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.**

Revised January 2021, January 2022
Reviewed July 2021, June 2024
Client Services – Appendix 2

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

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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

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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_____

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