



**...A LIFE SKILLS PROGRAM FOR
YOUNG ADULTS**

APPLICATION FORM

Please mail application attention: Camille Ushy
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- ☐ G.R.O.W. is an innovative program that focuses on enhancing the potential of young adults (21 and older) with social, intellectual and/or developmental disabilities through experience with life skills, opportunities for socialization with peers and engagement in community life.
- ☐ To be considered for G.R.O.W., the program application form must be completed and submitted prior to starting the program.
- ☐ The day program will run Monday – Friday 9:00 a.m. – 4:00 p.m.

Please Print

Participant's Name: _____
Last First Middle

Gender: _____

Previous G.R.O.W. in Gimli Participant: ☐ Yes ☐ No

If yes, please specify which years participant has previously attended

Years participated: _____

Address: _____
Street and Number City Province Postal Code

Home: (____) _____ **Email:** _____

Cell: (____) _____

Date of Birth: ____/____/____ **Age:** _____
M D Y

Guardian's Name (Relationship): _____
First Last

(____) (____) (____)
Home Phone Cell Phone Business Phone

Email: _____

Guardian's Name (Relationship): _____
First Last

(____) (____) (____)
Home Phone Cell Phone Business Phone

Email: _____

Legal Guardian Name: _____
First Last

(____) (____) (____)
Home Phone Cell Phone Business Phone

Email: _____

Legal Decision-Making Status

- Self
- Public Trustee – Name:

Financial Personal

Emergency Contact Name (other than guardian's):

• _____ Relationship: _____

Home: (____) _____ Cell Phone: (____) _____

Business Phone: (____) _____

• _____ Relationship: _____

Home: (____) _____ Cell Phone: (____) _____

Business Phone: (____) _____

Family Physician's Name: _____ **Phone:** _____

Case Worker (if applicable) Name: _____ **Phone:** _____

SIS Score (if applicable): _____

Manitoba Health Registration No. _____

Participants PHIN Number: _____

Participant Lives With:

The following questions are asked to ensure participants have an optimal level of support and does not impact admission.

1. State the participant's diagnosis and briefly describe their disability.

2. Describe the participant's greatest personal strengths.

3. Does the participant have hobbies or interests?

4. Check off any behavioral needs below that apply to the participant and describe.

General Behaviors

☐ Passive	☐ Anxious	☐ Physically Acts-Out	☐ Repetitious behaviours
☐ Assertive	☐ Overactive	☐ Self Injurious	☐ Defiant
☐ Impulsive	☐ "Street Wise"	☐ Verbally Acts-Out	☐ Introverted
☐ Cooperative	☐ Underactive	☐ Demanding	☐ Friendly
☐ Outgoing	☐ Motivated	☐ Leaves Group	☐ Sociable
☐ Emotional	☐ Enjoys Leadership Roles	☐ Challenges authority	
☐ Obsessive	☐ Wander in community		
☐ Sensory Needs (i.e. smells, noise, busy environments, touch)			

Please describe: _____

5. If the participant has any behavioral needs, describe potential triggers and strategies used to help.

8. Identify 3 goals you would like to see the participant achieve at the G.R.O.W. day program?

(for example, prepare grilled cheese sandwich)

1. _____
2. _____
3. _____
4. _____
5. _____

If the participant was a previous G.R.O.W. in Gimli participant, have you continued to work on previous goals? If so, please describe the goals and progress made.

9. Is the participant able to transition from one activity to another, one environment to another without assistance?

☐ Yes ☐ No, the participant needs help with transitions

If no, please describe _____

10. Rate the participant on the following scale:

5 =	Can do without any help
4=	Can do most of activity without help, but may need some verbal guidance (e.g. prompts, cues, reminders)
3=	Can do with a <i>little</i> help (you do <u>1-2 steps</u> of task; physical and/or verbal assistance provided)
2=	Can do with a <i>lot</i> of help (you do <u>most</u> of the task; physical and/or verbal assistance provided)
1=	The participant has never done this activity without help or the activity must be done by a helper

Food Skills:

