Individual Assessment for Service
Cover Page

Agency: **PLUS INDUSTRIES INC.**

Address: **609 HAMILTON AVE. W.** **BOX 2557**

City: **MELFORT** Province: **SK** Postal Code: **S0E 1A0**

Phone Number: **306-752-9329**

Date form Completed: _____

Services applied for (check all that apply):

Residential

- ☐ Group Home
- ☐ Supported Living Program
- ☐ Respite
- ☐ Group Living Home

Vocational

- ☐ Day Program
- ☐ Vocational Training Program/Pre-Vocational Program
- ☐ Supported Employment
- ☐ Employment Program

The indicated documents are required to process the assessment and must be included:

- ☐ Completed Individual Assessment for Service Form
- ☐ DLSA Summary Report/DPSA Summary Report
- ☐ Current Person Centered Plan
- ☐ Current Behaviour Support Plan (if applicable)
- ☐ Medical Report
- ☐ General Consent Forms
- ☐ Criminal Record Check
- ☐ Reference from Previous Support Provider (if applicable)
- ☐ Vocational Evaluation
- ☐ Occupational Therapy (OT)/Physical Therapy (PT) Assessment
- ☐ Other:

Insert AGENCY NAME (The Agency) **PLUS INDUSTRIES INC.**

CONSENT FOR RELEASE OF INFORMATION

Name of Individual: _____

I, [*myself, or legal guardian/representative]* (circle), hereby consent to the collection, use and disclosure of information to *The agency* any information concerning educational, financial, medical, psychiatric, residential, social, vocational, or any other relevant information required for admission purposes.

I understand that The Agency will:

- Collect and disclose personal information and share information both verbally and in writing to those who are part of the admissions process with The Agency
- Only disclose as much information as is required to make decisions regarding admission process.
- Only disclose information in accordance with my consent and as required by law.

I understand that:

- I may refuse to sign this consent or I may revoke this consent in writing at any time
- This form will be valid for two years unless otherwise noted.

Dated at _____ this _____ day of _____ AD, 20 _____

-
_____

Participant or Agent (please print)

-
_____

Signature of Participant or Agent

-
_____

Signature of Legal Guardian (if applicable)

-
_____

Witness (please print)

-
_____

Signature of Witness

-
_____

Signature of Witness

INDIVIDUAL ASSESSMENT FOR SERVICE FORM

Benefits of Using the Individual Assessment Form

The Individual Assessment for Service form is a document centred on the individual applying for service. When applying to numerous agencies at one time, the form can be completed once and copied for numerous agencies, attaching the agency specific cover page. This simplifies the process for the applicant who wishes to apply to numerous agencies.

Instructions for filling out the assessment form:

This Individual Assessment for Service Form will apply to all Agencies that you apply to. Each Agency will have their specific cover page. Please contact the agency being applied to for their specific cover page. The assessment form can be photocopied and have the specific cover page attached for each agency applied to.

The form can be used for numerous applications at one time, however, if it is more than 6 months since it was completed, it is suggested that the assessment be done again.

A guide book has been included in this manual as a reference tool to be used when completing the Individual Assessment for Service. All comments that are a resource for the person completing the form are ***bolded, italicized and highlighted***.

Where the question indicates "you", this refers to the person who is wishing to receive services.

Who should complete this form?

The Participant and/or family members will be involved in the process and provide valuable information, but it is recommended that the designated Agency and/or the designated CLD Staff will complete this form.

Table of Contents

INTRODUCTION:

Why are you applying to THIS agency?

What are your desired outcomes and expectations of the agency?

A. INDIVIDUAL'S PERSONAL INFORMATION

Name: Phone Number:

Address:

City: Province: Postal Code:

Date of Birth (mm/dd/yyyy):

Are you a legal resident of Saskatchewan? *(Minimum of 3 months residence in Saskatchewan)*
☐ Yes ☐ No

Guardianship:

Is there legal guardianship in place?
☐ Yes ■ No

If **Yes,** please provide date of legal guardianship order:

Legal Guardian Name:

Address:

City: Province: Postal Code:

Phone Number:

Previous Service Providers:

Please list the previous Service Providers (both residential and vocational), starting with the most recent. The list below should cover the previous 7 years.

