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

Intake Information Package
Printable Version

Updated June 20, 2016
Sept. 7. 2016
June 28, 2021
August 27, 2025

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)

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Organizational Checklist

- ☐ Intake Information Package sent – include link to relevant Agency Website and/or Guardian package if applicable.
- ☐ 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 Integrated Supports, Progressive Residential Supports, and Complex Needs. Service Area coordinates/schedules the risk assessment and the SAT. SAT Clinical Lead, or designate will conduct the 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) if applicable
    - 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 individual in service for medication binder (if applicable)
    - AISH information, copy of benefits card if applicable
- ☐ 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

- Pre-authorized Payment Form

- -Authorization Package
- Service Area Financial Package (if applicable)
- Individuals in ServiceServices Guide
- PDD requires LMTA Checklist (Employment Information Form) required for all individuals in service 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.**

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Suite 700, 5940 Macleod Trail SW, Calgary, AB, T2H 2G4

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,

_____

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)**

_____

Demographic Data
Please complete all relevant sections

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

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

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

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

INTERNAL AGENCY CONTACTS – if applicable (service area transfer)		
Home Supervisor	**FT:**	**PT:**
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:	

MEDICAL	**Alberta Health Care Number:**	
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:

OTHER AGENCY SUPPORTS	☐**Not Applicable** ☐ **Residential** ☐ **Day Services** ☐ **School**
Name of Agency Address:	**Contact Name:** **Phone:** Fax: **Email:**

Medic Alert Bracelet	☐ Yes ☐ No

Advance Care Planning/Goals of Care (Personal Directives) in place See Health Care Consent for additional information on Advance Care Planning	☐ Yes ☐ No

Intake Questionnaire

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

SERVICE
Check all applicable types of service the Individual is seeking:

Integrated Supports Services

- ☐ 24 hour Staffed model
- ☐ Supportive Roommate
- ☐ Supportive Neighbor
- ☐ Respite
- ☐ Other _____

- ☐ Community Access. Paid employment
- ☐ Volunteer Work
- ☐ Recreation/Leisure Activities
- ☐ Recreation classes
- ☐ Education/classes

Complex Needs

- ☐ 24 hour support model home
- ☐ Complex Needs Community Supports

Support Approach Team:
☐Consultation

Preferred worker characteristics: While the agency values the guardians' and individuals in service input, the hiring decision and how the employees are supervised are left up to the agency.

_____
_____
_____

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

_____
_____
_____

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.):

MEDICAL INFORMATION

Diagnosis: Describe Cognitive Disability, Mental Health Illness, Medical Diagnosis (please include source/date of diagnosis):

Describe general health:

Allergies and allergy management:

Any medical conditions, past hospitalizations:

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

Date of last dental check up?

Date of last eye exam?

Dietary considerations and or restrictions; likes and dislikes:

Dietary supports needed (feeding tubes, specialized utensils, food needing to be cut into specific sizes i.e. ¼", ½", or 1" etc.):

Describe eating habits:

Medication - note assistance required with medication administration:

Any concerns with drug interactions:

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.)):

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

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

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.):

COMMUNICATION

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

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

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 individuals in service care by providing safe, consistent and efficient ways for us to acquire and administer medications to our individuals in service.

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.

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 individuals in service have an everyday discount of 15% on all over the counter medications, the pharmacy communicates directly with the individuals in service's'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 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.

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

_____

_____

_____

Any Environmental **Interventions**? (e.g., sharps locked up, guardian locks, window/door alarms, constant supervision latch etc.):

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

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

INTERPERSONAL AND EMOTIONAL SUPPORT
Relationships and Sexuality and Gender Identity

Describe general social skills and areas of strengths:

Family relationships (include type and frequency of contact):
Include full names and contact info
Is there anyone that the Individual is not to have contact with? What steps are to be taken should contact with the individual occur i.e. Contact Guardian immediately, ask individual to leave residence, report to SAS/Crisis Response, etc.?

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

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):

Where applicable, discuss gender identity and their contacts, supports, routines, and how staff can support the individual.

