P.O. Box 2013
Lloydminster SK, S9V 1R5
Telephone: 780.874.9917
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APPLICATION FOR SERVICES

**** FORM MUST BE COMPLETED IN ITS ENTIRETY FOR CONSIDERATION ****

Part I – Program Applying For

❒ **Life Skills Program** ❒ **Supported Independent Living Program** ❒ **Day Program**

Part II – General Information

Name: ____

Address: ____

Telephone Number: ____________________ **Cell Phone Number:** ____________________

Date of Birth: ______________________________ **Sex:** Female ❒ Male ❒
DAY / MONTH / YEAR

Family Physician: ______________________ **Telephone:** ____________________

Psychiatrist: ______________________ **Telephone:** ____________________

Mental Health Therapist: ______________________ **Telephone:** ____________________

Pharmacy: ______________________ **Telephone:** ____________________

Income Support Worker: ______________________ **Telephone:** ____________________

Health Care #: ______________________ **S.I.N #:** ____________________

Allergies: ____

Financial Information: (Life Skills/Supported Independent Living Programs)

Source of Income: ____

Monthly Income Received From All Sources: ______________________________

Monthly Expenses for Personal Needs: ______________________________

Monthly Expenses for All Other Needs: ______________________________

Part III – Psychiatric History

Registered with Lloydminster Mental Health Services: Yes ❐ No ❐

Community Mental Health Worker: ______________________________

Telephone: ______________________

Diagnosis: ______________________________

Medication(s): ______________________________

Current Treatment / Intervention: ______________________________

History of Problem Areas: (Pertinent Information **MUST** be Included)

Psychiatric Concerns: ______________________________

Psychiatric Institutionalization (Include Dates of Past Admissions / Discharges): ____________

Emotional / Behavior: ______________________________

Drug / Alcohol / Chemical / Gambling Abuse: ______________________________

Self-Medicating: ____

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Suicidal Behavior: ____

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Self-Harm: ____

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Physical Aggression: ____

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Criminal Activity: ____

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Other – Specify: ____

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Part IV – Areas of Services Requested

- ❑ Stabilization
- ❑ Medication Management
- ❑ Assessment / Observation
- ❑ Goal Setting / Strategy Planning
- ❑ Affordable Housing
- ❑ Financial Management / Budgeting
- ❑ Nutritional / Meal Preparation
- ❑ Daily Living Skills
- ❑ Socialization / Integration
- ❑ Personal / Mental Wellness Education
- ❑ Interpersonal / Social Skills Development
- ❑ Career Planning
- ❑ Job Search Supports
- ❑ Other – Specify Below

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Part V – Applicant's Objectives (MUST Be Completed By Applicant)

Short Term Goals:

Long Term Goals:

What is your understanding of the Program you are applying for?

How will this Program assist you in achieving your Goals?

What commitments are you willing to make to ensure the Program is successful for you?

Section VI

Applicant Name: ______________________________ ______________________________
PRINT NAME SIGNATURE

Referral Source: ______________________________ ______________________________
PRINT NAME SIGNATURE

Referral Telephone Number: ____

Referral Email: ____

Date: ___________________________________
DAY / MONTH / YEAR

Section VII – Emergency Contacts

Contact Name: ______________________________ **Relationship:** ______________________

Address: ____

Telephone (Home): __________________________ (Work): ____________________________

Contact Name: ______________________________ **Relationship:** ______________________

Address: ____

Telephone (Home): __________________________ (Work): ____________________________

Contact Name: ______________________________ **Relationship:** ______________________

Address: ____

Telephone (Home): __________________________ (Work): ____________________________

- FOR OFFICE USE ONLY –

Referral Date: ____________________ **Interview Date:** _________________________

Admission Date: ___________________ **Discharge Date:** _________________________