

Social Leisure Youth Program (SLYP-Out)

INFORMATION SHEET

Participants

Participants are in the age range of 16 to 23 as of the start date of the program. The SLYP-Out Program is limited to 24 spaces for participants and will be filled on a first-come, first-served basis. Participants who require or utilize additional attendant care for medical and/or behavioral reasons are asked to provide an attendant.

Activities

When planning activities for the SLYP-Out sessions, the Regina Branch of SaskAbilities uses the Quality of Life Model. The Model's template has three life domains which will be the basis for program planning and desired participant outcomes: Being, who one is; Becoming, achieving personal goals, hopes and aspirations; and Belonging, connections with one's environments.

Activities will take place on Monday or Wednesday evenings every other week, starting September 23 and running until December 4. Participants will receive a minimum of 5 evenings during the Fall session. Activities may vary based on changing variables.

Fees

A registration fee will be charged to all applicants and is set at a reduced price. Should the registration fee be a barrier to applying, please contact SaskAbilities. The fee for attending the Fall Session is \$20.

Participants will be responsible for costs such as admission fees and/or snacks when out on program activities. Participants will be advised in advance of the activities that may have additional costs.

Transportation

Transportation to and from the program is the responsibility of the participant.

Application Submission

Applicants are required to complete and submit all of the following forms:

- Services Application Form*
- Support Guide – SLYP-Out
- Social Media Consent*

**These forms are not required for those who attended sessions in Winter, Spring or Summer for 2019 and previously submitted them.*

Completed forms can be submitted as follows:

Mail or SaskAbilities
in person: 825 McDonald Street
Regina, SK S4N 2X5

Fax: 306-352-3717
Email: regina@saskabilities.ca

Applications that are incomplete may not be processed or accepted.



The Regina Branch of SaskAbilities would like to acknowledge and thank the Community Initiatives Fund (CIF) for the grant it has provided in support of the Social Leisure Youth Program.

SUPPORT GUIDE

2019 SLYP-Out Fall Program

PLEASE PRINT OR TYPE IN THE FIELDS PROVIDED.

All sections of the program application form should be filled out as completely as possible.

Name: _____ Date: _____

I'M A NEW PARTICIPANT

I'M A RETURNING PARTICIPANT

Section 1 – PROGRAM

Please select one of the following program session offerings:

MONDAYS (6:30pm to 8:30pm)

WEDNESDAYS (6:30pm to 8:30pm)

No Preference on Day

NOTE: The program will try to accommodate the applicant's selected date where possible. Spots will be filled on a first come, first served basis.

If possible, I wish to be in the same group as: _____

REMINDER

Participants who require or utilize additional attendant care for medical and/or behavioural reasons are asked to provide an attendant. Staff are not able to administer or dispense medications.

Section 2 – ACTIVITIES

What types of activities do you enjoy?

What new activities would you like to try?

What do you hope to experience and/or achieve by participating in the program?

Are there any home routines the facilitators would benefit from knowing while providing programming for your child?

What do people like and admire about you?

What is important to you?

How can we best support you?

Section 3 – MEDICAL

Medication

List all medications and dosages including PRN's, condition they are prescribed for, and how they are administered. Indicate any medications that are to be administered during program hours with a star (*) beside it.

Medication	Dosage	Prescribed for	Administered / By Whom

In accordance with Saskatchewan Abilities Council policy, clients requiring administration of medications shall provide prescription and non-prescription medications, licensed practitioners' written recommendations, medication administration record forms, and pharmacy-provided patient education information forms. Prescription and non-prescription medications shall be provided in the packaging as dispensed by the pharmacist or in reasonably secure packaging with appropriate labels.

Allergies

List all known allergies and reaction(s) if stimulated.

	Allergy	Reaction
Food		
Drugs		
Other		

Do you have an allergy response plan? YES NO

Seizures

Epilepsy YES NO

Seizures YES NO

If Yes, list the type(s) (i.e. petit mal, grand mal), duration, and frequency:

Do you have a seizure response plan? YES NO

Emergency intervention

Are there any medical conditions that occur for which you recommend emergency intervention? YES NO

If Yes, what are these conditions?

Section 4 – SUPPORT CARE

Are the following required?

Personal Care (associated with personal presentation such as feeding, skin care, etc.) YES NO
 Intimate Care (associated with bodily functions such as dressing/undressing, toileting, menstrual care, etc.) YES NO

In accordance with Saskatchewan Abilities Council policy, clients requiring personal or intimate care shall provide documented care plans to the designated employee prior to participation. In the event of a change in personal or intimate care requirements, clients shall provide an updated care plan.

Special Equipment Needs

List any special equipment that is needed for the following areas. Be specific in the type and use of the equipment. The applicant must supply any special equipment they require.