Agency	Contact Person and Phone Number

Consent must be obtained for release of information from previous agency and must be attached.

B. HEALTH STATUS INFORMATION FORM

Known Medical Conditions:

Seizure Disorder: ☐ Yes ☐ No
Type
(If yes to above question please complete attached Appendix 2 – Seizure Description Form.)

Diabetic: ☐ Yes ☐ No
Controlled by: ☐ Diet ☐ Oral Medication ☐ Insulin
Describe Treatment:

Heart Problems/Conditions: ☐ Yes ☐ No
Describe Treatment:

Lung Problems/Conditions: ☐ Yes ☐ No
Describe Treatment:

Gastrointestinal Conditions: ☐ Yes ☐ No
Describe Treatment:

Gastroesophageal Reflux Disease (GERD or Reflux): ☐ Yes ☐ No
Describe Treatment:

Urinary Conditions: ☐ Yes ☐ No
Describe Treatment:

Skin Conditions: ☐ Yes ☐ No
Describe Treatment:

Bone/Joint Conditions: ☐ Yes ☐ No
Describe Treatment:

Muscular Conditions: ☐ Yes ☐ No
Describe Treatment:

Communicable Illnesses/Diseases: ☐ Yes ☐ No
Describe Treatment:

Psychiatric/Mental Health Supports: ☐ Yes ☐ No
Describe Treatment:

Other Known Medical Condition(s):
Describe Treatment:

Vision: ☐ Normal
Wears: ☐ Glasses ☐ Contact Lenses
Legally Blind: ☐ Yes ☐ No

Teeth: ☐ Has own
Wears: ☐ Full Denture
☐ Partial Plate (upper/lower)

Hearing: ☐ Normal ☐ Impaired
Wears: Hearing aide(s): ☐ Left ☐ Right

Diet: ☐ Regular ☐ Cut Up ☐ Ground ☐ Pureed ☐ Tube Feed
☐ Low Sodium ☐ Diabetic ☐ Low Caloric ☐ Choking Risk ☐ Low Cholesterol

Therapies: ☐ Occupational Therapy ☐ Physical Therapy ☐ Positioning
☐ Other:

Last Tetanus Vaccination:

Previous Surgeries:

Previous Hospitalizations:

Dates Reason

Mobility:

☐ Independent ☐ 1 or 2 Person Assist ☐ Uses Walker ☐ Uses Wheelchair
☐ Uses Crutches ☐ Uses Prosthetics ☐ Uses Cane ☐ Requires Supervision

Comments:

Transfers/Lifts:

Has an Occupational Therapy or Physical Therapy Assessment been completed: ☐ Yes ☐ No

☐ Independent ☐ Uses Slide Board/Transfer Board ☐ Total Lift
☐ Sit/Stand Lift ☐ Requires Mechanical Equipment ☐ Other:

Comments:

Allergies:

Anaphylaxis: ■ Yes ☐ No Anaphylaxis to:

Do you carry an EpiPen? ■ Yes ☐ No
Can you administer EpiPen? ☐ Yes ■ No

Where is EpiPen Stored?

Food Allergies: ■ Yes ☐ No
Allergy to:

Describe Reaction(s):

Drug Allergies: ☐ Yes ■ No
Allergy to:

Describe Reaction(s):

Environmental Allergies: ☐ Yes ☐ No

Allergy to:

Describe Reaction(s)

*If an allergy report from an Allergist is available, please attach it to the assessment.

Other Medical Information:

C. WORK AND WORK RELATED ACTIVITIES

If Day Program Skills Assessment (DPSA) is available please attach and indicate if information is included in the DPSA.

