centre FOR autism services ALBERTA

Participant Intake: Application Form

EMPLOYMENT WORKS

DATE OF APPLICATION: _____

PERSON COMPLETING APPLICATION:

☐ Participant ☐ Parent/Guardian ☐ Care Provider ☐ Other_____

PARTICIPANT INFORMATION		
Participant First Name: Chosen Name (if different):	Participant Last Name:	
Date of Birth (yyyy-mm-dd):		Current Age:
Permanent Address:		
City:	Province:	Postal Code:
Telephone Number:	E-mail:	
Preferred Method of Contact: Phone ☐ E-mail ☐		
Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Gender Neutral ☐ Other _____		
Preferred pronouns: ☐ He/him/his ☐ She/her/hers ☐ They/them/theirs ☐ Other _____		
Member of Visible Minority: ☐ Yes ☐ No ☐ Decline to answer	New Immigrant: ☐ Yes ☐ No ☐ Decline to answer	
Indigenous Group: ☐ Yes ☐ No If yes, please specify: ☐ Registered On-Reserve ☐ Registered Off-Reserve ☐ Non Status ☐ Inuit ☐ Metis ☐ Decline to answer		

GUARDIANSHIP STATUS
☐ Under 18 and under guardianship ☐ Over 18, under guardianship ☐ Over 18, own legal guardian
Are there any legal issues regarding the participant that we should be aware of?

GUARDIAN INFORMATION	
First Name:	Last Name:
Address:	
City:	Province:
Postal Code:	Home Phone:
Cell Phone:	Email:

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

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Does the participant take any medication? ☐ Yes ☐ No	Does the participant take their medication independently? ☐ Yes ☐ No

OTHER PARTICIPANT INFORMATION

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

Current Living Arrangement: ☐With parents ☐Independent ☐Supportive Roommate ☐ Group Home

☐Other (specify): _____

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): _____

Is the individual independent in transportation? ☐ Yes ☐ No

Primary Mode of Transportation:

☐Parents/Guardian/Family ☐ Public Transportation ☐ Drive Independently ☐ Walk/Bike

☐ Specialized Transit (e.g. Handi-Bus)

Related to their diagnosis/disability, does the participant currently receive:

☐ Disability benefits
☐Health related benefits
☐ Other income benefits or supports: _____
☐None

Does this impact the participant's employment goals? ☐ Yes ☐ No

☐ If yes, please state how: _____

How did the participant hear about EmploymentWorks? ☐EW Website ☐Social media

☐ Advertisement (flyers, posters) ☐ Radio ☐ Current program/organization

☐ Word of Mouth ☐ Other (describe): _____

If referred to EmploymentWorks by a previous participant, please provide their full name:

_____

EMERGENCY CONTACT INFORMATION

1. Contact name:	Address:
Relationship:	Phone Number:
2. Contact name:	Address:
Relationship:	Phone Number:

PLEASE EMAIL THE COMPLETED APPLICATION FORM TO: EMPLOYMENTWORKS@CENTREFORAUTISM.AB.CA