

1144 rue Amirault Street, Dieppe, NB, E1A 1E2 ………………………………………………………………………………………………………..Form 40

**The Admission Committee reserves the right to return all applications that have not been fully completed.**

**RESIDENTIAL APPLICATION**

**REFERRAL INFORMATION**

|  |  |  |
| --- | --- | --- |
| Referral Date: | Referring Worker: | Phone: |
| Address: | E-mail: |

**APPLICANT'S PERSONAL INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Application's Name: | Age: | DOB (Y/M/D) | Medicare # |
| Address | Marital Status | Sex: Male Female  |
| Phone: | Language Spoken English French | Financial Support:Health Benefits Card: YES NO |

**MEDICAL**

|  |  |
| --- | --- |
| Psychiatric Diagnosis: | Psychiatrist:Mental Health Worker: |
| Allergies: | General Practitioner: |
| Relevant Medical Problems: | Dentist: |
| Physical Handicaps: | Present Medication: |

**ADDITIONAL INFORMATION**

|  |
| --- |
| Workshop Experience or Employment: |
| Leisure Activities / Hobbies enjoyed: |

**NEXT OF KIN OR GUARDIAN / EMERGENCY**

|  |  |
| --- | --- |
| Name: | Phone:E mail: |
| Relationship: |
| Address: |
| Power of Attorney: | Phone:E mail: |
| Other: | Phone:E mail |

**FAMILY INFORMATION**

|  |  |
| --- | --- |
| Spouse's Name: | Phone:E mail: |
| Address: |
| Father's Name: | Phone:E mail: |
| Address: |
| Mother's Name: | Phone:E mail: |
| Address: |

**CHILDREN**

|  |  |
| --- | --- |
| Name: | Phone:E mail: |
| Address: |
| Name: | Phone:E mail: |
| Address: |
| Name: | Phone:E mail: |
| Address: |

**FUNCTIONING LEVEL ASSESSMENT**

|  |  |  |
| --- | --- | --- |
| **1. PHYSICAL FUNCTIONING** | **ACQUIRED ABILITIES** | **COMMENTS** |
| Smoker | YES NO |  |
| Dressed adequately, (no supervision) | YES NO |  |
| Takes care of personal hygiene | YES NO |  |
| Appropriate eating habits | YES NO |  |
| Maintains personal cleanliness | YES NO |  |
| Helps with household chores | YES NO |  |
| Can prepare simple meals | YES NO |  |
| Goes in the community unaccompanied | YES NO |  |
| Balance sleeping pattern | YES NO |  |
| Has good table manners | YES NO |  |
| Practices physical activity regularly | YES NO |  |
| **2. EMOTIONAL FUNCTIONING** | **ACQUIRED ABILITIES** | **COMMENTS** |
| Has a stable mood | YES NO |  |
| Socializes with others | YES NO |  |
| Keeps in touch with his/her family | YES NO |  |
| Controls his/her aggressiveness | YES NO |  |
| Is on friendly terms with others | YES NO |  |
| Enjoys going on outings | YES NO |  |
| Respects authority and rules | YES NO |  |
| Shares personal problems | YES NO |  |
| Maintain contact with reality | YES NO |  |
| Has a history of suicidal thinking/attempts | YES NO |  |

|  |  |  |
| --- | --- | --- |
| **3. INTELLECTUAL FUNCTIONING** | **ACQUIRED ABILITIES** | **COMMENTS** |
| Has decision making process | YES NO |  |
| Utilizes public services | YES NO |  |
| Takes medication on his/her own | YES NO |  |
| Follows rules | YES NO |  |
| Manages his/her money | YES NO |  |
| Makes own appointments | YES NO |  |
| Reads and writes | YES NO |  |

**TYPES OF SERVICE REQUESTED**

|  |  |
| --- | --- |
| Long Term Residential Facility - 24 hrs Support Transition House (2 years Max) |  |
| Subsidized Housing (Shared Accommodation) |  |
| Bachelor Apartment (ACA) |  |
| Reason for referral: |
| Previous Placement: | Date: | Reason: | Reason for leaving: |
| Special needs: | Mobility: | Diet: |
| In-Patient Psychiatric Care | Number of admissions: | Length of stay: |
| Does the applicant have a problem with non prescription drugs: | YES If YES please specify:NO |
| Does the applicant have a problem with alcohol: | YES If YES please specify:NO |
| Are you aware of other service agencies providing services to this person? | YES If YES, state type of service:NO Contact person: Telephone #: E mail: |
| Please describe the family dynamics: |
| Additional information (i.e. supervisory requirements, fears, fixations, habits, etc.) |
| Is the applicant stable? YES NO , explain: |
| Early signs of decompensation: |

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Signature of referring agent Date

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Signature of Applicant Date

**ASSURANCE OF COOPERATION**

DO YOU OR YOUR AGENCY AGREE TO CONTINUE THE TREATMENT SERVICE OF THE APPLICANT AND TO PROVIDE CONSULTATION TO ALTERNATIVE RESIDENCES ALTERNATIVES INC. STAFF AS REQUIRED?

YES NO

|  |
| --- |
| IF NO, STATE REASON |

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Signature of referring agent Date

N.B.

 Person referred to all services Alternative Residences Alternatives Inc. must be followed by a case manager or nurse on a regular basis.

 Case manager and/or Nurse must be available to meet with Alternative Residences Alternatives Inc. staff as the need arise.

 Exceptions to this will be evaluated by the admission committee.

Revised June 2008