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.):

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:

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

_____

_____

_____

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, hair pull etc.) PPE required:				
Use of weapons/sharps* (e.g., guns, knives, box cutters, broken glass, blunt objects etc.)				
Verbal aggression (e.g., swearing, threats etc.) Threats or thoughts of harm and/or kill people.				
Threats or instances of self-harm/suicide attempts.				
Fears				
Theft				
Property destruction				
Hoarding/Excessive				

Collection of Items				
Sexuality Issues				
Issues with fire/explosives*				
Eloping/AWOL/ Bolting				
Police/ legal involvement Any warrants or charges, court order, CTO pending?				
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:

_____

_____

Harm Reduction Approaches

This section is used when an individual chooses a lifestyle they do not yet want to change or approaches to address the lifestyle are limited to health and safety (e.g., issues with substances and high risk sexual behaviors etc.). The approaches in this section are focused on limiting risk to the individual or to staff (e.g., the individual is meeting strangers to sell something). If this section is not needed for an individual you can delete the table from the profile.

SAFETY AND EMERGENCY INFORMATION

Individual's general safety awareness:

_____

_____

_____

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

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

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

Please complete the chart indicating the level of supervision required in each Area: (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).**Supervision Requirements in the Home Independent time is not approved unless otherwise stated below**		
Bathroom:	**Bedroom – Awake:** **Bedroom – Asleep:**	**Kitchen:**
Shared Living Spaces:	**Housemate's Bedroom:**	**Laundry/Utility Room:**
Basement:	**Staff Office:**	**Calming Room:**
Garage:	**Front Yard:**	**Backyard:**
Supervision Requirements in the Presence of Others Independent time is not approved unless otherwise stated below		
Housemates:	**Family/Friends:**	**Intimate Partners:**
Visitors:	**Contractors:**	**Children/Minors:**
Supervision Requirements around Food and Mealtimes		
Eating with Others: e.g., stealing food from others, etc.	**Choking Risk & Pace of Eating:** 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.	**Portion Sizes:** Describe whether the individual dishes out their own food or requires assistance. Include dietitian/professional restrictions.
Use of Cutlery: e.g., plastic only, ability to use fork and knife, etc.	**Food Hoarding:**	**Other:** e.g., tube feeding

Supervision Requirements in the Community **Independent time is not approved unless otherwise stated below**		
Safety Awareness & Mobility: e.g., traffic safety, unsteady gate, tends to fall when icy, link arms, etc.	**Location Specific Concerns:** 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.	**Animal Concerns:** e.g., fear of animals, restrictions regarding animals, good with animals, etc.
Approved Independent Outing Details: e.g., check in details, frequency of outings, duration of outings, approved destinations, etc.		
Supervision Requirements for Technology in the Home and Community		
TV Use: can they operate the TV independently, are there restricted shows, are "parental controls" authorized, etc.	**Phone Use:** 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.	**Computer Use:** 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.
Internet Use: 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.	**Video Game Use:** 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.	**Social Media Use:** e.g., what social media sites, do staff have to have a visual on the screen, any restrictions, etc.

PREFERRED DAILY ROUTINES & ACTIVITIES

Preferred daily routines & recommended supports:

_____

_____

_____

_____

_____

Describe likes/dislikes/motivation:

Ability to cope with transitions or changes to routine:

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

Describe support needed for activities:

Community Supports

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

Bathing/Showering Procedure and Personal Care needs

Describe personal care and any routines and supports needed.

Describe how best to ask permission and involve individual:

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

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

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

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?:

Please comment on preference for water temperature:

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

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

Does the individual enjoy their bathing routine?:

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

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.)?:

Is there a treatment plan associated with the bathing routine i.e. topical lotion application following bathing routine, use of bath salts, or oatmeal baths during bathing routine, etc.?:

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

FINANCIAL

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

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

Public Trustee,Informal Trustee, Guardians (as applicable):

TRANSPORTATION

□ City Transit (attendant card?) □ Access Calgary □Staff Vehicle □School Bus

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

_____

_____

_____

_____

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				
Yard maintenance				
Other:				

Additional Information (e.g. Schools attended):

_____

_____

Previous Service Providers

Name of Agency	Service Provided	Time frame	Reason for leaving

Other:

_____
_____
_____
_____

Initial Review of Individual in Service Service Guide Orientation Package

All individuals in service 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).
Individual in service 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 Individual in Service File