

Supported Lifestyles Ltd.    Responsive Childrens Supports Ltd.  
 Positive Developments Ltd.

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# Intake Information Package

## Printable Version

Updated June 20, 2016

Sept. 7. 2016

June 28, 2021

Updates to this package must be approved by Policy and Procedure Committee

Included : Organization Checklist; Information Letter; Demographic Data; Service Preference; Intake Questionnaire ; Initial Review of Client Services Guide; Pharmacy Forms; PDD Labour Market Transfer Agreements (LMTA) Checklist (Employment Information Form)

# INTAKE INFORMATION PACKAGE

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# INTAKE INFORMATION PACKAGE

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## Organizational Checklist

- Intake Information Package sent – include link to relevant Agency Website or a copy of the Agency brochure (available at reception) and/or Guardian package
- Share website information
- Share rent and other expenses/costs (groceries, personal spending, transportation, damage deposit, maintenance etc.)
- Support Approach Team notified of referral and consulted about meeting times. Ensure SAT Clinical Director or Program Director are included in intake meetings for Residential Services, Progressive Residential Supports, Community Supports and Complex Needs Residential/Community Supports. SAT will initiate the initial Risk Assessment process.
- Time and location for Intake Meeting booked
- Coordinate with other Service Area(s) if applicable
- Documents to request that Guardian bring to meeting
  - Guardianship and/or Trustees order(s)
  - Completed Intake Information Package
  - Any past or existing assessments, Reports, and/or Support plans
  - Copies of Doctor's orders, treatment plans (if applicable)
  - Photo of client for medication binder (if applicable)
  - AISH information, copy of benefits card
- Request Release Forms, Assessments and relevant information from relevant funder/referral source
- Documents to take to Intake Meeting (date scheduled \_\_\_\_\_)
  - Intake Information Package
  - Extra Intake Information Package
  - CareRX Pharmacy Forms
    - Pharmacy Authorization Form
    - Billing Information Form

## INTAKE INFORMATION PACKAGE

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- Pre-authorized Payment Form
  - -Authorization Package
  - Service Area Financial Package (if applicable)
  - Client Services Guide
  - PDD requires LMTA Checklist (Employment Information Form) required for all clients who have been or plan to be employed – available in Forms drawer.
  - Information about potential requirements (furniture, household items, maintenance etc.)
  - Completed intake package and additional information to be used to establish initial “intake” profile. Final profile to be completed and authorized within six months of service commencement (Policy 1280)

This checklist is for Service Area use only. **Please detach from Intake Information Package.**

## INTAKE INFORMATION PACKAGE

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Supported Lifestyles Ltd.    Responsive Children's Supports Ltd.  
 Positive Developments Ltd.

210, 495-36 Street NE Calgary, Alberta T2A 6K3

Dear\_(\_\_\_\_\_),

Please complete this package. Your participation will assist us in facilitating a more efficient and responsive intake process. Any attachments (as requested below) may be faxed or sent to us prior to your intake meeting or provided at that time.

Please feel free to contact (\_\_\_\_\_) at 403-207-5115 (ext.\_\_\_\_) if you have any questions regarding this package.

Thank you for your participation!

Sincerely,

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Please attach the following:

- a) Completed Intake Information Package – Demographic Data and Intake Questionnaire
  - b) Completed Pharmacy forms
  - c) Any additional assessment information (psychological, psychiatric, functional, diagnostic etc.)
  - d) Guardianship and/or Trusteeship orders (if applicable)
  - e) Copies of current support plans
  - f) Medical information (including current medications being administered)
  - g) Photo of individual for Medication Binder (if applicable)
  - h) History of police involvement (if applicable)
  - i) AISH information ( Medical Benefits Card)
  - j) PDD LMTA Checklist (Employment Information Form)
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# INTAKE INFORMATION PACKAGE

## Demographic Data

**Please complete all relevant sections**

INDIVIDUAL'S PERSONAL INFORMATION				
Name and Address		<b>D.O.B:</b>	<b>Funder Type:</b>	Identification Number:
Phone Number	(H) (C)			
DESCRIPTION OF INDIVIDUAL				
Physical Description	Height:	Weight:	Hair Colour:	Eye Colour:
Distinguishing Features				

LEGAL SERVICES		
<b>Guardianship Status</b>	Name:  Address	(H): (C): (F) : Email address:
<b>Trustee Status</b>	Name:  Address:	(H): (C): (F) : Email address:
<b>Emergency Contact</b>	Name:  Address:	(H): (C): (F) : Email address:

