Participant Application Form

DATE OF APPLICATION (day/month/year)**: August, 2016**

STEP #1: Participant Information Form (PIF): Complete the section titled, "Part B – Participant Information" only, and sign as appropriate. Participants ages 15 and older should sign the form, unless a parent/guardian has legal authority to sign on their behalf. If a parent/guardian is signing on behalf of the participant, they should note their relationship to that individual per this example, "Bill Smith (guardian) for John Smith (participant)".

STEP #2: Participant Application Form: Provide the information requested below, and submit this form together with the signed PIF completed in Step #1, to Program Staff for review and to confirm program eligibility.

WORKTOPIA PROGRAM: ☐ Community*Works* Canada® ☐ Employment*Works* Canada ☐ School*Works* Canada

Participant Application Form: (This form is completed with fictitious names and information)

PARTICIPANT INFORMATION	
Participant First Name: Suzie	Participant Last Name: Cue
Name of the person completing the forms (if different from participant):	
Relationship to participant: ☐ Parent ☐ Friend ☐ Care Provider ☐ Other	
How did you heard about this Worktopia Program? ☐ Social media ☐ Advertisement (flyers, posters) ☐ Current program/organization ☐ Family/friends ☐ Other (describe): _____	
PARENT / GUARDIAN INFORMATION	
First Name: Sally & John	Last Name: Cue
(☐ Check here if contact information is the same as Participant's entered on the attached PIF Form, and if so, provide only the cell phone and e-mail information requested below.)	
Address:	
Postal Code:	Home Phone:
Cell Phone:	Email:

EMERGENCY CONTACT INFORMATION (list at least two who do not live at the participant's address)	
Contact name:	Address:
Relationship:	Phone Number:
Contact name:	Address:
Relationship:	Phone Number:
Contact name:	Address:
Relationship:	Phone Number:

FAMILY DOCTOR	
First Name: Dr.	Last Name: Jones
Address:	
Postal Code:	Telephone:
Does participant have regular contact with his/her family doctor? ☒ Yes ☐ No	
When did the participant last see his/her family doctor? ☐ Within last 3 months ☐ In the last 3 – 6 months ☒ In the last 6 months to a year ☐ More than a year ago, but less than 3 years ago ☐ More than 3 years ago	
Doctor to be called in case of accident or illness (if different from family doctor):	
First Name:	Last Name:
Address:	
Postal code:	Phone Number:

MEDICAL INFORMATION	
Does the participant have allergies? ☐ Yes ☒ No If yes please describe:	
Does the participant require an EpiPen? ☐ Yes ☒ No If so, does the participant carry an EpiPen at all times? ☐ Yes ☐ No	
Does the participant have a heart/lung condition that restricts activity? ☐ Yes ☒ No If so, please describe:	
Does the participant take any medication? ☒ Yes ☐ No	Does the participant take their medication independently? ☒ Yes ☐ No
Please list medications: Wellbutrin	

Please specify participant's specific ASD diagnosis:
☒ Autism Spectrum Disorder (ASD) ☐ Atypical Autism ☐ Pervasive Developmental Disorder (PDD)
☐ Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS),
☐ Asperger's Syndrome ☐ Other

How old was participant when diagnosis was provided (select one)?
☐ <3 years ☐ 3-5 years ☒ 6-12 years ☐ 13-18 years ☐ ≥19 years ☐ Not sure

Is the participant aware of the diagnosis?
☒ Yes ☐ No

Please check any of the following that apply to participant:
☒ Depression ☒ Low self-esteem ☒ Difficulty concentrating ☐ Alcohol/Substance abuse/Dependence
☒ Anger management ☐ Self-injury ☐ Eating problems/Disorder ☐ Panic attacks ☒ Mood swings
☐ Anxiety/Worry/Nervousness ☐ Uncomfortable in social situation ☐ Too much/too little sleep
☐ Excessive fatigue ☐ Hyperactive/Excessive energy ☐ Housing problems ☒ Financial problems
☐ Transportation problems ☐ Poor hygiene ☐ Isolated from family/friends ☒ Other (specify): Learning Disabilities

