**A close-up of a logo

Description automatically generated**

**APPLICATION FOR SERVICE**

**810 EDGAR STREET, BOX 1517**

**REGINA, SASKATCHEWAN S4P 3C2**

**Phone: (306) 569-0535**

**FAX: (306) 569-5858**

***www.cosmolearningcentre.ca***

***\*\* All sections of the program application form should be filled out as completely as possible.***

***\*\*Please check mark where applicable.***

**SECTION. 1 - PERSONAL INFORMATION**

**APPLICANT INFORMATION:**

|  |  |
| --- | --- |
| Applicant’s Name:  Address:  City:  Email Address:  Birthdate:  Social Worker:  CLSD Assessment: DPSA DLSA | Date of Application:  Telephone #:  Postal Code:  Gender: M F Other  S.H.S.P #:  Telephone Number (Social Worker) #: |

**PERSON COMPLETING APPLICATION:**

|  |  |
| --- | --- |
| Name: | Telephone #: |

|  |  |
| --- | --- |
| **PRIMARY CONTACT:**  Name:  Telephone #:  Relationship:  Email Address: | **SECONDARY CONTACT:**  Name:  Telephone #:  Relationship:  Email Address: |

**Has the applicant been convicted of a criminal offence:** Yes No

|  |  |
| --- | --- |
| ***Office Use Only*** | |
| ***Note:*** | |
| ***Initials:*** | ***Date Received:*** |

***\*\*Please check mark, where applicable.***

**SECTION. 2 – HOUSING/LIVING ACCOMMODATIONS**

**Where does the applicant reside:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Independent Living** |  |  | **Group Home** |
|  | **Approved Home** |  | **Long-term Care** |
|  | **Parental Home** |  | **Other** |

**Further information, if applicable:**

|  |
| --- |
|  |

**SECTION. 3 – EDUCATION, TRAINING & PROGRAM HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Grade/ Course/ Program** | **School/ Institution** | **Telephone**  **&**  **Contact Information** | **Grade/ Complete Year** | **Work**  **Experience** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**SECTION. 4 – TRANSPORTATION**

**Is the applicant a registered Para Transit user:** Yes No

**If no, what type of transportation is required for the applicant:**

Para Transit City Bus Taxi Able Bus Other (please specify)

**SECTION. 5 – MEDICAL INFORMATION**

Height: Weight:

Diagnosis:

**Medical History (please specify):**

|  |  |
| --- | --- |
| **History** | **Note** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Medications:**

***\*\*Please list all medications and dosages.***

|  |  |
| --- | --- |
| **Medication** | **Dosage** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Allergies:**

|  |  |
| --- | --- |
|  | **Details of Allergy** |
| **Food** |  |
| **Drugs** |  |
| **Other** |  |

Is there an emergency protocol needed for an allergic reaction? Yes No

Describe the emergency protocol in detail:

**Seizures:** Yes No

**If yes, please provide the following information in detail:**

|  |  |
| --- | --- |
| **Description** |  |
|  |
|  |
| **Protocol** |  |
|  |
|  |

**Note:** A medical appendix will be provided upon acceptance for the physician to fill out.

**SECTION. 6 – SUPPORT CARE**

Is assistance with personal care required: Yes No

If yes, please explain:

Is assistance with intimate care required: Yes No

If yes, please explain:

**\*\*Please check mark where applicable**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Supports Required** | **Full**  **Assistance** | **Partial**  **Assistance** | **Supervision**  **Only** | **Independent** | **Comments** |
| **Washing face/hands** |  |  |  |  |  |
| **Dressing** |  |  |  |  |  |
| **Walking with Safety** |  |  |  |  |  |
| **Transfer to Toilet** |  |  |  |  |  |
| **Feeding** |  |  |  |  |  |
| **Toileting** |  |  |  |  |  |

**Special Equipment Needed**:

|  |  |  |
| --- | --- | --- |
|  | **Type of Equipment** | **Note** |
| **Eating** |  |  |
| **Transfers** |  |  |
| **Toileting** |  |  |
| **Communicating** |  |  |
| **Hearing** |  |  |
| **Speaking** |  |  |
| **Other** |  |  |
|  |  |
|  |  |

**Communication:**

Please describe the individual’s communication method:

|  |  |
| --- | --- |
| **Verbal** |  |
| **Gestural** |  |
| **PECS** |  |
| **Body Language** |  |
| **Facial Expression** |  |

|  |  |  |
| --- | --- | --- |
| **Language** | **Primary** |  |
| **Secondary** |  |
| **Others** |  |

**Sensory Supports (please describe):**

|  |
| --- |
|  |

**\*\*Please check mark where applicable.**

**Vision:** Good Poor

**Glasses:** Yes No

**Hearing:** Good Poor

**Hearing Aids** Yes No

***Note:***

***\*\*Please check mark where applicable.***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Supports Required** | **Full**  **Assistance** | **Partial**  **Assistance** | **Supervision**  **Only** | **Independent** | **Comments** |
| **Walking with an Aid** |  |  |  |  |  |
| **Using a Wheelchair** |  |  |  |  |  |
| **Transfer to Chair** |  |  |  |  |  |
| **Follow Simple Direction** |  |  |  |  |  |
| **Judging Personal Safety** |  |  |  |  |  |
| **Vocational Skills** |  |  |  |  |  |
| **Employment Support** |  |  |  |  |  |
| **Community Support** |  |  |  |  |  |

***Note:***

**Likes/Dislikes:**

|  |  |
| --- | --- |
| **Describe Likes** |  |
| **Describe Dislikes** |  |

**Psychosocial/Cognitive**

**\*\*Please check any that are applicable.**

Orientation intact

Orientation impaired (person has trouble recognizing any of the following)

Time Place Person Family Staff

Memory Deficit: Long term Short term

Reduced Awareness

Impaired Judgement/Decision Making

Psychiatric Symptoms

Delusions Hallucinations Other

If checked any of the above, please provide details.

|  |
| --- |
|  |
|  |

***\*\*Please check mark, where applicable.***

**SECTION. 7 – BEHAVIOR SUPPORTS**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Yes | No |
| **The applicant is:** | Co-operative |  |  |
| Aggressive |  |  |
| Destructive |  |  |
|  | | | |
| **The applicant has:** | Tendencies to Wander |  |  |
| Mood Swings |  |  |
| Unpleasant Habits |  |  |

If the answers to any of the above are yes, please explain:

|  |
| --- |
|  |

Is there a Comprehensive Behavior Support Plan / Crisis Cycle: Yes No

***\*\* If yes, please attach plan***

I/we agree to the release of information to or from requesting agencies or others concerned with the application. We also allow the exchange of information pertaining to the participant with the following people:

**SECTION. 8 – CONSENT RELEASE**

Participant:

Parents:

Guardian:

**Signature Parents/Guardians Date:**

The following reports have been completed and submitted:

**SECTION. 9 – CHECK LIST & SUMMARY**

|  |  |  |
| --- | --- | --- |
| **Name of Reports** | **Yes** | **No** |
| Education Report |  |  |
| Vocational Report |  |  |
| Comprehensive Behavior Support Plan |  |  |
| Release of Information |  |  |
| Latest Person Centered Plan *(If applicable)* |  |  |
| **Others (please specify)** | | |
|  |  |  |
|  |  |  |
|  |  |  |

**Note: All applications for program services to be addressed to the following:**

**Executive Director of Cosmopolitan Learning Centre**

**Box 1517**

**Regina, Sask.**

**S4P 3C2**

**Parents/Guardians Signature**

**Participant Signature Date:**