Gene's Place Support Services Inc.

Confidential Client Intake Application

1. Participant Information

Please complete all applicable fields. Type directly into the form, save a copy, and print or submit as instructed.

PARTICIPANT DETAILS

Legal name

Preferred name

Date of birth (YYYY-MM-DD)

Pronouns (optional)

Home address

City / Province

Postal code

Primary phone

Email (if applicable)

Preferred communication method

PRIMARY CONTACT / AUTHORIZED REPRESENTATIVE

Full name

Relationship to participant

Phone

Email

Mailing address (if different)

Authorized decision-maker? Yes / No

EMERGENCY CONTACTS

Emergency contact 1 - name

Relationship

Phone

Alternate phone

Emergency contact 2 - name

Relationship

Phone

Alternate phone

2. Health, Safety and Support Information

PHYSICIAN AND HEALTH INFORMATION

Family physician / clinic

Physician phone

Health card number (optional)

Preferred hospital

Diagnosis / relevant health information

Allergies and required response

Seizure history, protocol or emergency instructions

MEDICATION

List medications, dosage, time and reason (attach medication record if needed)

Medication assistance required during program hours

MOBILITY, PERSONAL CARE AND SAFETY

Mobility, transfers, equipment or accessibility supports

Personal care, toileting, eating or swallowing supports

3. Communication, Goals and Program Preferences

COMMUNICATION AND LEARNING

How does the participant communicate? Include speech, gestures, AAC, visual schedules or other methods.

How does the participant understand information and make choices?

STRENGTHS, INTERESTS AND GOALS

Strengths, talents and things the participant enjoys

Goals for independence, communication, friendship, employment readiness or community participation

PREFERRED ACTIVITIES

Select all activities of interest:

- ☐ Cooking / baking
- ☐ Bowling
- ☐ Swimming
- ☐ Arts / crafts
- ☐ Music / karaoke
- ☐ Just Dance / movement
- ☐ Games / puzzles
- ☐ Technology / learning
- ☐ Community outings
- ☐ Volunteering / employment

Other interests, routines, dislikes or activities to avoid

SCHEDULE AND TRANSPORTATION

4. Funding, Service Planning and Additional Information

FUNDING SOURCE

Select all that apply:

- [ ] Passport Funding
- [ ] Private payment
- [ ] Agency funding
- [ ] Other approved funding

Funding contact / agency

Funding or file number

Billing contact name

Billing email / phone

Additional funding details or limits

SUPPORT CIRCLE AND CURRENT SERVICES

Current service providers, school, agency, group home or support team

Important cultural, religious, language, identity or family considerations

Anything else Gene's Place should know to provide safe, respectful and person-centred support

DOCUMENTS THAT MAY BE REQUESTED

- Current support plan or developmental assessment
- Medication record, allergy plan or seizure protocol
- Behaviour, mobility, transfer or communication plan
- Funding approval or billing information
- Proof of authorized representative, where applicable

5. Consent and Acknowledgement

CONSENT CHOICES

Please select Yes or No for each item. Consent may be withdrawn in writing, subject to legal and safety requirements.

Emergency medical care when necessary	☐ Yes	☐ No
Information sharing with approved members of the support circle	☐ Yes	☐ No
Participation in approved community outings	☐ Yes	☐ No
Transportation according to the signed service plan	☐ Yes	☐ No
Photos or video for private program documentation	☐ Yes	☐ No
Photos or video for public social media / promotional use	☐ Yes	☐ No

Photography and social media consent is separate and optional.

Refusing public photo, video or testimonial use will not affect eligibility for services. Gene's Place will explain what information is collected, why it is needed, how it may be used, who may receive it, and how to request access or withdraw consent where permitted.

ACKNOWLEDGEMENT

- I confirm the information provided is accurate and complete to the best of my knowledge.
- I will notify Gene's Place of changes to health, medication, emergency, funding or support information.
- I understand that fees, schedules, transportation, cancellation terms and services will be confirmed in writing.
- I understand that records will be stored and handled according to privacy requirements.

Participant / representative full name

Relationship / authority

Typed signature

Date (YYYY-MM-DD)

Gene's Place representative

Date reviewed

6. Optional Medication Continuation Sheet

Use this page when more space is needed. Attach additional pages or clinical instructions where applicable.

MEDICATION AND ADMINISTRATION DETAILS

Medication name	Dose	Time	Reason / instructions

ADDITIONAL EMERGENCY OR HEALTH INSTRUCTIONS

Detailed instructions

ATTACHMENTS CHECKLIST

- ☐ Medication record
- ☐ Allergy plan
- ☐ Seizure protocol
- ☐ Behaviour support plan
- ☐ Mobility / transfer plan
- ☐ Communication plan