APPLICATION FOR LIFE SKILLS PROGRAM

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

Telephone: 780-874-9917

Fax: 780-874-9957

Email: info@libbie.ca

** 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 INFORMATION:

Name: ______________________________

Address ______________________________

Street, City/ Town, Province, Postal Code

Phone Number (Home): ____________________ (Cell): ____________________

Date of Birth: ____________________

(Month / Day / Year)

Gender: Male Female Non-binary Transgender Other: Prefer not to say

Health Care Number: ____________________

Family Physician: ____________________ Phone: ____________________

Psychiatrist: ____________________ Phone: ____________________

Community Mental Health Nurse: ____________________ Phone: ____________________

Other Professionals: ____________________ Phone: ____________________

Pharmacy: ____________________ Phone: ____________________

Financial Information

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

Other: ______________________________

Monthly Income Received From All Sources: ____________________

Approximate Start Date of Secured Income: ____________________

Income Support Worker Contact Information - Name: ____________________

Email: ____________________ Phone: ____________________

Revised March 2024

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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
Heart disease
Hyper/hypotension
Hyper/hypothyroidism
Epilepsy/seizures
HIV/aids
Organ transplant

Asthma/emphysema
Gait/ambulatory challenges
Visual impairment
Hearing impairment
Cancer
Hepatitis
Major surgery

Arthritis
Kidney disease
Liver disease
Chronic pain
Gout
Brain injury
High cholesterol

Other(s) please specify: ____________________

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

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Medication(s): (Please List all Current Medications)

Emotional / Behaviour: (Please describe any emotional or behavioral issues that are impacting daily living)

Drug / Alcohol / Gambling / Other: (Please describe any history of addictions or substance abuse)

NOTE: Minimum of 90 days sobriety is required prior to admission

Suicidal Behavior / Self-Harm: (Please provide any relevant history or current concerns)

Criminal Activity / Probation / Court Dates: (Please describe any previous or current activity including any upcoming court dates)

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PART III – SERVICES: Please identify Life Skills Areas Client Requires Support in Developing

Household Management / Cleaning

Financial Management / Budgeting

Food Safety / Nutrition / Cooking Skills

Hygiene and Daily Routines

Medication Management

Interpersonal Skills & Healthy Social Supports

Health and Wellness Management

Emotional Wellness, Self-Care and Coping Strategies

Goal Setting and Community Resource Access

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

PART IV – EMERGENCY CONTACTS:

Contact Name: ______________________ Relationship: ______________________

Address: ____

Phone (Cell): ______________________ (Home): ______________________

Contact Name: ______________________ Relationship: ______________________

Address: ____

Phone (Cell): ______________________ (Home): ______________________

PART V – SIGNATURES:

Applicant Name: ____

Print Name Signature

Referral Source: ____

Print Name Signature

Referral Phone Number: ______________________

Referral Email: ______________________

Date: ______________________

Please note: application follow up is completed through the referral source. What is the best way to contact you as the referral source once the application is received?

Please submit application form via:
Fax: 780-874-9957
or
Email: info@libbie.ca