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 JOBLINKS SERVICES

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

Revised January 2021
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

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 JobLinks or Ability Resource Centre? 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**

_____

JobLinks Signature **Title** **Date**

_____

Guardian Signature **Name (print)** **Date**

Ability Resource Association
And
JobLinks Employment Centre

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 and/or JobLinks Employment Centre 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_____