GOVERNMENT WORKERS			
<b>PDD/FSCD/CFS</b>	Name	Phone Number	Email Address
<b>AISH</b>	Name	Phone Number	Email Address
<b>Other</b>	Name	Phone Number	Email Address
<b>Other</b>	Name	Phone Number	Email Address

MEANS OF TRANSPORTATION choose all that are applicable
Calgary Transit <input type="checkbox"/> Access Calgary <input type="checkbox"/> Staff Vehicle <input type="checkbox"/> Independent <input type="checkbox"/> School Bus <input type="checkbox"/> Other <input type="checkbox"/>
Instructions for Travel: E.g., where individual sits in car, locks that need to be engaged, access information/passwords, etc.,

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<b>INTERNAL AGENCY CONTACTS – if applicable (service area transfer)</b>		
Home Supervisor	<b>FT:</b>	<b>PT:</b>
Service Area Supervisor	Name: (O) Office phone number: (C) Work cell phone number: Email address:	
Community Supports Supervisor	Name: (O) Office phone number: (C) Work cell phone number: Email address:	
Support Approach Consultant	Name: (O) Office phone number: (C) Work cell phone number: Email address:	
Psychologist	Name: (O) Office phone number: (C) Work cell phone number: Email address:	

<b>MEDICAL</b>	<b>Alberta Health Care Number:</b>
Family Physician	Name: Address:  Phone Number:  Fax:
Closest Medical Center	Name: Address:  Phone Number:  Fax:
Psychiatrist	Name: Address:  Phone Number:  Fax:
Pharmacy	Name: Address:  Phone Number:  Fax:
Dentist	Name: Address:  Phone Number:  Fax:

<b>OTHER AGENCY SUPPORTS</b>	<input type="checkbox"/> Not Applicable <input type="checkbox"/> Residential <input type="checkbox"/> Day Services <input type="checkbox"/> School
Name of Agency	<b>Contact Name:</b>
Address:	<b>Phone:</b>
	Fax:
	<b>Email:</b>

<b>Medic Alert Bracelet</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Advance Care Planning/Goals of Care</b>	<input type="checkbox"/> Yes
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<b>( Personal Directives) in place See Health Care Consent for additional information on Advance Care Planning</b>	<input type="checkbox"/> No
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## Intake Questionnaire

Please refer to the Agency brochure or website (<http://www.supportedlifestyles.com/> , <https://www.responsivechildrenssupports.com/> , [www.positivedevelopments.ca](http://www.positivedevelopments.ca)) for a brief overview of Service areas.

### SERVICE

Check all applicable types of service the Individual is seeking:

#### Residential Services

- 24 hour Staffed model
- Supportive Roommate
- Respite
- Other \_\_\_\_\_
  
- Community Supports, Paid employment
- Volunteer Work
- Recreation/Leisure Activities
- Recreation classes
- Education/classes

#### Complex Needs

- 24 hour support model home
- Complex Needs Community Supports

#### Psychology

- Consultation
- Counseling

#### Support Approach Team:

- Consultation

Preferred worker characteristics:

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Current involvement or referrals to other agency services or external services:

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# INTAKE INFORMATION PACKAGE

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## INTRODUCTION TO THE INDIVIDUAL

**Description of individual.** Please provide a brief description of the individual focusing on personality traits (e.g., quiet, outgoing, sense of humor, etc.):

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## MEDICAL INFORMATION

Diagnosis (please include source/date of diagnosis):

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Describe general health:

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Any medical conditions, past hospitalizations:

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Date of last full physical exam? (i.e., annual exam)

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Date of last dental check up?

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Date of last eye exam?

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Dietary considerations and or restrictions; likes and dislikes:

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# INTAKE INFORMATION PACKAGE

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Dietary supports needed (feeding tubes, specialized utensils, etc.):

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Describe eating habits:

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Allergies and allergy management:

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**Medication – NOTE:** Current doctor’s prescription(s) is required for all prescription and over-the counter medication prior to service start date. For more information about the Agency’s Medication Administration process please ask during the intake meeting

Medication	Prescribed for	Dosage	Time	Possible side effects

Pharmacy:

Our agency has partnered with Care RX Pharmacy to assist us with enhancing our client care by providing safe, consistent and efficient ways for us to acquire and administer medications to our clients.

Using Care Rx is optional.

We partner with Care RX based on many factors including high reviews from other agencies who currently use them, their central point of contact for communication, 24/7 after hours support telephone answered by a pharmacist, their standardized packaging system of medications, as well as the detailed documentation including pharmacy policies, procedure manuals, and standardized MARs (medication administration records) as well as medication administration training for our staff. Care RX also has the technology for our agency to advance in the future.