	Type of equipment	Required use
Eating		
Transfers		
Toileting		
Communicating		
Hearing		
Speaking		
Other		

Sensory Difficulties

SPEECH	<i>If speech is non-verbal, please describe means of communication:</i>		
<input type="checkbox"/> Verbal <input type="checkbox"/> Non-Verbal			
VISION	GLASSES	HEARING	HEARING AIDS
<input type="checkbox"/> Good <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Good <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No

Daily Activities

Indicate level of assistance required with the following activities and provide any additional comments.

ACTIVITY	Full Assistance Required	Partial Assistance Required	Supervision Only	No Assistance Required	Comments
Walking with safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walking with an aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Using a wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Transfer to toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Transfer to chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Follow simple directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Judging personal safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Concept of money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Read	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Write	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Behavioural Issues & Support

Indicate the following behavioural issues:

		YES	NO
<i>The applicant is...</i>	Uncooperative	<input type="checkbox"/>	<input type="checkbox"/>
	Aggressive	<input type="checkbox"/>	<input type="checkbox"/>
	Destructive	<input type="checkbox"/>	<input type="checkbox"/>
<i>The applicant has...</i>	Tendencies to wander	<input type="checkbox"/>	<input type="checkbox"/>
	Mood swings	<input type="checkbox"/>	<input type="checkbox"/>
	Unpleasant habits	<input type="checkbox"/>	<input type="checkbox"/>
	Behaviour problems	<input type="checkbox"/>	<input type="checkbox"/>

If any of the above have been answered "Yes", provide details:

If there are aggressive tendencies and behaviour difficulties, list what programs have been developed to support the applicant: (ex. Comprehensive Behaviour Support Plan, Crisis Cycle, etc.). **Please attach the program to this application.**

If you have not attached a Behaviour Support Plan please indicate any triggers such as situations, environment, stimulus, etc. that may create the possibility of the applicant escalating and any strategies to de-escalate the applicant.

APPLICATION FOR SERVICES

PLEASE PRINT OR TYPE IN THE FIELDS PROVIDED.

All sections of the program application form should be filled out as completely as possible.

SERVICES REQUESTED

EMPLOYMENT SERVICES		QUALITY OF LIFE SERVICES	
<input type="checkbox"/> Vocational Evaluation <input type="checkbox"/> Partners in Employment <input type="checkbox"/> New Opportunities for Work	Complete All Sections of Application	<input type="checkbox"/> Helping You Be, Belong and Become (HUB) <input type="checkbox"/> Social Leisure Youth Program (SLYP-Out) <input type="checkbox"/> Summer Fun	Complete Sections 1-7 and Section 11 of Application

Other (please explain) _____

Section 1 – PERSONAL INFORMATION

Applicant's Name: _____ Gender: M F X

Address: _____

City: _____ Postal Code: _____ Phone: _____

Email: _____ Marital Status: _____

Date of Birth (DD/MM/YYYY): _____ Citizenship: _____

Health Card #: _____ Social Insurance #: _____

Community Living Service Delivery (CLSD) Involvement: YES NO

CLSD Worker: _____ Phone: _____

Optional – Please check if any of the following apply:

First Nation
 Métis
 Inuit
 Non-Status First Nation

Band Affiliation: _____ Treaty #: _____

Visible Minority

Barrier to Employment If yes, explain: _____

Section 2 – EMERGENCY CONTACTS

Primary

Name: _____ Relationship: _____

Home Phone: _____ Mobile: _____ Work: _____

Email: _____

Address: _____ City: _____

Secondary

Name: _____ Relationship: _____

Home Phone: _____ Mobile: _____ Work: _____

Email: _____

Address: _____ City: _____

Section 3 – SUPPORT CATEGORIES

SaskAbilities collects this information to guide our development of programs and services and secure related funding. This information is also used for reporting purposes to government ministries and agencies.

Please indicate all current intensive support categories:

<input type="checkbox"/>	Blind or Visual Impairment
<input type="checkbox"/>	Deaf or hard of Hearing
<input type="checkbox"/>	Intellectual Disability
<input type="checkbox"/>	Mental Health Concerns (Bipolar, Depressive, Disorders such as Obsessive-Compulsive, Post-Traumatic Stress, Psychotic, etc.) Specify: _____
<input type="checkbox"/>	Orthopaedic Disability Specify: _____
<input type="checkbox"/>	Autism Spectrum Disorder (Includes Asperger's Syndrome and Pervasive Developmental Disorder. Also includes Autism Spectrum Disorder associated with a known medical or genetic condition (e.g., Rett's Disorder, Childhood Disintegrative Disorder) or environmental factor).
<input type="checkbox"/>	Physical Impairment Specify: _____
<input type="checkbox"/>	Neurodevelopmental Disorder associated with prenatal substance exposure (Includes Fetal Alcohol Spectrum Disorder)
<input type="checkbox"/>	Substance-related and Addictive Disorders
<input type="checkbox"/>	Acquired Brain Injury
<input type="checkbox"/>	Other – Diagnosed condition: _____
<input type="checkbox"/>	Other – Undiagnosed condition

