

# Adult Services Application Form



*Please Note: Prior to applying for WDDS Adult Services, you must be registered with Developmental Services Ontario (DSO). You can reach DSO Southwest Region at 519-963-1891.*

Select which Adult Service(s) you are requesting: (Please check all that apply)

- |  |                  |                 |
|--|------------------|-----------------|
| <input type="checkbox"/> Options           | Learning Centre  | Fee For Service |
| <input type="checkbox"/> Nexus             | Employment       | Fee For Service |
| <input type="checkbox"/> Overnight Respite | Caregiver Relief | Fee For Service |

**Invoicing:** Payment methods include: cash, cheque or Credit Card (in person or over the phone) or if WDDS is to bill your funding source, please provide:

Name of agency / funding source: \_\_\_\_\_

Contact person name: \_\_\_\_\_ Email: \_\_\_\_\_

- Applying:**
- By fax: 519-539-7332  
Attn: Intake
  - By mail: Woodstock & District Developmental Services (WDDS)  
Attn: Intake  
212 Bysham Park Drive  
Woodstock, Ontario  
N4T 1R2
  - By email: [intake@wdds.ca](mailto:intake@wdds.ca) (you can request a fillable PDF)

## GENERAL INFORMATION

**Person's Name:** \_\_\_\_\_  Male  Female

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Primary Contact: \_\_\_\_\_ Relation to Person: \_\_\_\_\_

Primary Cell #: \_\_\_\_\_ Email: \_\_\_\_\_

Secondary Contact: \_\_\_\_\_ Relation to Person: \_\_\_\_\_

Secondary Cell #: \_\_\_\_\_ Email: \_\_\_\_\_

Primary Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Person's Name: \_\_\_\_\_

Please provide an overview of the person's / caregiver's needs and goals:

Are there any other agencies/services being accessed during this time (if so, please explain)?

May we contact the agencies/services you listed for additional information?  Yes  No

Agency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Agency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Please check all that are applicable:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Intellectual Disability          | <input type="checkbox"/> Cerebral Palsy          | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Down Syndrome                    | <input type="checkbox"/> Spina Bifida            | <input type="checkbox"/> Seizure Disorder       |
| <input type="checkbox"/> Autism Spectrum Disorder         | <input type="checkbox"/> Tourette's Syndrome     | <input type="checkbox"/> Heart Problems         |
| <input type="checkbox"/> Asperger's Syndrome              | <input type="checkbox"/> Hearing Impairment      | <input type="checkbox"/> Communication Disorder |
| <input type="checkbox"/> Pervasive Developmental Disorder | <input type="checkbox"/> Visual Impairment       | <input type="checkbox"/> ADD/ADHD               |
| <input type="checkbox"/> Asthma/respiratory problems      | <input type="checkbox"/> Mental Health Diagnosis | <input type="checkbox"/> Other: _____           |

Please highlight the person's strengths and abilities:

## MEDICAL INFORMATION

Does he/she use any of the following? Please check all that apply.

- |   |                                  |  |                                   |   |
|---|----------------------------------|--|-----------------------------------|---|
| <input type="checkbox"/> Wheelchair       | <input type="checkbox"/> Walker  | <input type="checkbox"/> Tubes (in ears) | <input type="checkbox"/> Earplugs | <input type="checkbox"/> Hearing aids         |
| <input type="checkbox"/> Orthotics        | <input type="checkbox"/> Shunt   | <input type="checkbox"/> G-tube          | <input type="checkbox"/> Catheter | <input type="checkbox"/> Helmet for daily use |
| <input type="checkbox"/> Glasses/contacts | <input type="checkbox"/> Inhaler | <input type="checkbox"/> Epi-Pen         |                                   |   |
| <input type="checkbox"/> Other: _____     |                                  |  |                                   |   |

Person's Name: \_\_\_\_\_

If he/she uses a wheelchair, are there any concerns you feel we should be aware of (rashes, etc)?

Please list any pertinent medical information or present treatments you feel we should be aware of (recent operations or illnesses, skin rashes, etc):

| Medication(s) | Dosage | Time(s) | Reason for Taking |
|---------------|--------|---------|-------------------|
|               |        |         |                   |
|               |        |         |                   |
|               |        |         |                   |
|               |        |         |                   |
|               |        |         |                   |

## COMMUNICATION AND SUPPORT NEEDS

Please describe the area(s) in which he/she requires the most support or assistance:

Does he/she require assistance or restraint (belt, harness, adapted seat) on the bus?  Yes  No

Please explain: \_\_\_\_\_

Does he/she require Para-Transit transportation?  Yes  No

How does he/she communicate? Please check all that apply.

- Functional speech       Gestures       Picture/photo book       Leading/pointing  
 Sign language       PIC-SYM       Picture Exchange Program (PECS)  
 Isolated sounds       Other: \_\_\_\_\_

Please describe:

### Is he/she capable of:

- Being responsible for belongings       Yes  No  
Communicating in sentences       Yes  No  
Communicating with gestures or sounds       Yes  No  
Carrying out tasks when shown how       Yes  No  
Eating Independently       Yes  No  
Following simple instructions       Yes  No

### Please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Person's Name: \_\_\_\_\_

Please list potential problems for the person while accessing supports (eg. wandering, homesick, fears)?

Does he/she experience behavioural/social difficulties (eg. physical aggression, outbursts)?  Yes  No  
If yes, please explain what happens when he/she is agitated:

What, if anything, triggers these behaviours?

## DAILY LIVING

He/she:  is independent using the washroom  wears incontinent briefs

Describe the support he/she needs in changing/using the washroom:

## Self-Care Abilities

| TASK                              | INDEPENDENT              | NEEDS SOME HELP          | DEPENDENT ON STAFF       |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| Dressing/undressing               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Washing hands                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking up stairs or hills        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Oral Hygiene                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bathing                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Menstrual hygiene (if applicable) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eating / Meal Times               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If applicable, describe the assistance he/she needs at meal times, including any special dietary needs or allergies:

**Respite Services ONLY:** How many weekends per month (Friday – Sunday) are you requesting?

Person's Name: \_\_\_\_\_

**ADDITIONAL COMMENTS:**

Is he/she willing and able to wear a face covering (due to covid-19)? If not, please explain:

Please note anything else that would be helpful for us to know about the person and/or additional tips for their success while accessing services:

**I have reviewed the form and I certify that the statements above are true, complete and accurate to the best of my knowledge and belief. *\*If submitting electronically, you may sign at a later date.***

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Your application for service will be reviewed and you will be contacted to discuss your request by the appropriate department.

**OFFICE USE ONLY:**

*Date Received:* \_\_\_\_\_ *Date Reviewed:* \_\_\_\_\_

*Manager's Signature:* \_\_\_\_\_

*Comments:*

Person's Name: \_\_\_\_\_