# INTAKE INFORMATION PACKAGE

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Care RX also has a great billing process and is cost saving: medications are processed through any eligible direct bill plan (including medical benefits through AISH), the least cost generic medication is always used (unless otherwise noted on a doctor's prescription). All clients have an everyday discount of 15% on all over the counter medications, the pharmacy communicates directly with the client's doctors to identify the most appropriate therapy, can assist in special authority process, and provides free delivery and free packaging of medications with no extra or hidden fees. You are welcome to visit their website here: <https://carerx.ca/>

There are three forms that must be completed, signed and returned. They are attached to this package. If you are unsure of how to complete the form please call your agency contact. We are willing to help you in any way we can

1. Pharmacy Authorization Form. This is specific to the individual and it authorizes CareRX to contact your current pharmacy and family doctor to transfer to our new pharmacy.
2. Billing Information Form.
  - Section A: This is where you will fill in the information that can be found on the AISH benefits card, or any other kind of drug coverage plan you may have. This covers almost all prescribed medication.
  - Section B: For any medication (including over the counter drugs like Tylenol, vitamins, etc.) NOT covered by the drug plan, please fill in how you would like to be contacted and billed.
  - Section C: This information is typically sent to the same person that tax statements go to.
3. Pre-Authorized Payment (PAP) Agreement. This form makes it easier to pay for any medication that is not covered by the drug plan (like vitamins or cough syrup or Tylenol). You will have indicated on the billing information form how you would like to be contacted and billed, so there will be no surprises. If the office of the public trustee or an insurance company (like WCB) is the one who pays for this they will continue to be invoiced and will send the pharmacy a cheque. Please indicate that on this form.

Please complete and return these forms to us.

Medication - note assistance required with medication administration:

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Any concerns with drug interactions:

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Advance Care Planning, have any plans (Goals of Care/Personal Directives) been made:

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Please ask us about advance care planning or see our website <http://www.supportedlifestyles.com/client/advance-care-planning.html> for more information

Mobility Issues: (stairs, bathroom, winter conditions etc.) Any Assistive Technology required (e.g., wheelchair, walker, walking belts, lifts, canes, walking sticks, ramps etc.):

# INTAKE INFORMATION PACKAGE

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## COMMUNICATION

Describe general communication (e.g., non-verbal; verbal – single words, sentences; signing, ASL Level; gestures):

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Describe communication skills (e.g., repetitive topics, difficult to understand, reading, writing, and problem-solving):

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Any Assistive Technology used for communication? (e.g., picture symbols, apps, software, etc.):

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Describe receptive communication (i.e., how much is understood):

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What is the best approach to obtain understanding (e.g., simple words, visual clues, eye contact, pictures, gestures, etc.):

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## INTERPERSONAL AND EMOTIONAL SUPPORT

### Relationships and Sexuality

Describe general social skills and areas of strengths:

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Family relationships (include type and frequency of contact):  
Include full names and contact info

# INTAKE INFORMATION PACKAGE

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Friends /Intimate Partners; include type and frequency of contacts  
Include full names and contact info

## Religious and cultural considerations

Please include any relevant or important information regarding Religious / Cultural background; considerations for support (e.g., religion, ethnic, social, deaf culture etc.):

Friends (include type and frequency of contact, include intimacy if applicable):

Supports needed to help individuals develop and maintain relationships:

Outline guardian or independent adult's wishes with regard to agency personnel responding to questions about relationships and sexuality (including consent to address questions when asked):

## Trauma Informed Care and Relevant History

List RELEVANT trauma (such as exposure to abuse, neglect, discrimination, violence, and other adverse experiences) and/or personal history related information:

## INTAKE INFORMATION PACKAGE

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Previous involvement with a Counsellor, Psychologist or Psychiatrist? If so, when and for what reason(s)?  
Individual or group counselling?

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**Addictions/Substance Use/Harmful lifestyle choices**

(i.e., the individual chooses a lifestyle they do not yet want to change (e.g., drug use, sex work, picking up cigarette butts and smoking them, the individual is meeting strangers to sell something, etc.)):

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At intake meeting review service area/locations expectations regarding intoxication, and what will happen is substances are brought into the site

**Please fill out this chart with as much detail as possible:**

Specific Behavior: Elaborate Below	Frequency	Intensity/Duration	Triggers	Effective past support approaches
Physical aggression (e.g., hit, kick, bite, etc.)				
Use of weapons/sharps* (e.g., guns, knives, box cutters, broken glass, blunt objects etc.)				
Verbal aggression (e.g., swearing, threats etc.)				

