Life Empowerment Inc.
Application for Service

Unit-E, 5002 – 54th Street
Barrhead, Alberta T7N 0M8
Email: admin@LifeEmpowerment.ca
Fax: 780-674-6886
Phone: 780-674-7664

Name				**Date of Birth**			
Address				**Phone Number**			
Legal Status	Minor Child ☐		Independent Adult ☐		Dependent Adult ☐		
Cultural Background				**Religious Preference**			
Social Insurance No.				**Alberta Health Care No.**			
Other Health Care No.				**Personal Identification**		**Male ☐**	**Female ☐**
Height		**Weight**		**Eye Color**		**Hair Color**	
Identifying Marks				**Picture Included**	**Yes ☐**	**No ☐**	
Emergency Contact(s)							

Personal Contacts							
Parent/Next of Kin		**Home Ph.**		**Work Ph.**		**Cell Ph.**	
Address					**Email**		
Parent/Next of Kin		**Home Ph.**		**Work Ph.**		**Cell Ph.**	
Address					**Email**		
Guardian		**Home Ph.**		**Work Ph.**		**Cell Ph.**	
Address					**Email**		
Trustee		**Home Ph.**		**Work Ph.**		**Cell Ph.**	
Address					**Email**		

Please note that when you are accepted into service, Life Empowerment will require copies of the following:

- → *Court Appointed Guardian/Trusteeships, or AISH Trustee Agreements*
- → *Alberta Health Care Number*
- → *Social Insurance Number*
- → *Photo ID*
- → *For all Status First Nations People, a copy of their Treaty and White card will also be needed*

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Medical, Professional, and Previous Placements Contacts						
Family Doctor		Office Ph.		Fax		
Office Address		Consent to contact	☐ Yes ☐ No	Initials to Consent		
Dentist		Office Ph.		Fax		
Office Address		Consent to contact	☐ Yes ☐ No	Initials to Consent		
Optometrist		Office Ph.		Fax		
Office Address		Consent to contact	☐ Yes ☐ No	Initials to Consent		
Pharmacist		Office Ph.		Fax		
Office Address		Consent to contact	☐ Yes ☐ No	Initials to Consent		
Mental Health		Office Ph.		Fax		
Office Address		Consent to contact	☐ Yes ☐ No	Initials to Consent		
Other		Office Ph.		Fax		
Office Address		Consent to contact	☐ Yes ☐ No	Initials to Consent		
Other		Office Ph.		Fax		
Office Address		Consent to contact	☐ Yes ☐ No	Initials to Consent		
Other		Office Ph.		Fax		
Office Address		Consent to contact	☐ Yes ☐ No	Initials to Consent		
Other		Office Ph.		Fax		
Office Address		Consent to contact	☐ Yes ☐ No	Initials to Consent		
Other		Office Ph.		Fax		
Office Address		Consent to contact	☐ Yes ☐ No	Initials to Consent		

Does the applicant have a history/or require support for any of the following:

Diabetes	☐	Migraine Headaches	☐	Respiratory Ailments	☐	Heart Ailments	☐
Epilepsy	☐	High Blood Pressure	☐	Low Blood Pressure	☐	Urinary Disorders	☐
Back Ailments	☐	Arm Ailments	☐	Hand Ailments	☐	Leg Ailments	☐
Foot Ailments	☐	Poor Vision	☐	Poor Hearing	☐	Allergies	☐

Explain any checked:

Describe any health or medical needs:

Describe any current or relevant history of contagious and infectious disease such as HIV, hepatitis, tuberculosis, measles, etc.:

Any other health issues, limitations, precautions or further explanations:

Please List Current Medications (include over-the-counter medications)

Medication Name	Dosage	Delivery Time

Social/Emotional Development (describe to the best of your ability)

Level of independence for age:

Social interactions skills/maturity – any delays in social development/concerns. Does he/she prefer small groups 1 or 2 friends, is he/she shy/outgoing, etc.?

Areas of special skill or need (e.g. behavioral or emotional): (Please attach assessments)

Mobility

General comments on the Individuals mobility level (able to travel alone, need support to get from place to place, uses public transportation, drives, etc.):

Does the Individual have any physical disabilities or limitations?

Basic Functional Profile

General functional comments, level of independence, level of comprehension:

Independent living skills/abilities:

Basic Functional Profile continued

Self-help skills (level of independence in dressing, eating, personal hygiene, etc.):

Community inclusion independence level:

Employment/work skills, history, level of independence, previous employers and contact information:

Personal Preferences

Individual's Likes:

Individual's Dislikes:

Special Interests/Hobbies:

Financial Status: check all that apply

AISH ☐	Employment ☐	Insurance ☐	Other ☐

Requested Supports

Check all that applies

Community Living Supports – Overnight this support is a 24/7 program that will include Community Access Supports. → Employment Access ☐ Yes ☐ No Total Units: _____ → School ☐ Yes ☐ No Total Units: _____ School: _____	Choose the appropriate Community Living Supports 24/7 ☐

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Community Living Supports – Non-Overnight - Total Weekly Units: _____ → Community Access Supports ☐ Yes ☐ No Total Units: _____ → Employment Access ☐ Yes ☒ No Total Units: _____	Non – Overnights ☐
Respite Supports → Community Access ☐ Yes ☐ No Total Units: _____ → Hourly Respite ☐ Yes ☐ No Total Units: _____ → 24 hour/daily Respite ☐ Yes ☐ No Total Units: _____ - ☐ in own home - ☐ in employee's home	
Home Care → Personal Care ☐ Yes ☐ No Total Units: _____ → Meals ☐ Yes ☐ No Total Units: _____ → House Work ☐ Yes ☐ No Total Units: _____ → Sibling Care ☐ Yes ☐ No Total Units: _____	
Transition Services Yes ☐ No ☐	

❖ ***Units = how many hours you are requesting***

Referring Agent			
Name		**Phone Number**	
Relationship to Individual			
Facility/Agency/Service			
Address			
Email		**Fax**	
Agent's Signature		**Date of Referral**	
Additional Comments			

Release of Information Clause

I, _____ give permission for Life Empowerment Support Services Inc. to speak to the following agencies/people for exchange of information regarding _____ for the purpose of establishing support services and establishing a support plan.

Signature: _____ Date: _____

❖ Please attach copies of any assessments to the Application for Support

Initial Approval: January, 2013
Latest Review: September, 2019

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