Health Help Alberta Application Form

PATIENT INFORMATION:

Patient last name: _____ Patient first name: _____

Patient Date of Birth: _____

Canadian resident status:

- Citizen
- Permanent Resident
- Refugee
- Other (Please Specify) _____

Current Supports (FSCD caseworker, social worker, etc.? Other therapies/supports?):_____
_____
_____
_____
_____
_____
_____
_____

Language most comfortable with: _____

English language proficiency: _____
On a scale of 1 to 5 (1 being not at all and 5 being excellent), how proficient is the patient in English?

Other languages which individual is proficient in: _____

Country of Birth: _____

Other Relevant Information (Optional): _____
_____
_____
_____
_____
_____
_____
_____

Health Help Alberta

GAURDIAN 1 INFORMATION:

Last name: _____ First name: _____

Canadian resident status:

- Citizen
- Permanent Resident
- Refugee
- Other (Please Specify) _____

Language most comfortable with: _____

English language proficiency: _____
On a scale of 1 to 5 (1 being not at all and 5 being excellent), how proficient are you in English?

Other languages which individual is proficient in: _____

Country of Birth: _____

Other Relevant Information (Optional): _____
_____
_____
_____

GAURDIAN 2 INFORMATION:

Last name: _____ First name: _____

Canadian resident status:

- Citizen
- Permanent Resident
- Refugee
- Other (Please Specify) _____

Language most comfortable with: _____

English language proficiency: _____
On a scale of 1 to 5 (1 being not at all and 5 being excellent), how proficient are you in English?

Other languages which individual is proficient in: _____

Country of Birth: _____

Other Relevant Information (Optional): _____
_____
_____
_____

CASE INFORMATION:

Patient diagnosis: _____
_____
_____

Please provide as much information as possible about the patient's diagnosis, or about their condition in general that makes you want to reach out

Service required: _____
_____
_____
_____
_____
_____
_____
_____
_____

Please provide as much information as possible about the service that you wish to receive. For example, you may need help with finding government programs that may be useful to the patient, assistance in completing/understanding health application forms, etc.

Other relevant information (Optional): _____
_____
_____

Please use this section to include any other relevant information that you have not mentioned before

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CONTACT INFORMATION:

Email: _____

Home Phone: _____

Cell Phone: _____

Home Address: _____

Date: _____

Applicant name: _____ Applicant Signature: _____