## INTAKE INFORMATION PACKAGE

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Threats or instances of self-harm/suicide attempts				
Theft				
Property destruction				
Hoarding/Excessive Collection of Items				
Sexuality Issues				
Issues with fire/explosives*				
Eloping/AWOL/ Bolting				
Police/ legal involvement  Any warrants or charges pending?				

## INTAKE INFORMATION PACKAGE

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Depression				
Anxiety				
Compulsive behaviours				
Low motivation				

**\*If weapons and/or fire starting /explosives are of concern this will be reviewed at the intake meeting and will include discussion of the service area/locations expectations regarding what will happen if weapons/ fire-starting materials etc. are brought into the site and will be reviewed with Service Area Director /Executive Director**

Past staff requiring WCB involvement       yes    no    unsure  
 Specify, if yes:

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### SAFETY AND EMERGENCY INFORMATION

Individual's general safety awareness:

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Safety in vehicles: (more information can be included in Transportation section below):

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## INTAKE INFORMATION PACKAGE

Are any lifts or transfers required? Any other Assistive Technology/Environmental Intervention(s) required for safety?:

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Any considerations regarding workers attire (hats, footwear, jewelry, other Personal Protective Equipment)?:

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Are any Environmental Precautions &/or Restrictives required: (locking up of sharps, cleaning supplies, food, etc.)?:

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<b>Please complete the chart indicating the level of supervision required in each Area:</b> (e.g., continuous, intermittent, line of sight, arm's reach, physically supporting, or none), frequency of check-in (e.g., every 10 minutes) type of check-in (verbal/ auditory, visual or more than one). <b>Supervision Requirements in the Home</b> <b>Independent time is not approved unless otherwise stated below</b>		
<b>Bathroom:</b>	<b>Bedroom – Awake:</b>  <b>Bedroom – Asleep:</b>	<b>Kitchen:</b>
<b>Shared Living Spaces:</b>	<b>Housemate's Bedroom:</b>	<b>Laundry/Utility Room:</b>
<b>Basement:</b>	<b>Staff Office:</b>	<b>Calming Room:</b>
<b>Garage:</b>	<b>Front Yard:</b>	<b>Backyard:</b>
<b>Supervision Requirements in the Presence of Others</b> <b>Independent time is not approved unless otherwise stated below</b>		
<b>Housemates:</b>	<b>Family/Friends:</b>	<b>Intimate Partners:</b>

## INTAKE INFORMATION PACKAGE

<b>Visitors:</b>	<b>Contractors:</b>	<b>Children/Minors:</b>
<b>Supervision Requirements around Food and Mealtimes</b>		
<b>Eating with Others:</b> e.g., stealing food from others, etc.	<b>Choking Risk &amp; Pace of Eating:</b> e.g., supervision to reduce choking; describing “bite-sized” by approximate dimensions (e.g., the size of a quarter). Specify if solid (hard) foods are presented differently than soft foods.	<b>Portion Sizes:</b> Describe whether the individual dishes out their own food or requires assistance. Include dietitian/professional restrictions.
<b>Use of Cutlery:</b> e.g., plastic only, ability to use fork and knife, etc.	<b>Food Hoarding:</b>	<b>Other:</b> e.g., tube feeding
<b>Supervision Requirements in the Community</b> <b>Independent time is not approved unless otherwise stated below</b>		
<b>Safety Awareness &amp; Mobility:</b> e.g., traffic safety, unsteady gait, tends to fall when icy, link arms, etc.	<b>Location Specific Concerns:</b> e.g., may include restricted places or things to be mindful of that may be a risk to the client or may cause a behavior, Transfers to and from vehicles supervision requirements, etc.	<b>Animal Concerns:</b> e.g., fear of animals, restrictions regarding animals, good with animals, etc.
<b>Approved Independent Outing Details:</b> e.g., check in details, frequency of outings, duration of outings, approved destinations, etc.		
<b>Supervision Requirements for Technology in the Home and Community</b>		
<b>TV Use:</b> can they operate the TV independently, are there restricted shows, are “parental controls” authorized, etc.	<b>Phone Use:</b> e.g., any limitations, can they have private conversations or do they need to be on speaker phone to monitor them, how often can they use the phone, is there a list of people they are allowed to call or a list of restrictions, etc.	<b>Computer Use:</b> e.g., can they use a computer independently or do they require assistance, any restrictions on its use, can they use the computers at the library or other public places, etc.
<b>Internet Use:</b> e.g., can they use the internet at home, can they have the password, can they use the internet at the library or other public places, do staff have to maintain visual of the computer screen, restricted websites, etc.	<b>Video Game Use:</b> e.g., what games, how long, can they use the chat feature when playing with others online, do staff have to have a visual on the screen, etc.	<b>Social Media Use:</b> e.g., what social media sites, do staff have to have a visual on the screen, any restrictions, etc.

