

# APTUS APPLICATION

Day(s) requested:  Monday  Tuesday  Wednesday  Thursday  Friday  
 Day Program: 9am to 3pm  Before Respite: 8:30am to 9 am  Afterhours Respite: 3pm to 4:30 pm

## Staff to Client Ratio Requested

2:1@\$66/hr  1:1@\$37/hr  1:2@\$22.50/hr  1:3@\$19/hr  
 1:4@\$17.50/hr  1:5@\$16/hr  Coming with own support \$10/hr

## Contact Information

Applicant's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
Day / Month / Year

Age: \_\_\_\_\_

Preferred pronoun

She  He  
 They

Wheel-Trans I.D. #: \_\_\_\_\_

(Most outings are done by Wheel-Trans. If needed, please complete Wheel-Trans application. Application can be brought to interview for support.)

Address: \_\_\_\_\_ City: \_\_\_\_\_ PostalCode: \_\_\_\_\_

Applicant's cell phone (if applicable): \_\_\_\_\_

Applicant's email (if applicable): \_\_\_\_\_

## Parent/Primary Caregiver

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Home phone: \_\_\_\_\_ Email: \_\_\_\_\_

## Other Parent/Primary Caregiver (Optional)

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Home phone: \_\_\_\_\_ Email: \_\_\_\_\_

## Applicant Information

Primary Diagnosis: \_\_\_\_\_

*Reports may be requested to be brought to the interview.*

Mental Health Diagnosis: \_\_\_\_\_

(if applicable) *Reports may be requested to be brought to the interview.*

Medical  seizures  dietary issues  epilepsy  hearing impairment  visual impairment

auto-injector required  allergies: \_\_\_\_\_

other: \_\_\_\_\_

I will be taking medication to the program

I require assistance with medication  PRN (as-needed medication, e.g., re: seizure)

I am independent with my medication

Does the participant have any medical conditions that may impact ability to engage in physical activity or community outings (e.g., epilepsy, previous surgery)?  YES  NO

Medical Condition: \_\_\_\_\_

## Applicant Information

Communication (check off as many as are applicable)	<input type="checkbox"/> uses spoken words to communicate <input type="checkbox"/> vocalizations <input type="checkbox"/> non-vocal <input type="checkbox"/> gestures/sign language <input type="checkbox"/> communication device <input type="checkbox"/> Picture Exchange Communication System <input type="checkbox"/> Other: _____
Mobility (check off as many as are applicable)	<input type="checkbox"/> independent <input type="checkbox"/> walker <input type="checkbox"/> cane(s) <input type="checkbox"/> independent with wheelchair <input type="checkbox"/> staff support needed to move wheelchair <input type="checkbox"/> other: _____ <input type="checkbox"/> requires transfer assist <input type="checkbox"/> 1 person pivot <input type="checkbox"/> 2 person mechanical lift
Self-Care (check off as many as are applicable)	Hygiene/Washroom <input type="checkbox"/> support needed for hygiene/washroom <input type="checkbox"/> reminders only <input type="checkbox"/> supervision only  Eating/Drinking <input type="checkbox"/> support needed for eating/drinking <input type="checkbox"/> setup assistance needed (e.g., opening containers, heating food) <input type="checkbox"/> supervision only

Staff to Client ratio at current or previous program/school    2:1    1:1    1:2    1:3    1:4    1:5    other: \_\_\_\_\_

Does the participant have any types of challenging behaviours?    YES    NO   If yes, check which apply:

self-injury    property destruction    pacing    bolting/elopement    aggression    screaming/yelling

emotional outburst    stealing    non-compliant    sexual aggression    other: \_\_\_\_\_

Is the participant currently receiving community behaviour services?    YES    NO

If yes, name of agency: \_\_\_\_\_ Therapist \_\_\_\_\_ From: \_\_/\_\_/\_\_\_\_ To: \_\_/\_\_/\_\_\_\_

Other programs/services currently enrolled in: \_\_\_\_\_

Applicant is able to be successful in a group setting.

Applicant is able to follow directions, e.g., stop, wait, redirection instructions, or activity instructions.

Comment: \_\_\_\_\_

Last Grade completed: \_\_\_\_\_

Reading level: \_\_\_\_\_

Comprehension    reading comprehension    understands when spoken to

Writing skill level: \_\_\_\_\_

Computer skill level: \_\_\_\_\_

Applicant likes/dislikes: \_\_\_\_\_

Applicant goals: \_\_\_\_\_

Applicant/Parent/Primary Care Giver Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please forward completed Application Form to: Aptus Treatment Centre

40 Samor Road Toronto, ON M6A 1J6   Fax: 416-630-2236   Email: [anitak@aptustc.com](mailto:anitak@aptustc.com)

## Office Use Only

Accepted to Program    Wait listed    Declined

Day(s) and Times Scheduled:

Monday    Tuesday    Wednesday    Thursday    Friday    8:30 - 9    9 - 3    3 - 4:30

Prospective Support Ratio: \_\_\_\_\_    Coming with own support   Desired Start Date: \_\_\_\_\_

interview date: \_\_\_\_\_    observation required – date(s): \_\_\_\_\_

acceptance letter and Service Agreement sent    signed Service Agreement and Schedules

finance notified    file created   A, B and C received