ADAPTABILITIES

MEANINGFUL DISABILITY PROGRAMS

Inquiry Form

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MEANINGFUL DISABILITY PROGRAMS

ABOUT ME

Note: Our forms are in the first person.

Participant

Name: _____ _____ _____
First Name Middle Initial Last Name

Date of Birth: _____ Age: _____ Diagnosis: _____
(dd/mm/yyyy)

Funding Agency: _____ Caseworker: _____

Does the individual reside with the parent/guardian? ☐ Yes ☐ No

If no, complete address in full below:

Contact Name(s): _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Intake/Membership Fee

Please be advised that a $50 one-time Intake Fee is charged upon completion of an Intake.

How did you find out about our programming?

☐ School ☐ Advertisement ☐ Website ☐ Friend ☐ Other: _____

Guardians

Name(s): _____

Please check one of the following:

☐ Parent ☐ Permanent Guardian ☐ Temporary Guardian ☐ Social Worker
☐ Other: _____

Home Phone Number: _____ Cell Number: _____

Preferred Contact Number ☐ Home ☐ Work ☐ Cell

Address: _____ City: _____

Province: _____ Postal Code: _____

Email: _____

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Request for Care

Please identify the program you are interested in, including location/centre. For interest in In Home Supports, please provide the days and times per week support is needed.

What makes me GREAT?

What are my strengths, interests, talents, goals?

Interests

I enjoy: _____

I do NOT enjoy: _____

I would like to try: _____

Independence

Daily routine, decisions, choice and control, what do you want to do independently?

Communication

☐ Verbal ☐ Limited Language ☐ Non-Verbal

What is your means of communication? (i.e. iPad, pictures, stories)

☐ Device/Technology ☐ Pics ☐ ASL ☐ Signed Language

☐ Other: _____

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Level of Support

Challenging Behaviours ☐ Yes ☐ No

If yes, please explain:

Flight Risk ☐ Yes ☐ No

If yes, please explain:

Require a lifejacket while swimming? ☐ Yes ☐ No

School: _____ Program: _____ Level: _____

# of students in class: _____ # of Teachers: _____ # of Educational Assistants: _____

Does the person have 1:1 support while in school? ☐ Yes ☐ No

Adaptive Equipment

☐ N/A ☐ Manual Wheelchair ☐ Electric Wheelchair ☐ Walker ☐ Crutches

☐ Glasses ☐ Helmut ☐ Other (i.e. commode, bath chair, lift): _____

Personal/Self-Care

Are there personal/self-care tasks that you would seek support with?

☐ Toileting ☐ Diapers ☐ Menstrual Care ☐ Eating ☐ Drinking ☐ Dressing

Please explain: _____

Additional Comments

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Individual/Parent/Guardian Waiver

All information provided is complete to the best of my knowledge. I have not withheld any information that will affect the care of the individual.

_____	_____	_____
Individual/Parent/Guardian	Signature	Date
_____	_____	_____
Inquiry Employee	Signature	Date

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