Have you held a job or attended an Activity Centre or Workshop? ☐ Yes ☐ No

Place of Work	Type of Work	Reason for Leaving

Additional Comments:

What are your likes, dislikes, and job interests?

What are your dreams in regards to working?

D. DAILY LIVING SKILLS AND PERSONAL CARE

If Daily Living Skills Assessment (DLSA) is available please attach and indicate if information is included in the DLSA.

What is your typical day?

What are your likes and dislikes? (e.g., food, activities, dreams, goals, etc.)

Communication:

Languages Spoken: ☐ English ☐ (Other please specify)

Languages Understood: ☐ English ☐ Other (please specify)

Do you:	**Yes**	**No**	**Unknown**
Use gestures to communicate	☐	☐	☐
Respond to others	☐	☐	☐
Communicate wants and needs	☐	☐	☐
Initiates conversations	☐	☐	☐
Use sign language	☐	☐	☐
Follow simple instructions	☐	☐	☐
Understand 2 – 3 part sentences	☐	☐	☐
Speak clearly	☐	☐	☐
Follow step by step instructions	☐	☐	☐
Understand complex instructions	☐	☐	☐

If assistance is required with communication, please specify the nature of assistance that is required:

Please rate your independence in carrying out the following activities of daily living by checking the appropriate box:

Personal Hygiene and Grooming:

	Independent	Requires Prompting	Requires Partial Assistance	Total Assistance
Shampooing hair	☐	☐	☐	☐
Combing hair	☐	☐	☐	☐
Brushing teeth	☐	☐	☐	☐
Bathing	☐	☐	☐	☐
Shaving (face/legs)	☐	☐	☐	☐
Use of deodorant	☐	☐	☐	☐
Menstrual cycle	☐	☐	☐	☐
Cutting toe/fingernails	☐	☐	☐	☐
Dressing/Undressing	☐	☐	☐	☐
Wardrobe coordination	☐	☐	☐	☐
Appropriate dress for climate/season	☐	☐	☐	☐

If assistance is required, please specify the nature of assistance that is required:

Eating Habits and Meal Planning:

	Independent	Requires Prompting	Requires Partial Assistance	Total Assistance
Eating and drinking	☐	☐	☐	☐
Table setting	☐	☐	☐	☐
Eating etiquette	☐	☐	☐	☐
Menu planning	☐	☐	☐	☐
Grocery shopping	☐	☐	☐	☐
After-meal cleanup	☐	☐	☐	☐

If assistance is required, please specify the nature of assistance that is required:

Toileting Routine:

	Independent	Requires Prompting	Requires Partial Assistance	Total Assistance
Urine	☐	☐	☐	☐
Bowels	☐	☐	☐	☐

Do you use: Protective undergarments (e.g. attends) ☐ Yes ☐ No
Catheter ☐ Yes ☐ No

Is there a specific toileting schedule? ☐ Yes ☐ No

If yes, please specify

Mobility:

	Independent	Requires Prompting	Requires Partial Assistance	Total Assistance
Ability to walk	☐	☐	☐	☐
Stairs	☐	☐	☐	☐

Comments:

Personal Safety Skills:

	Independent	Requires Prompting	Requires Partial Assistance	Total Assistance
Wandering risk	☐	☐	☐	☐
Traffic safety (e.g. crossing street, do they understand and obey traffic lights and crosswalks)	☐	☐	☐	☐
Knowledge of what to do in an emergency	☐	☐	☐	☐

Comments:

Homemaking Skills:

	Independent	Requires Prompting	Requires Partial Assistance	Total Assistance
Use of appliances	☐	☐	☐	☐
Bed making	☐	☐	☐	☐
Sweeping floors	☐	☐	☐	☐
Scrubbing floors	☐	☐	☐	☐
Dusting	☐	☐	☐	☐
Laundry	☐	☐	☐	☐
Ironing	☐	☐	☐	☐
Cleaning bathroom	☐	☐	☐	☐
Care of living space	☐	☐	☐	☐
Cleaning/maintenance of appliances	☐	☐	☐	☐
Care of clothing: folding and putting away clean clothes	☐	☐	☐	☐

