Life Empowerment Support Services Inc.

Initial Contact and Request for Services

P.O. Box 4637
5028-49a Street
Barrhead, Alberta T7N 1A5
Email: admin@LifeEmpowerment.ca
Fax: 780-674-6886
Phone: 780-67-7664

GENERAL INFORMATION / CONTACT INFORMATION

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**		

PURPOSE OF THE REFERRAL: (SERVICES REQUESTED)

Financial Status: check all that apply			
AISH ☐	Employment ☐	Insurance ☐	Other ☐

Requested Supports	
Check all that applies	
	Choose the appropriate Community Living Supports

A-1 - ADMISSIONS

Appendix: A-1.1.1

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: _____	24/7 ☐
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 Respite 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***

URGENCY RATING SCALE

High	*Time sensitive* (I.E. Homeless/or about to be homeless; family breakdown, need immediate respite, etc.)	☐
Moderate	*Less urgency*, (I.E. Currently working on some changes for breakdown, to transition into new services, plan respite, etc.)	☐
Low	*Low Priority.* (Current situation is stable, looking for planned out transition into new services)	☐

GENERAL INFORMATION OF THE PERSON REQUIRING SERVICES

Who is the Person applying for Services? General information about their disability. Please include what the applicant requires for supports, their basic needs and level of understanding, etc.

ADDITIONAL COMMENTS:

Any additional information like recommendations from doctors, etc. Please provide any addition documentation or assessments that the applicant has available. Do you currently have approved funding?

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: _____

1. _____ Ph. # _____.
2. _____ Ph. # _____.
3. _____ Ph. # _____.
4. _____ Ph. # _____.
5. _____ Ph. # _____.
6. _____ Ph. # _____.
7. _____ Ph. # _____.
8. _____ Ph. # _____.
9. _____ Ph. # _____.
10. _____ Ph. # _____.

Office use only:

Received by: _____ Date: _____

Reviewed by Admissions (date): _____