



# Horizons Training Centre Society

## Application for Services

Date of Application: \_\_\_\_\_ Applicants Legal Name: \_\_\_\_\_

Applicants Preferred Name: \_\_\_\_\_

Gender: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Applicants Telephone Number: \_\_\_\_\_ Applicants E-mail Address: \_\_\_\_\_

Applicants Mailing Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

S.I.N. \_\_\_\_\_

Health Care Number: \_\_\_\_\_

Medical Services Number: \_\_\_\_\_

Band Number: \_\_\_\_\_

Treaty Number: \_\_\_\_\_

### Residential Supports:

Name of Organization: \_\_\_\_\_

Contact: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Emergency Contact:

Emergency Contact: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Cell phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Relationship: \_\_\_\_\_

### Guardianship Information

Is the applicant an independent adult? \_\_\_\_\_

*If the answer is no, please complete the following section.*

*A copy of applicable Guardianship Order must be filed with the Agency prior to the commencement of services.*

Guardian: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Cell phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Relationship: \_\_\_\_\_

**Trusteeship Information**

Trustee: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Request for Documents**

In order to better tailor supports/services, a copy of the following documents are requested with this *Application for Service*.

Document/Information Requested	Copy Included with Application		
	Yes	No	N/A
P.D.D. Outcome Plan			
Individual Support Plan			
Risk Analysis			
Functional Assessment			
Mental Health Documents/Information			
Psychological Assessments			
Medical Information/ Alberta Health Services Assessments			
Behavioral Support Plans			
Current Behavior Management Strategies			
Critical Incident Reports			
Other:			

**Desired Start Date:** \_\_\_\_\_

**Desired Program Hours:** \_\_\_\_\_ per week

**Mon:** \_\_\_\_\_ **Tues:** \_\_\_\_\_ **Wed:** \_\_\_\_\_ **Thurs:** \_\_\_\_\_ **Fri:** \_\_\_\_\_

**Type of Service:** Community Access \_\_\_\_\_

Employment \_\_\_\_\_

**Nature of Disability**

Diagnosis: \_\_\_\_\_

Overview and/or general perceptions and comments of the disability: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical Information (please list all applicable information)**

Name of Doctor: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Medication (at time of application)

Dosage

Time of Administration

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the applicant capable of self-administration of these medications? \_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Record of immunizations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Chronic medical conditions, including communicable diseases: (Describe physical signs, frequency, recommended treatment method) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Previous serious illness/injuries, surgeries, hospitalizations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Medical/Physical Limitations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List Assistive Technical Devices Used or Required: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dietary Restrictions: \_\_\_\_\_  
\_\_\_\_\_

**Communication**

Language(s) spoken? \_\_\_\_\_

What is the communication ability of the applicant? \_\_\_\_\_  
\_\_\_\_\_

Applicants reading ability? \_\_\_\_\_

Applicants writing ability? \_\_\_\_\_

**Traits/Characteristics**

Please rate the individual in the following areas:

	Low	1	2	3	4	5	High
Positive attitude		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Positive motivation		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Positive interaction with others		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Responds appropriately to correction		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Responds appropriately to direction		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Appropriate grooming		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Attending to tasks		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Describe any traits, activities, behaviours that may affect the individual's relationship with others.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Behavioural Information**

Is there any history of violent, threatening, unlawful, sexual, or suicidal behavior? If Yes, please explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the applicant ever been part of a Behavioural Support Program? If yes, please explain: \_\_\_\_\_

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How does the applicant perceive themselves? \_\_\_\_\_

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How does the applicant express feelings? \_\_\_\_\_

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What situations can influence the applicant's mood/behavior? (positively and negatively) \_\_\_\_\_

Positively -

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Negatively -

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The Applicant has completed *Horizons Training Centre Society Disclosure of Applicant Information* form.

### **Employment and Volunteer History**

Please list any employment positions held by the applicant over the past five years:

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Please list any volunteer positions held by the applicant over the past five years:

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### **Leisure Pursuits**

What activities has the applicant enjoyed in the past/present? \_\_\_\_\_

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What activities would the applicant like to pursue? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Service History**

Please give a brief overview in the following service areas.

Education: \_\_\_\_\_  
\_\_\_\_\_

Residential: \_\_\_\_\_  
\_\_\_\_\_

Day Program: \_\_\_\_\_  
\_\_\_\_\_

Type of supports utilized: (e.g. Specialized, 1-1) \_\_\_\_\_  
\_\_\_\_\_

**Circle of Support** (please list the names and relationship to the applicant of any individuals who are important and supportive in the life of the applicant)

<u>Name</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____
_____	_____

**Community Connections** (list sites of past employment/volunteer sites and/or individuals where there may have been favourable connections i.e. church/group association)

<u>What/Who</u>	<u>Connection</u>
_____	_____
_____	_____
_____	_____
_____	_____

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signatures**

Name of person who completed the application (if different from applicant): \_\_\_\_\_

In signing below, you are indicating that the information you have provided is complete and accurate to the best of your knowledge.

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Guardian Signature (If Applicable)**

\_\_\_\_\_  
**Date**

**Agency Use Only**

**Documents Received**

Document/Information	Copy Received			Date Received
	Yes	No	N/A	
P.D.D. Outcome Plan				
Individual Support Plan				
Risk Analysis				
Functional Assessment				
Mental Health Documents/Information				
Psychological Assessments				
Medical Information/ Alberta Health Services Assessments				
Behavioral Support Plans				
Current Behavior Management Strategies				
Critical Incident Reports				
Other:				

**Horizons Centre Approval** (as per Executive Director):       Yes    No

**Resource Team Approval** (P.D.D. and Horizons Centre):       Yes    No  
(If yes please fill out information below)

**Official Start Date:** \_\_\_\_\_

**Program Hours/Week:** \_\_\_\_\_

**Mon:** \_\_\_\_\_      **Tues:** \_\_\_\_\_      **Wed:** \_\_\_\_\_

**Thurs:** \_\_\_\_\_      **Fri:** \_\_\_\_\_

**Type of Service (Hours/Week):** Community Access (3000) \_\_\_\_\_  
Employment Prep. (2010) \_\_\_\_\_  
Employment Supports (2020) \_\_\_\_\_



**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signatures:**

\_\_\_\_\_  
**Program Director**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Executive Director**

\_\_\_\_\_  
**Date**