



A Division of the Ability Resource Association
416 – 8 Street South Lethbridge AB T1J 2J7
Phone: 403-317-4550 Fax: 403-317-4552

APPLICATION FOR ABILITY EMPLOYMENT SERVICES

***All information in this package will remain confidential unless
otherwise requested by the client or guardian.**

PERSONAL INFORMATION

Referral Source: _____

Date of Application: _____

Name: _____
First Middle Last

Address: _____

Phone: (home) _____ (cell) _____

Email: _____

Date of Birth: _____
Month Day Year

Social Insurance Number: _____

Alberta Health Care Number: _____

What is your Primary Diagnosis? _____

What is your Secondary Diagnosis? _____

If applicable

Please list any health care professionals who are involved in your overall health and well-being:

Family Doctor: _____ Specialist: _____

Therapist: _____ Other: _____

Guardian: _____

If applicable

GENERAL INFORMATION

Are you using any “street drugs”? YES NO

Have you used them in the past 2 months YES NO

If yes, how often do you use them? _____

If you have a criminal record for which you have not been pardoned? If yes,
please list the nature of the charges and the year:

Please describe your current living situation and list the people who give you
support (Service Providers, Family,
etc.) _____

FUNDING INFORMATION

Are you on Medical Employment Insurance (EI)? YES NO

Do you receive Persons with Developmental Disability (PDD) funding? YES NO

Have you received services from Ability Employment or Community Access (or
both)? YES NO

Have you had a WCB claim in the last 6 months? YES NO

If YES, what was the claim for and are you still on this funding?

EMERGENCY CONTACT INFORMATION

Name: _____

Name: _____

Phone Number: _____

Phone Number: _____

Relationship: _____

Relationship: _____

Applicant Signature

Name (print)

Date

Ability Staff Signature

Title

Date

Guardian Signature

Name (print)

Date

**Ability Resource Association
And
Ability Employment**

Release of Information

***Purpose:** To allow Ability Resource Association staff to contact and receive personal information from significant others, medical professionals, therapists, and any agencies currently involved with the individual.*

I, _____ hereby authorize the Ability Resource Association to obtain and/ or release information concerning _____ between the listed agencies and professionals. This information will relate directly to and is necessary for the operation and activities provided by the program.

AGENCY/PROFESSIONAL

Doctor: _____ Therapist: _____

Guardian: _____ Parent: _____

Other: _____ Potential Employer ☐ _____
Your initials

Date: _____

Signature of Legal Guardian: _____

Signature of Individual: _____

Witness: _____

***Note:** This release is valid for the period stated below (one year preferably):*

_____, 20____ to _____, 20____