

APPLICATION FOR LIFE SKILLS PROGRAM

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

** Section 2, 3 & 5 need to be completed by a medical/allied health professional who is familiar with the client's mental health history and current care plan**

PART I – CLIENT INFOR	<u>RMATION</u> :					
Name:						
Address						
		Street, City,	Town, Province, Postal C	ode		
Phone Number (Home):			(Cell):			
Date of Birth:			_			
	(Month /	Day / Year)				
Gender: Male	Female	Non-binary	Transge	ender	Other:	Prefer not to say
Health Care Number: _						
Family Physician:			Phone:			
Psychiatrist:			Phone:			
Community Mental Heal	lth Nurse: _		Phone:			
Other Professionals:			Phone:			
Pharmacy:			Phone:			
Financial Information						
Source of Income:	AISH	Alberta Works	SAID	SIS	El	No secured income
Other:						
Monthly Income Receive	ed From All S	Sources:				
Approximate Start Date	of Secured I	ncome:				
Income Support Worker	Contact Info	ormation - Name:				
Fmail·		Pho	ne·			



PART II - PSYCHIATRIC & HEALTH HISTORY:

Psychiatric Diagnosis / Mental Health History: (Please list all psychiatric diagnoses. Please attach relevant assessments and reports.)

Psychiatric Admissions: (Please attach relevant assessments and reports)

Facility/Location & Reason for Admission	Length of admission	Date of Discharge

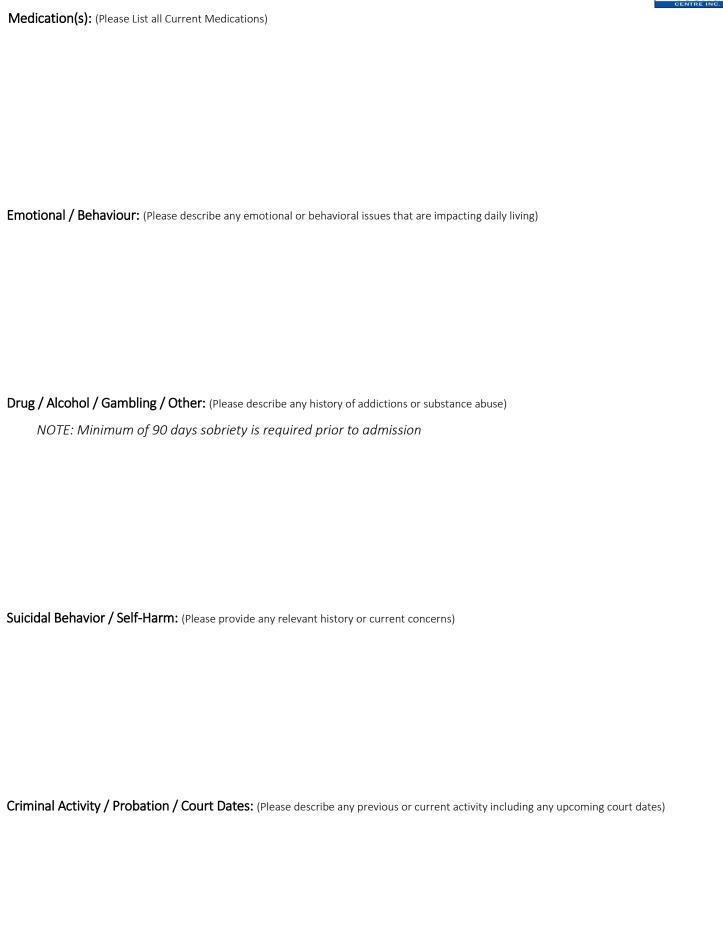
Community Treatment Order in place? Yes No Details:

Other Health Diagnoses / Concerns: (Check all that apply and provide details below)

	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	s) please specify:		

Allergies: (Please List Allergies to Medication / Food / Environment and type of reaction)









Interpersonal Skills & Healthy Social Supports Household Management / Cleaning Financial Management / Budgeting Health and Wellness Management Food Safety / Nutrition / Cooking Skills Emotional Wellness, Self-Care and Coping Strategies Hygiene and Daily Routines Goal Setting and Community Resource Access Medication Management Other: Describe reason for request and goals for services: What is the applicant's desired outcome from attending the Libbie Young Center Life Skills Program? Please provide any other relevant information that would inform this application: The goal of the LYC programs is to support clients to learn / re-learn the life skills necessary to live independently in the community. Do you believe the applicant can live independently in the community in the future? Yes No



<u>PART IV – EMERGENCY CONTACTS</u>:

Home):
Relationship:
Home):
Signature
Signature
gh the referral source. What is the best way to contact you?

Please submit application form via: Fax: 780-874-9957

or

Email: info@libbie.ca