# INTAKE INFORMATION PACKAGE

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## PREFERRED DAILY ROUTINES & ACTIVITIES

Preferred daily routines & recommended supports:

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Describe likes/dislikes/motivation:

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Ability to cope with transitions or changes to routine:

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Fun activities - (where possible please include name of activity, time frames, contact person and number, address of activity (directions, bus info, etc.):

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Describe support needed for activities:

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Fears:

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# INTAKE INFORMATION PACKAGE

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## **Community Supports**

Describe previous and/ or current employment or volunteer experience(include contacts, addresses and schedule; provide and complete PDD LMFTA information form)

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## **Bathing/Showering Procedure and Personal Care needs**

Describe personal care and any routines and supports needed:

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Describe how best to ask permission and involve individual:\_\_\_\_\_

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When is bathing typically completed and how long does it take?:

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Are there any challenges in participation? What approaches are used to encourage the individual to complete a bathing routine?:

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Does the individual assist in preparing for bathing (helping to gather items, choosing change of clothes etc.)?:

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Will encouraging/teaching independence for the individual in his/her bathing routine (teaching what items are necessary to complete a bathing routine, how to wash properly etc. be a goal?:

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Please comment on preference for water temperature:

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# INTAKE INFORMATION PACKAGE

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Does the individual enjoy their bathing routine?:

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Are there any concerns (seizures, behaviours etc.) of which staff need to be aware while completing bathing?:

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Does the individual require the use of any Environmental Interventions or Assistive Technology to assist in the completion of the bathing routine (lifts, bath chairs etc.)?:

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Is there a treatment plan associated with the bathing routine?:

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Will the individual have approval for any independent time within this routine?:

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Guardian and physician approval is required to have a bath/shower that is warmer than 40°C. Provide documentation:

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How will the individual communicate that the water temperature is too hot/cold (note nonverbal cues for clients with communication challenges)? Does the individual require support to set the water temperature?:

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# INTAKE INFORMATION PACKAGE

## FINANCIAL

Review general budget (rent, utilities, grocery, recreation, clothing, transportation, household expenses, maintenance, etc.):

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General supports required to handle cash, budget, banking, etc.,:

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Public Trustee or informal trustee:

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## TRANSPORTATION

City Transit (attendant card?)  Access Calgary  Staff Vehicle

If vehicle safety is an issue please outline any previous safety plans that have been used:

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As specified in Policy 3383 Preventative Measures to Ensure Safe Driving; If an individual in service begins to exhibit signs of agitation, anxiety or demonstrates any behaviour of concern in a staff vehicle, the staff will immediately pull over to the side of the road when safe to do so. Do not attempt to drive to your planned destination. The employee will call their supervisor, or follow on-call procedures to obtain assistance. If needed ask for assistance from people in the community (e.g., use a cellular phone). If a behavioural situation occurs in a staff vehicle, the staff will write an incident report that day, and forward to their supervisor. Use of staff vehicle will be suspending until a safety plan is in place.

## HOME LIVING SKILLS

### Home Living Skills

Task	Independent	Needs some assistance	Needs full support	Does not wish to participate
Room care				
Dishes				
Vacuuming				
Laundry				
Meal preparation				
Shopping				

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Yard maintenance			
Other:			

**Additional Information (e.g.Schools attended):**

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**Previous Service Providers**

Name of Agency	Service Provided	Time frame	Reason for leaving

Other:

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# INTAKE INFORMATION PACKAGE

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## Initial Review of Client Service Guide Orientation Package

All clients entering into new services will receive an introduction to services and have their rights and responsibilities reviewed within seven days of commencing services.

Date Services Commenced; \_\_\_\_\_

I have reviewed the service Orientation with \_\_\_\_\_ (individual) on \_\_\_\_\_ (date).

Client feedback and Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of qualified staff: \_\_\_\_\_ date: \_\_\_\_\_

Witness: \_\_\_\_\_

Thank you for completing this Intake Package, please forward to agency service contact.

Date: \_\_\_\_\_

Name of Person Completing Referral Package: \_\_\_\_\_

Signature: \_\_\_\_\_

Name of Supervisor Reviewing Referral Package: \_\_\_\_\_

Signature: \_\_\_\_\_

Date Intake Package Completed: \_\_\_\_\_

**Complete package to be placed on Client File**