OUR HAPPY PLACE

TOGETHER WE SHINE

DAY PROGRAM APPLICATION

APPLICANT INFORMATION		
Name:		
Date of birth:	Age:	Gender: M F
Height:	Weight:	
Current address:		
City:	Province:	Postal Code:
Phone #:	Alt Phone #:	Date of Graduation:

CAREGIVER INFORMATION	
Name:	Name:
Occupation:	Occupation:
Employer:	Employer:
Relationship:	Relationship:
Phone:	Phone:

EMERGENCY CONTACT		
Name:		
Address:		Phone:
City:	Province:	
Relationship:		

OUR HAPPY PLACE

Adult Day Program – 20489 Leslie Street Queensville

Mailing Address: 9981 Old Homestead Road, Pefferlaw, ON L0E 1N0

Tel: 289-926-6618

email: info@ourhappyplaceadp.ca *fb page: @ourhappyplaceadp website: www.ourhappyplaceadp.ca*

MEDICAL INFORMATION

List all pertinent medical conditions and diagnosis:

_____

_____

_____

_____

Please indicate all assistive devices the applicant uses regularly

[ ] Wheelchair [ ] Walker/Cane [ ] Braces/ Orthotics [ ] Communication Device

[ ] Hearing Aids [ ] Glasses [ ] Other: _____

Does the applicant have any allergies? [ ] YES [ ] NO

- If YES, please list: _____
  _____
- **If YES,** does the applicant carry an Epi-pen? [ ] YES [ ] NO

Does the applicant require medications at home? [ ] YES [ ] NO

- **If YES,** please list _____
  _____

Does the applicant require medications while attending the program? [ ] YES [ ] NO

- **If YES,** does the applicant self-administer the required medication? [ ] YES [ ] NO, please describe
  _____
  _____

List all medications to be administered at the program

Medication Name	Times to be administered	Dosage	Route of administration	Reason for taking

Family Physician Name: _____

Address: _____**Phone:** _____

OHIP CARD #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
(10 numbers plus 2 letters)

MEDICAL HISTORY

ALLERGIES	**[ ] NO [ ] YES, Please list intervention or modification**
EPILEPSY	**[ ] NO [ ] YES, Please list intervention or modification**
SEIZURES	**[ ] NO [ ] YES, Please list intervention or modification**
SLEEPING DIFFICULTIES	**[ ] NO [ ] YES, Please list intervention or modification**
DIETARY ISSUES	**[ ] NO [ ] YES, Please list intervention or modification**
HEARING ISSUES	**[ ] NO [ ] YES, Please list intervention or modification**
VISION ISSUES	**[ ] NO [ ] YES, Please list intervention or modification**
BLOOD PRESSURE	**[ ] NO [ ] YES, Please list intervention or modification**
HEART CONDITIONS	**[ ] NO [ ] YES, Please list intervention or modification**
ASTHMA	**[ ] NO [ ] YES, Please list intervention or modification**
DIABETES	**[ ] NO [ ] YES, Please list intervention or modification**
OTHER: _____	**[ ] NO [ ] YES, Please list intervention or modification**

ABOUT THE APPLICANT

Communication:

a) Preferred Language [ ] English [ ] French [ ] Other_____

b) Describe the applicant's communication method:

[ ] Verbal [ ] Sign Language
[ ] Picture symbols [ ] Gestures/ Pointing/ Sounds
[ ] Computer/tablet [ ] Other:_____

c) Clarity of communication:

[ ] Clear [ ] Unclear

d) How is the applicant's receptive communication (understanding words)?

[ ] Good [ ] Fair [ ] Poor

Social Interactions:

How does the applicant interact socially?

[ ] Prefers to work and play alone
[ ] Prefers one on one interaction
[ ] Enjoys group interactions
[ ] Likes to be center of attention
[ ] Does not like to be center of attention

Learning:

How does applicant learn best?

[ ] One on one with regular prompts
[ ] Independently, instructions at the beginning of a task
[ ] With some assistance
[ ] Ongoing Support
[ ] Other _____

ABOUT THE APPLICANT

Washroom Assistance:

Is the applicant continent of the bowel?

[ ] Yes, has no accidents
[ ] Sometimes has accidents
[ ] No, has frequent accidents

Is the applicant continent of the bladder?

[ ] Yes, has no accidents
[ ] Sometimes has accidents
[ ] No, has frequent accidents

What type of assistance does the applicant require?

[ ] Reminders to use the bathroom
[ ] Follows a schedule
[ ] Wears adult briefs
[ ] Other: _____

Dietary Needs:

What are the applicants - food likes?

What are the applicants - food dislikes?

Are there any dietary concerns, restrictions or accommodations we should be aware of?

