...A Life Skills Program For
Young Adults

Application Form

Please mail application attention: **Sandy Sheegl**
91 Willow Avenue
Winnipeg, Manitoba R3N OG9
Phone: 204 505-3799
ssheggl@growourway.ca
www.gainingresourcesourway.ca

- **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

March 2023

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 <u>3 goals</u> 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 little* help (you do 1-2 steps of task; physical and/or verbal assistance provided)
2=	Can do with *a lot* of help (you do most 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 <u>most difficulty</u> 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?	Frequency	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