LIVING ARRANGEMENTS

Relationship Status: ☒ Single ☐ Married/Common-law ☐ Separated ☐ Divorced ☐ Widowed

Who does the participant live with? Check all that apply: ☐ Spouse ☒ Mother ☒ Father ☐ Alone
☐ Roommate ☐ Supportive Roommate ☐ Group Home ☒ Other (specify): older brother

Primary Language(s) spoken in the participant's home: ☒ English ☐ French ☐ Other (specify):

Primary Language(s) understood in the participant's home: ☒ English ☐ French ☐Other (specify):

Secondary Languages ☐ English ☐ French ☐ Other (specify): _____

LEGAL INFORMATION

Is the participant their own legal guardian? ☒ Yes ☐ No

Are there any legal issues regarding the participant that we should be aware of?

EMPLOYMENT INFORMATION

Is participant currently enrolled in any other employment programs? ☐ Yes ☒ No

Within the last year was the participant enrolled in any employment programs? ☐ Yes ☒ No

If yes, please describe past programs:

Is participant currently employed? ☐ Yes ☒ No

If yes, is participant employed:
☐ Full-time (More than 20 hours/week)

☐ Part-time (Less than 20 hours/week)

Has the participant been employed in the last year? ☒ Yes I was recently laid off. ☐

Is participant interested in being competitively employed? ☒ Yes ☐ No

Is participant currently volunteering? ☐ Yes ☒ No

If yes, how many hours does the participant volunteer?
☐ Under 10 hours per week
☐ 10 or more hours per week

Is participant currently enrolled in any school and/or a training program other than Worktopia? ☐ Yes ☒ No

If yes, what is participant currently doing? ☐ High school ☐ College/University
☐ Job readiness or job search programs (e.g. resume writing, job interviews)
☐ Work experience programs (e.g. community service, job internship, volunteer work)

The participant's school or training program is:
☐ Under 10 hours per week ☐ 10 or more hours per week

OTHER SERVICES INFORMATION

Does the participant have recent reports from any of these service providers (check all that apply)?
☐ Counselor ☐ Occupational Therapist ☐ Psychologist ☐ Social Worker ☐ Habilitation Provider
☐ Physical Therapist ☒ Psychiatrist ☐ Speech Language Pathologist ☐ Other: _____

Would this information assist us in supporting the participant in the program? ☒ Yes ☐ No

If so, please feel comfortable sharing this information with us.

Admitted to the hospital 3 years ago with severe depression, suicidal thoughts and a suicide attempt. Currently being treated with antidepressant medication and followed by an outpatient psychiatrist.

TRANSPORTATION INFORMATION

Participants are responsible for arranging transportation to and from programming.

Is the individual independent in transportation? ☒ Yes ☐ No

If YES, AUTHORIZATION NOT REQUIRED.

If NO, please complete the Authorization for Participant Pick Up section below.

PEOPLE AUTHORIZED TO PICK UP PARTICIPANT FROM PROGRAMS (at least two):

Written arrangements must be made in advance with the Program Supervisor/Coordinator, if on a particular day, you wish someone other than those indicated below to pick up this participant.

First name:	Last Name:
Address:	
Relationship:	Phone Number:
First name:	Last Name:
Address:	

Participant Name: ______________________

Relationship:	Phone Number:
First name:	Last Name:
Address:	
Relationship:	Phone Number:
OTHERS NOT AUTHORIZED TO PICK UP THIS PARTICIPANT	
Name:	
Name:	
Name:	

PLEASE SUBMIT THIS FORM IN PERSON

NOTE: E-mail travels on the open Internet, and any information sent or received over the Internet is generally not secure. The [**insert Regional Site name**] cannot guarantee the security or confidentiality of any e-mail communication and takes no responsibility for misdirected or intercepted e-mails.

Please fill out the form below and submit along with the application:

✂- -

EMERGENCY INFORMATION CARD			
Name: ____________________		Date of Birth: __________	
Phone: ____________________		Cell Phone: __________	
Parent / Guardian: ____________________			
Phone: ____________________		Cell Phone: __________	
Emergency Contact: ____________________		Relationship: __________	
Phone: ____________________		Cell phone: __________	
NOT Authorized for Pickup:			