ABOUT THE APPLICANT

TASK	INDEPENDENT	NEEDS ASSISTANCE	FULL SUPPORT	COMMENTS
Dressing/ Undressing Self				
Eating				
Washroom Routine				
Participating in activities				
Communicating basic needs/wants				
Requesting support/ assistance/ help				
Follows simple directions				
Menstrual Hygiene Routine				
Preparing Food				
Housekeeping				
Hygiene Routine				
Climbing/ Descending Stairs				
Understands Money Value				
Makes Purchases at Store				
Emergency Procedures				
Concept of Time				
Telephone Skills				
Walking				
Social skills in the community				
Safety skills in the community				

ABOUT THE APPLICANT

Please describe the applicant's level of comfort with the following:

	Uncomfortable/ Anxious	Comfortable	Very Comfortable	Not sure
Swimming				
Animals				
Walking in community				
Change in Routines				
Street Crossing				
Public Transit				
Car Rides				
New Environments				
New People				
Large groups				
Noisy Environments				

Does the applicant prefer: [ ] Small Groups [ ] Large Groups [ ] Neither

Has the applicant worked or volunteered in the community? [ ] YES [ ] NO

- **If yes**, please describe: _____

What recreational or community involvement has the applicant participated in?

_____

What are the applicants likes?

_____

What are the applicant's dislikes?

_____

How does the applicant spend their leisure time?

_____

What is the applicant's favorite activities?

_____

What is the applicant's least favorite activities?

_____

Does the applicant require and cultural and/or religious considerations? If so please describe

_____

ABOUT THE APPLICANT

Are there any behavioral issues we should be aware of? [ ] YES [ ] NO

- **If YES,** please explain
  _____
  _____
  _____
  _____

Are there any behavioral plans in place for the applicant? [ ] YES [ ] NO

- If YES, please explain _____
  _____
  _____

If the applicant is agitated, anxious, frustrated, ect indicate the behaviors that may occur:

[ ] Yelling [ ] Hitting [ ] Throwing Objects [ ] Run Away / Hide [ ] Break Objects

[ ] Kicking [ ] Swearing [ ] Self Injurious _____

[ ] Biting [ ] Other, please specify _____

What tends to trigger these behaviors?

[ ] Change [ ] Noise [ ] Weather [ ] Fear/ Anxiety

[ ] Excitement [ ] Unknown places [ ] Large Groups [ ] Other, please specify _____

How frequently do these behaviors occur?

[ ] Rarely [ ] Occasionally [ ] Weekly [ ] Daily [ ] Other _____

How do you currently manage these behaviors?

Check off any safety concerns that apply to the applicant:

[ ] Attempts to harm self [ ] Attempts to harm others [ ] Choking Risk

[ ] Wanders off [ ] Runs away [ ] Puts unsafe objects in mouth

[ ] Other: _____

What supports or services does the applicant receive?

[ ] Occupational Therapist [ ] Speech and Language Pathologist [ ] Behavioral Services

[ ] Other _____

Please list any agencies providing service or support:

ABOUT THE APPLICANT

Who does the applicant reside with? [ ] Parents/Guardians [ ] Assisted living residence [ ] Independently [ ] Other:

_____

Does the applicant speak and/ or understand English? [ ] YES [ ] NO, other language_____

How will the applicant travel to and from the program?

[ ] Pick up/ Drop off [ ] Transit [ ] Other:_____

Who is authorized to pick up?

_____

Who is <u>not</u> authorized to pick up?

_____

Who is the important people in the applicant's life? (Family, friends, community members)

_____

_____

Please describe your needs for service and support at the program?

_____

_____

What are the applicant's goals for attending the program?

_____

_____

What are the applicant's strengths and abilities?

_____

What are the applicant's limitations?

_____

Are there any other considerations we should be aware of to ensure a positive, safe and comfortable experience?

_____

_____

What concerns, if any, do you have with the applicant's participation in the program?

_____

_____

What can we at Our Happy Place do to alleviate those concerns?

_____

_____

HISTORY OF SUPPORT SERVICES

Please check any services used currently or previously

MCSS FUNDING	SCHOOL HISTORY
[ ] ODSP	CURRENT/ LAST SCHOOL: _____
[ ] PASSPORT	GRADUATION YEAR: _____
[ ] SSAH	PROGRAM: _____
[ ] ACSD	
MOH SERVICES	**OTHER:**
[ ] CCAC/LHIN	
[ ] MARCH OF DIMES	
[ ] LTC	

Please list any agencies/ programs CURRENTLY involved in

AGENCY/ PROGRAM	LENGTH OF TIME

Why is the applicant looking to combine multiple programs?

_____

_____

_____

Please list any agencies/ programs PREVIOUSLY involved in

AGENCY/ PROGRAM	LENGTH OF TIME

Why did the applicant discontinue service with the above organizations?

_____

_____

_____

OUR HAPPY PLACE

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SIGNATURES

By signing below, I am confirming that the information provided to OUR HAPPY PLACE is accurate and complete. I am permitting the applicant to fully participate in all program activities.

[ ] In the event of an emergency accident or illness involving the applicant, I give permission to OUR HAPPY PLACE to authorize on my behalf procedures including admission to the hospital and necessary treatment. Such action would only be taken if immediate contact cannot be made with guardians or emergency contact person.

[ ] I give permission for OUR HAPPY PLACE Day Program to use any photographs taken while at the center for promotional purposes

Signature of applicant:	Date:
Signature of Guardian:	Date:

Join us at Our Happy Place

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