Comments:

Transportation:

	Independent	Requires Prompting	Requires Partial Assistance	Total Assistance
Ability to use local accessible transportation system	☐	☐	☐	☐

Comments:

Independent Living Skills:

	Independent	Requires Prompting	Requires Partial Assistance	Total Assistance
Use of telephone	☐	☐	☐	☐
Ability to tell time	☐	☐	☐	☐
Money management	☐	☐	☐	☐
Problem solving	☐	☐	☐	☐
Decision making	☐	☐	☐	☐
Ability to shop: groceries, clothing, etc.	☐	☐	☐	☐

Comments:

Leisure Activities:
What leisure activities do you choose to participate in? Please describe the assistance required for each activity.

Activity	Independent	Level of Assistance Required

Social Interaction:

	Independent	Requires Prompting	Requires Partial Assistance	Total Assistance
Large Group gathering	☐	☐	☐	☐
One-on-one situation	☐	☐	☐	☐
Maintains friendships	☐	☐	☐	☐
Initiates conversations	☐	☐	☐	☐

Comments:

Sleep and Rest:

Do you require medication to aid in sleep? ☐ Yes ☐ No

If yes, please specify:

Do you have any difficulty sleeping through the night? ☐ Yes ☐ No

If yes, please specify:

Do you require rest periods during the day? ☐ Yes ☐ No

If yes, please specify:

When is your usual bedtime?

Smoking, Drugs, and Alcohol:

	Yes	No	Unknown
Responsible with matches/lighter	☐	☐	☐
Requires supervision while smoking	☐	☐	☐

Do you use drugs or alcohol? ■ Yes ☐ No

If yes, how often?

E. FINANCIAL STATUS

☐ What are your sources of income? (Please check all that apply)
☐ Indian Affairs
☐ Saskatchewan Assistance Plan/Saskatchewan Assured Income for Disability
☐ CPP Disability Payments
☐ Canadian Pension Plan (CPP)
☐ Old Age Security (OAS)
☐ Trust Fund
☐ Other :

Who is responsible for handling your finances?
☐ Self ☐ Financial Trustee ☐ Income Security Trustee ☐ Appointed Guardian ☐ Family

F. BEHAVIOURAL

Do you have a Comprehensive Behaviour Support Plan (CBSP)?

☐ Yes ☐ No

If yes, when was the plan last reviewed by a behavioural specialist?

If yes, please attach the Comprehensive Behaviour Support Plan to this assessment (where "☐ In CBSP" is indicated in the questions below, simply check it off if the question is answered in the Comprehensive Behaviour Support Plan).

Has there been Program Development Coordinator (PDC) involvement?
☐ Yes ☐ No

Please describe any approved restrictive procedures?
☐ In CBSP

Please describe any challenging behaviours that are ongoing:
(Please include frequency and intensity)
☐ N/A ☐ in CBSP

Please describe any dangerous/harmful behaviours that are ongoing:
(Please include frequency and intensity)

☐ N/A ☐ in CBSP

List past successes with behavioural interventions:
☐ N/A ☐ in CBSP

What are the known triggers that set the stage for the behaviour to occur?
☐ N/A ☐ in CBSP

Have you had any behavioural management supports?
☐ N/A ☐ in CBSP

How do you react to changes in your environment?
☐ N/A ☐ in CBSP

Do you have any ongoing support requirements regarding a mental health support needs?
☐ N/A ☐ in CBSP

Referral Source:
Who is part of the assessment team:

☐ Self ☐ Community Living Division Worker ☐ Family
☐ Corrections Worker ☐ Mental Health Worker ☐ Education Representative
☐ Indian and Northern Affairs Canada (INAC)

☐ Other:

Name of professional(s) completing assessment: Phone
Agency Designate

CLD Designate

Date assessment was completed:

My signature below indicated I have participated in this assessment.

Applicant's signature Guardians signature (if applicable)