APPLICATION FOR SERVICES

P.O. Box 2013 Lloydminster SK, S9V 1R5

Telephone: 780-874-9917

Fax: 780-874-9957

** FORM MUST BE COMPLETED IN ITS ENTIRETY FOR CONSIDERATION **

PART I – PROGRAM APPLYING FOR:

☐ **Life Skills Program** – *(In treatment / live-in program provided on site at LYC - 24 hour support)*
☐ **Day Program** – *(Recreation and wellness activities provided on site at LYC and in the community)*
☐ **Community Outreach Program** – *(In home support provided at individual community residence)*

PART II – GENERAL INFORMATION:

Name: _____

Address: _____

Telephone Number (Home): _____ **(Cell):** _____

Date of Birth: _____
(Month / Day / Year)

Family Physician: _____ **Telephone:** _____

Psychiatrist: _____ **Telephone:** _____

Other Professionals: _____ **Telephone:** _____

Pharmacy: _____ **Telephone:** _____

Health Care Number: _____ **Allergies:** _____

Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Transgender ☐ Intersex ☐ I prefer not to say

Financial Information:

Name of Income Support Worker: _____

Email: _____ **Telephone:** _____

Source of Income: ☐ AISH ☐ Alberta Works ☐ SAID ☐ EI ☐ No secured income

Other: _____

Monthly Income Received From All Sources: $ _____

Approximate Start Date of Secured Income: _____
(Month / Day / Year)

PART III –PSYCHIATRIC & HEALTH HISTORY:

Mental Health Diagnosis / Psychiatric Concerns:

Other Health Diagnoses / Concerns:

☐ Diabetes	☐ Asthma/emphysema	☐ Arthritis
☐ Heart disease	☐ Gait/ambulatory challenges	☐ Kidney disease
☐ Hyper/hypotension	☐ Visual impairment	☐ Liver disease
☐ Hyper/hypothyroidism	☐ Hearing impairment	☐ Chronic pain
☐ Epilepsy/seizures	☐ Cancer	☐ Gout
☐ HIV/aids	☐ Hepatitis	☐ Brain injury
☐ Organ transplant	☐ Major surgery	☐ High cholesterol

Other(s) please specify:

Medication(s):

Psychiatric Institutionalization: (Dates of Past Admissions / Discharges In Past Year)

Emotional / Behaviour:

Drug / Alcohol / Gambling / Other:

Suicidal Behavior / Self-Harm:

Criminal Activity / Community Treatment Order / Probation / Court Dates:

Other – Specify:

PART IV – AREAS OF SERVICES REQUESTED:

- ☐ Coping Strategies Education
- ☐ Medication Management
- ☐ Establishing Healthy Routines
- ☐ Goal Setting / Strategy Planning
- ☐ Financial Management / Budgeting
- ☐ Nutritional / Meal Preparation
- ☐ Daily Living Skills
- ☐ Socialization / Community Integration
- ☐ Interpersonal / Social Skills Development
- ☐ Career Planning
- ☐ Job Search Supports
- ☐ Personal / Mental Wellness Education

Other(s) please specify: _____

PART V – EMERGENCY CONTACTS:

Contact Name: _____ Relationship: _____

Address: _____

Telephone (Cell): _____ (Home): _____

Contact Name: _____ Relationship: _____

Address: _____

Telephone (Cell): _____ (Home): _____

PART VI:

Applicant Name: _____

Print Name Signature

Referral Source: _____

Print Name Signature

Referral Telephone Number: _____

Referral Email: _____

Date: _____

(Month / Day / Year)