

Supported Lifestyles – Women’s Group Application Form
Thursdays; 1:00-2:30pm. February 4th to April 7th, 2016.

| <p>Name: _____</p> <p>First Last</p> | <p>Home Mailing Address:</p> <p>City: Postal Code: Phone:</p> | | | | | | | | | | | | | | | |
|--|--|------------------|--|--|-------|------|---------|--|--|--|--|--|--|--|--|--|
| <p>PDD ID #:</p> | <p>Guardianship:</p> <p>Is Individual Own Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | | | | | | | | | | | | | | | |
| <p>Date of Birth:</p> | <p>Do not fill out this area, for OFFICE use only!</p> <p>Date Received</p> | | | | | | | | | | | | | | | |
| <p>Who to Contact for Interview: (select one only) <input type="checkbox"/> Self/Individual <input type="checkbox"/> Day Support Office Contact <input type="checkbox"/> Residential Support Office Contact <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other: _____</p> <p>Contact Name: _____</p> <p>Contact Phone #: _____</p> <p>Contact Email Address: _____</p> | | | | | | | | | | | | | | | | |
| <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th colspan="3" style="text-align: left;">Dates Contacted:</th> </tr> <tr> <th style="width:20%;">Date:</th> <th style="width:20%;">Who:</th> <th style="width:60%;">Result:</th> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table> <p><input type="checkbox"/>AM <input type="checkbox"/>BUDS <input type="checkbox"/>WG <input type="checkbox"/>MG <input type="checkbox"/>AM</p> <p>Interview booked for: _____ <input type="checkbox"/>RevApp <input type="checkbox"/>GuardSig</p> | | Dates Contacted: | | | Date: | Who: | Result: | | | | | | | | | |
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| Date: | Who: | Result: | | | | | | | | | | | | | | |
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Are there any medical concerns (e.g. seizure disorder, allergies, etc.) that we need to be aware of in case of emergency?

Yes (please list below) No Not relevant

Do you take any medications to address these concerns? If yes, please list:

Do you have any food allergies? Yes (please list below) No

Risk Assessment for group participants:

Our goal is to provide a safe environment for all. Please identify if you have had challenges with any of the following:

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Sexual Behaviours (e.g., inappropriate touching) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Suicide | <input type="checkbox"/> Smoking, Drug, or Alcohol Problems | <input type="checkbox"/> None of the above |

It is the individual’s responsibility to get to and from the group. If assistance is needed, a support staff from your agency MUST be available. Please indicate your means of transportation to and from the group:

- | | |
|---|--|
| <input type="checkbox"/> ACCESS Calgary | <input type="checkbox"/> Calgary Transit |
| <input type="checkbox"/> Staff vehicle | <input type="checkbox"/> Other |

****Please note that the doors close 15 minutes after group ends and that Support Approach Team staff are not able to supervise individuals waiting for transportation past that time.**



Please check if you require assistance with any of the following:

- Reading Writing Sight
 Speech Hearing Mobility

Please identify 3 goals you would like to achieve by the end of the 10-week group:

1. _____
2. _____
3. _____

Emergency Contact Information:

| Person's Name | Telephone Number(s): |
|----------------------------|----------------------|
| Guardian/Family: | |
| Day Support | |
| Agency _____ Name _____ | |
| Residential Support | |
| Agency _____ Name _____ | |

In the event that a sudden medical emergency occurs, efforts will be made to obtain treatment consent from the guardian and to notify the service provider involved. In the event that the guardian cannot be reached, I hereby authorize Supported Lifestyles Ltd. to **seek emergency services**. It is the responsibility of the attending physician(s) and support personnel to obtain consent, or for the physician to decide to treat without guardian consent.

Note: Guardian approval (if applicable) is required for this course! Guardian signature authorizes Supported Lifestyles to contact the client's service agency, PDD or other services to obtain information pertinent to the needs of facilitating the workshop and is effective for the duration of the group.

☀ **Individual's Signature** _____

☀ **Date** _____

☀ **Guardian Signature (if applicable)** _____

I, the Guardian/Agent/Independent Adult, give my permission to Supported Lifestyles Staff to videotape/record and or photograph the individual for the purpose of Educational, Training and /or Group promotion. I am aware that I can revoke, revise or terminate this authorization at any time.

Yes No _____ **Initials**

Application for Women's Group may not guarantee you a spot in the group.

The final selection of participants will be made once each applicant has had an interview. Once the participants for the group have been selected, all applicants will be notified by telephone.

Completed applications can be returned to:

Mail: Elyse Seppala
 Supported Lifestyles
 #210, 495 36 Street NE
 Calgary, Alberta
 T2A 6K3

Fax: (403) 207-5125
 Attention: Elyse

Email: seppalae@supportedlifestyles.com

Should you have any questions, please contact Elyse as above or at (403) 207-5115 ext. 264

