



To those wishing to apply to KIN Enterprises, Inc.:

Once the applicant has been shown to meet the mandate of our facility, (this is done through an interview with CLSD, unless a worker has already been working with the applicant) the following forms are required for us to consider the admission of a person to our facility:

- A. There are three parts to the application (all three forms follow) – 1. the Individual Assessment for Service – including the section indicating who will be funding the applicant (i.e. CLSD, INAC, etc.) This is normally done with the CLSD worker, who then brings the application forward to KIN Enterprises. 2. The Medical report – to be filled out by the applicant's regular medical doctor – preferably one who knows the applicant and has worked with the applicant over a period of time, and not a walk-in clinic where applicant's history is unknown. 3. Seizure Description Form – this is to be filled out ONLY if the applicant has seizures.
- B. The application is then submitted to KIN by the CLSD worker who worked on the application with the applicant.
- C. Prior to being scheduled for the Acceptance and Separation meeting, applicants are requested to tour both of our facilities with a member of the management team of KIN Enterprises, Inc. Please phone to make an appointment for the tours.
- D. Acceptance and Separation meetings are held periodically throughout the year. The applicant and caregiver(s) will be notified of the date and time of this meeting. They are encouraged to attend. Decisions will be made regarding placement within the agency at that meeting.
- E. In the event of a waiting list, applicants will be notified of an opening when suitable openings occur.

Head Office:
300, 15 Avenue East
Prince Albert, SK S6V 2N7
PH: 953-4120



457, 40th Street East
Prince Albert, SK S6V 2N7
Ph: 953-4129 Fax: 953-4136

Individual Assessment for Service

Date form completed: _____

Personal Information:

Name: _____ Phone Number: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Date of birth (mm/dd/yyyy): _____

Is applicant a legal resident of Saskatchewan? (Minimum 3 month residence in SK)

____ Yes _____ No

Guardianship:

Is there a legal guardianship in place? ____yes _____no

If yes, please provide date of legal guardianship order: _____

Legal Guardian Name: _____

Address: _____

Phone Number: _____

The following documents are required in order to process the application to KIN, Enterprises, Inc.

- Completed Individual Assessment for Service Form
- Medical Report, including Seizure Description Form, if applicable
- Funding approval. Agency: _____
- Other: _____

Referral Source:

Name of professional(s) completing assessment:

CLD Designate: _____

Name: Please Print

Signature

Phone: _____

Other Agency Designate: _____

Name of Agency

Phone

Name: Please Print

Signature

My signature below indicated I have participated in this assessment:

Applicant's Signature

Caregiver/Guardian's Signature (if applicable)

Health Status Information:

Known Medical Conditions:

1. Seizure Disorder: Yes No Type: _____
(If yes to above, please complete the Seizure Description Form)

2. Diabetic: Yes No
Controlled by Diet Oral Medication Insulin

3. Any other medical conditions that would impact daily work life? (i.e. heart, lungs, urinary, skin, bone/joint, muscle, etc.)

Describe:

4. Communicable Illnesses/Diseases: Yes No

Describe treatment: _____

5. Psychiatric/mental Health Supports: Yes No

Describe treatment:

6. Vision: Normal Wears glasses/contacts Legally blind

7. Hearing: Normal Impaired Deaf

Wears hearing aid Left ear Right ear

8. Feeding: Feeds self needs some assistance total assistance

Describe assistance needed (i.e. needs food cut, pureed, choking risk, etc.):

9. Mobility: Independent uses aids (walker, wheelchair, cane, etc.)

Requires supervision 1 or 2 person assist

Other: _____

10. Transfer Lifts: Not needed Uses slide or transfer board

Total Lift Sit/Stand lift Requires Mechanical equipment

Other: _____

11. Toileting: Assistance needed? Yes No

Describe assistance needed:

12. Allergies: Anaphylaxis Yes No Anaphylaxis to: _____
Do you carry an EpiPen? Yes No Self-Administer? Yes No
Where is EpiPen stored? _____

13. Any other allergies? (Food, drugs, environmental) _____

Describe Reaction(s):

14. Other medical information?

Daily Living and Work Related Activities:

Has applicant held a job or attended an Activity Centre or Workshop? Yes No
If yes, please state place, type of work, and reason for leaving:

At work, what are applicant's likes, dislikes, job interests and goals?