Section 4 – HOUSING/LIVING ACCOMMODATIONS

Living Arrangement	Name of Agency
<input type="checkbox"/> Independent <input type="checkbox"/> Family	<i>Not Applicable</i>
<input type="checkbox"/> Supported Independent	
<input type="checkbox"/> Group Home	
<input type="checkbox"/> Licensed Care Home	
<input type="checkbox"/> Other	

Caregiver/Support Worker's Name: _____

Work Phone: _____ Mobile: _____

Section 5 – TRANSPORTATION

Valid Driver's License: YES NO Class: _____ *If you possess a driver's license, please attach a copy.*

Registered Paratransit User: YES NO Method of Transportation: _____

Section 6 – HEALTH & WELLNESS

Physician: _____ Phone: _____ Date of Last Visit: _____

Psychiatrist/Psychologist: _____ Phone: _____ Date of Last Visit: _____

Mental Health Worker: _____ Phone: _____ Date of Last Visit: _____

Section 7 – EDUCATION & TRAINING

Grade/Course/Program	School/Institution	Location	Dates	Outcome

Section 8 – EMPLOYMENT

Check **ONE** of the following to indicate your current employment status:

- Employed Full-Time
 Employed Part-Time
 Self Employed
 Unemployed
 Training/Education
 Student
 Volunteer
 Homework
 Retired
 Other (please specify): _____

Please list most recent jobs:

Job #1

Job Title: _____ Wage: \$ _____ /hour or yearly salary

Employer: _____ Start of Employment: _____

Immediate Supervisor: _____ Length of Employment: _____

Address: _____ Phone: _____

Employment Type:
 Full-Time
 Part-Time
 Casual
 Seasonal
 Self-Employed
 Experience Type:
 Paid Employment
 Work Experience
 Volunteer
 On-the Job Training

Reason for Leaving: _____

Job #2

Job Title: _____ Wage: \$ _____ /hour or yearly salary

Employer: _____ Start of Employment: _____

Immediate Supervisor: _____ Length of Employment: _____

Address: _____ Phone: _____

Employment Type:
 Full-Time
 Part-Time
 Casual
 Seasonal
 Self-Employed
 Experience Type:
 Paid Employment
 Work Experience
 Volunteer
 On-the Job Training

Reason for Leaving: _____

Section 9 – FINANCIAL

Indicate income sources you are currently receiving:

- Social Assistance Employment Insurance Provincial Training Allowance Saskatchewan Assured
 Canada Pension Long Term Disability Transitional Employment Allowance Income for Disabilities
 Other (please specify): _____

Financial Worker: _____ Phone: _____

How long have you been receiving benefits? _____ Amount: _____

Do you have a Financial Trustee? YES NO If yes, Name: _____ Phone: _____

Are you involved with any public or private insurance companies such as SGI or WCB? YES NO

If yes, please list: _____

If you do not have an income, how do you meet your financial needs? _____

Section 10 – PROGRAM HISTORY

Have you been admitted to or involved with any of the following types of organizations:

Type	Name	Date
<input type="checkbox"/> Rehabilitation Centre		
<input type="checkbox"/> Psychiatric Treatment Program		
<input type="checkbox"/> Correctional Facility		
<input type="checkbox"/> Other		

Are there any pending legal issues for you such as litigation, court order, probation, etc.? YES NO

If yes, please specify: _____

Please provide information on any past behaviour that may have put you or others at risk (i.e. substance abuse, self harm, anger management issues, Comprehensive Behaviour Support Plans, etc.)? Please specify:

Section 11 – AUTHORIZATION

I, _____, hereby authorize SaskAbilities to obtain or release any relevant information concerning myself that will aid in my participation in SaskAbilities' programs.

I confirm all information in this document is true and accurate.

Participant/Legal Guardian
(PLEASE PRINT)

Signature

Date (DD/MM/YYYY)

Expires one year from this date

OFFICE USE ONLY

Medical Report Required

COMMENTS

Social Media Consent

Saskatchewan Abilities Council (“SaskAbilities”) is requesting your permission to post photos and/or videos on the SaskAbilities website, social media channels, and /or additional publications such as annual reports or promotional materials.

These photos and/or videos, either in its entirety or portions thereof, may be used for promotional purposes by SaskAbilities in print or in video format.

- I hereby authorize SaskAbilities to use my photo and/or videos for use in publications, videos and online materials that promotes SaskAbilities activities and programs*.

Participant (PLEASE PRINT)

Signature

Date

If you are under 18 years of age, a parent/guardian is required to sign this form.

Parent/Guardian (PLEASE PRINT)

Signature

Date

**Consent expires one (1) year from the date of authorization.*