Diphtheria/Pertussis/Tetanus		Tetanus	
Polio		Hepatitis B	
Measles/Mumps/Rubella			

Please check if had the following childhood illnesses:				
❑ Chicken Pox	❑ Measles	❑ Whooping Cough	❑ Scarlet Fever	❑ Mumps

Have you ever had a psychological or psychiatric assessment?	❑ Yes	❑ No
If yes, location and date this took place?		

Have you ever been institutionalized?	❑ Yes	❑ No
If yes, location and date this took place?		

Please indicate any emotional or behavioural concerns:

GENERAL INFORMATION:	
Education:	
Name of School(s) attended:	Dates Attended:
Previous Vocational/Employment Supported Received:	
Name of Agency:	Dates Attended:
Work/Volunteer Experience	
Name of Business/Agency:	Dates:
Past/Present Community Employment	
Name of Business:	Dates:
Previous Residential/Independent Living Supports Received:	
Name of Agency:	Dates Attended:

Level of Independence (List amount of support required):		
Eating:	❑ Independent	❑ Assistance Required
Dressing:	❑ Independent	❑ Assistance Required
Bathing:	❑ Independent	❑ Assistance Required
Bladder/Bowel Control:	❑ Independent	❑ Assistance Required
Budgeting Skills:	❑ Independent	❑ Assistance Required
Household Skills:	❑ Independent	❑ Assistance Required
Activities/Hobbies of Interest	❑ Independent	❑ Assistance Required
Outdoor	❑ Independent	❑ Assistance Required

Referral Source:	
Application completed by:	
Signature of Applicant:	

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CONDITIONS OF ACCEPTANCE & SERVICE

1. Applicant agrees to participate in services of Ability Development Services (Vocational and /or Residential) for the purpose of increasing independence.

2. Applicant must be willing and able to participate in a healthy lifestyle that does not put himself/herself or others at risk.

3. Applicant agrees that a transfer within the Residential/Vocational programs may occur as a result of a change in the training/care/supervision needs and/or wishes of the applicant (description of services offered are attached).

4. Applicant will participate in the ongoing assessment and evaluation of his/her strengths/needs for the development of the Support Plans.

5. Applicant will be expected to participate in Annual Service Review/Case Conferences to develop future Support Plans and personal goals development.

6. Applicant is required to follow the rules and lease agreements as outlined in Community housing.

7. Applicant in the Residential system must participate in household routines and assume a share of usual household responsibilities according to his/her capabilities.

8. Applicant is required to follow the rules and schedules as outlined in the various Vocational departments.

9. Agency reserves the right to discharge an applicant whose physical condition, conduct or influence is deemed unsatisfactory or not in the best interests of the applicant or Agency.

10. Discharge from one program component would not necessarily result in discharge from other programs offered by the Agency.

11. The Legal Guardian and/or Family Representative agree to encourage and support the applicant to comply with the conditions of acceptance as outlined above.

I, _____, hereby understand and accept the above conditions of acceptance.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Guardian or Family Representative Date

UPDATED: 2021-02-16
FORM: #PROG-0018

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SERVICE APPLICANT PHYSICAL EXAMINATION

This form is to be completed by the doctor. Please note that there may be a charge by the doctor's office for the completion of this form, which is the responsibility of the Applicant.

Name:		**Date of Birth:**	
Address:			
Primary Diagnosis:			
Secondary Diagnosis:			
Baseline Information:			
Ht.	**Laboratory**	**Urine**	
Wt.	**Hb.**	**Pap Test**	
B.P.		**CXR**	
TPR			
(The results for lab/x-ray would be appreciated when available.)			
Physical Examination:			
Eyes:			
E.N.T.:			
Chest/Breast:			
Abdomen:			
Rectal:			
G.U. System:			
C.V.S.:			
Musculoskeletal:			
Neurological:			
Integument:			
Any Other Comments:			
Date of Examination:			
Doctor's Name (please type or print):			
Address of Clinic:		**Phone:**	
Doctor's Signature:			