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
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_____