Knife safety skills	1	2	3	4	5
Stove safety	1	2	3	4	5
Oven safety	1	2	3	4	5
Prepares lunch	1	2	3	4	5
Washes dishes	1	2	3	4	5

Dries dishes 1 2 3 4 5

Comments: _____

Life Management Skills:

Makes bed	1	2	3	4	5	
Cleans bedroom	1	2	3	4	5	
Dusts furniture	1	2	3	4	5	
Cleans bathroom	1	2	3	4	5	
Vacuums	1	2	3	4	5	
Wash floors	1	2	3	4	5	
Street safety	1	2	3	4	5	
Personal Hygiene:	1	2	3	4	5	(brush teeth, comb hair, wash face, etc.)

Comments: _____

Social Skills:

Participates in group settings	1	2	3	4	5
Asks for help as required	1	2	3	4	5
Understands boundaries	1	2	3	4	5
Uses the telephone	1	2	3	4	5
Participates in leisure activities	1	2	3	4	5
Initiates interactions/conversations with others	1	2	3	4	5
Ability to make friends	1	2	3	4	5

Comments: _____

11. Check the box(es) that correspond to the social skill(s) that the participant is having the most difficulty with:

- ☐ Greetings
- ☐ Conversation
- ☐ Body Language
- ☐ Complimenting & Receiving Compliments
- ☐ Identifying & Expressing Emotions
- ☐ Dealing with Anger
- ☐ Assertiveness / Setting Boundaries
- ☐ Cooperation & Compromising
- ☐ Social Problem Solving

- ☐ Get along with others
☐ Other: _____

Comments: _____

12. A) Please indicate any health problems or other pertinent information.

B) Does the participant have any allergies? ☐ Yes ☐ No

C) Does the participant have a seizure disorder? ☐ Yes ☐ No

If Yes, please describe: _____

D) Is the participant taking any medications ☐ Yes ☐ No

If yes, complete the “Participant Medical Regime” form

13. Please describe the participant’s communication style and/or needs (e.g. verbal, non-verbal, impaired speech, use of device etc.)

14. Does the participant have any sensory loss (hearing, vision, etc.)?

☐ Yes ☐ No

If yes, please describe: _____

15. Please list current program(s) or school the participant is attending and provide contact information.

Name	Description & Responsibilities	Contact Person: Name: Phone Number:	

Please list previous programs the participant has attended (i.e., recreational, social, workshops, day services, work experience, volunteering or other educational programs).

Placement	Start Date	Finish Date	Reason Leaving	Placement Description & Responsibilities

17. Any additional information that would be helpful for program facilitators to be aware of: _____

Referral Source

How did you hear about the G.R.O.W. Day Program?

€ Family/Friend € Agency € Other: _____

If you were referred by an agency, please fill out the information below.

Referring Agency: _____

Contact Person (i.e. Teacher/CSW): _____

Address: _____ **Postal Code:** _____

Phone: _____ **Fax:** _____

Email: _____

Please attach a recent photograph of the participant in the space below or attach it to the email.



I hereby authorize and release the following to the G.R.O.W. day program staff:

- To contact the school and/or work program where the participant is currently attending.
- To have the participant observed by the staff of the G.R.O.W. day program during a trial.
- To have my name and address added to the G.R.O.W. mailing list.
- To have the information on these forms shared with the G.R.O.W. staff.
- The information I have provided is true and complete to the best of my knowledge.

Date: _____

Signature of Participant: _____

Date _____

Signature of Guardian: _____

PARTICIPANT MEDICAL REGIME

Name of Participant: _____

Session: _____

Please outline each of the **medications (prescription/non-prescription, supplements or vitamins)** that the participant is currently taking. Outline frequency, storage and how medication/non-prescription medication or vitamins are dispensed

Medication/Vitamin (including dosage)	Why has the medication/vitamin been prescribed?	Frequenc y	When is medication/ vitamin dispensed (List Times; Before or After Meals, etc)	How is medication/ vitamin given? puffer, pill or liquid form; with food/liquid, etc.)	Storage (refrigeration or room temperature)

All prescription medications must come to the G.R.O.W. in bubble packs