What are applicant's likes and dislikes? (i.e. food, activities, etc.)

Communication and functional skills:

Languages Spoken: ___ English ___ Other (specify) _____

Languages Understood: ___ English ___ Other (specify) _____

Communication: Does Applicant:	Yes	No	Unknown
Use gestures to communicate			
Communicate wants and needs			
Initiate conversation			
Use sign language (what type?)			
Follow simple instructions			
Understand 2-3 part sentences			
Speak clearly			
Follow step by step instructions			
Understand complex instructions			
Functional Skills:	Independent	Some Help	Total Assistance
Read basic words			
Read for entertainment			
Can manage money			
Can tell time			
Use phone			
Dress self			

Behaviour:

Does applicant have a Comprehensive Behaviour Support Plan? ___ Yes ___ No

If yes, please attach a copy to this assessment.

If no, please describe the following: (Numbers 1 through 6)

1. Approved restrictive procedures, if any _____

2. Challenging behaviours, if any _____

3. Dangerous/harmful behaviours that are ongoing (indicate frequency and intensity)

4. Past successes with behaviour interventions:

5. Known triggers that set the stage for the behaviour to occur?

6. Does applicant have any ongoing needs for mental health support?

7. Additional Comments:



Medical Report:

Consent:

I, _____ give my consent for the release of the information in this Medical Report to the following Agencies for consideration in applying for service with the agency:

Kin Enterprises, Inc.
300 15th Avenue East
Prince Albert, SK S6V 2N7

Applicant's signature

Signature of Legal Guardian (if applicable)

**** Please note: all fees related to the Physician's report are the responsibility of the applicant.**

Grey box to be completed by applicant, or designate:

Name:		
Address:		
City:	Province:	Postal Code:
Date of Birth (mm/dd/yyyy):		
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		
Personal Health Number:		

To be completed by Physician: (PLEASE PRINT)
Examining Physician:
Phone Number:
Date Examined:

Period of time under your care: _____

Diagnosis:

HISTORY: (Chronic and/or current conditions:)

Condition:	Treatment:
<input type="checkbox"/> Allergies	
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Dementia	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> TB	
<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Hep. Carrier	
<input type="checkbox"/> HIV/AIDS	
<input type="checkbox"/> Addictions:	
<input type="checkbox"/> Other:	

1. Can patient participate in physical exercise routines? ____ Yes
 ____ No

2. Physical limitations, if any:

3. Dietary Recommendations/Considerations:

4. Does patient wear glasses? ___Yes ___No ___Needs but doesn't wear.
5. Does patient wear hearing aids? ___Yes ___No ___Needs but doesn't wear.
6. Does patient use devices for mobility? (i.e. braces, walkers, etc.)
___Yes ___No ___Needs but doesn't use.
7. Does patient require protective appliances? (i.e. helmet)
___Yes ___No ___Needs but doesn't use.

MENTAL HEALTH:

Has there been a mental health diagnosis? ___Yes ___No

Are there any issues that arise from the Mental Health Diagnosis?

Is patient:	Yes	No	At times	Unknown
Withdrawn				
Aggressive				
Destructive				
Depressed				
Self-abusive				
Other:				

ALL CURRENT MEDICATIONS:

Please attach a medication list, if available.

Name of drug and dosage	Will this drug need to be administered during the work day?

Other comments or concerns:

Physician's Signature

Date

Head Office:
300, 15 Avenue East
Prince Albert, SK S6V 2N7
PH: 953-4120



457, 40th Street East
Prince Albert, SK S6V 2N7
Ph: 953-4129 Fax: 953-4136

Seizure Description Form

This form is to be filled out if the applicant has seizure disorder/epilepsy.

Name: _____ Birth date: _____

Date: _____

1. How often do seizures occur?

2. Date of last seizure _____

3. How long does a seizure last?

4. Describe what a typical seizure looks like:

5. Has applicant ever required emergency treatment/hospitalization for a seizure? If yes, describe what happened:

6. When the seizure is over, what typically happens, and what type of assistance may be needed from us?

7. What medications are currently being taken to treat the seizure disorder?

(for example: Tegretol, 200mg, 3 times a day)

8. Will meds need to be given during the work day? _____yes
_____no