

**ASSOCIATE FAMILY ASSESSMENT INTERVIEW**

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## SUITABILITY/COMPATIBILITY REVIEW

1. PLEASE DESCRIBE YOUR COMPATIBILITY/ABILITIES TO PROVIDE THE FOLLOWING:

A. PERSONAL CARE FOR CLIENTS WHO ARE:  
INCONTINENT \_\_\_\_\_  
REQUIRE BASIC NURSING CARE \_\_\_\_\_  
MALE/FEMALE BATHING \_\_\_\_\_

B. CLIENTS WHO CAN BECOME AGGRESSIVE: \_\_\_\_\_  
\_\_\_\_\_

C. DISCUSSING SEXUALITY EDUCATION WITH THE CLIENT: \_\_\_\_\_  
\_\_\_\_\_

D. ASSISTING CLIENT TO DEVELOP RELATIONSHIPS WITH OTHERS, TO INCLUDE  
OTHER FAMILY MEMBERS: \_\_\_\_\_  
\_\_\_\_\_

E. TEACHING CLIENTS WHO CAN BE VULNERABLE TO BE SAFE: EXAMPLE \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. DO YOU HAVE ANIMALS IN THE HOME? DESCRIBE \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. IN REGARDS TO YOUR EXPERIENCE AND EDUCATION, HOW DO THEY RELATE TO  
YOUR APPLICATION TO PROVIDE FAMILY CARE TO AN ADULT WITH AN  
INTELLECTUAL CHALLENGE. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. A. DO YOU SMOKE TOBACCO PRODUCTS OR CIGARETTES IN YOUR HOUSEHOLD?  
Check  Yes  No  
 Indoors  Outdoors

## PREFERENCE/SUPPORT

1.SMOKER: YES [ ] NO [ ] NO PREFERENCE [ ]

2.GENDER: YES [ ] NO [ ] NO PREFERENCE [ ]

3.APROX. AGE: CHILD : BIRTH-18 [ ]

(Under Child and Family Services)

ADULT : 18-25 [ ] 25-50 [ ] 50+ [ ]

NO PREFERENCE [ ]

4.NUMBER OF CLIENTS YOU ARE WILLING TO SUPPORT(max 3):\_\_\_\_\_

5.HOW MUCH SUPPORT /TIME ARE YOU WILLING TO PROVIDE ON A DAILY BASIS FOR TEACHING/SUPERVISION PROVIDING FOR INDIVIDUAL PERSONAL CARE AND LIVING SKILLS

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6.IN WHICH OF THE FOLLOWING AREAS WOULD YOU BE WILLING TO ASSIST A CLIENT:

	<b>Yes</b>	<b>No</b>	<b>Comments:</b>
Personal Hygiene	[ ]	[ ]	_____
Social Skills	[ ]	[ ]	_____
Smoking Habits	[ ]	[ ]	_____
Transportation	[ ]	[ ]	_____
Medication	[ ]	[ ]	_____
Care of Belongings and Room	[ ]	[ ]	_____
Recreational Skills	[ ]	[ ]	_____
Money Management	[ ]	[ ]	_____
Nutrition/Food prep.	[ ]	[ ]	_____
Responsibility	[ ]	[ ]	_____
Keep Appointments	[ ]	[ ]	_____
Literacy Skills	[ ]	[ ]	_____
Sexuality Awareness	[ ]	[ ]	_____
Anger/behavioural Management	[ ]	[ ]	_____

COMMENTS: \_\_\_\_\_

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**PERSONAL BELIEFS/ FAMILY RELATIONSHIPS**

1. EXPLAIN YOUR MOST IMPORTANT INTERNAL BELIEFS AND VALUES THAT YOU EXTERNALIZE THROUGH YOUR ACTIONS?

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2. ARE THERE CLIENTS YOU FEEL THAT YOU COULD NOT SUPPORT BASED ON RACIAL/ETHNIC ORIGINS, CRIMINAL RECORD, RELIGION, DEGREE OF DISABILITY ? IF YES PLEASE EXPLAIN.

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3. WHAT ARE THE RULES IN YOUR HOUSEHOLD? IF BROKEN, WHAT ARE THE CONSEQUENCES AND HOW ARE THE ENFORCED? \_\_\_\_\_

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4. WHAT ARE THE CURRENT PRESSURES IN YOUR FAMILY? DOES ONE FAMILY MEMBER CARRY MORE STRESS THAN OTHERS? \_\_\_\_\_

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5. WHAT POSITIVE ATTRIBUTES COULD YOUR FAMILY PROVIDE? HOW DOES YOUR FAMILY SHOW POSITIVE ROLE MODELLING? \_\_\_\_\_

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**HOUSING/ COMMUNITY**

**CURRENT ADDRESS:** \_\_\_\_\_

**YEARS RESIDING AT CURRENT ADDRESS** \_\_\_\_\_

**PREVIOUS ADDRESS IF CURRENT ADDRESS IS LESS THAN 10 YEARS :**  
\_\_\_\_\_

**1. TYPE OF DWELLING:**

- House     Apartment     Duplex     Semi Detached     Townhouse     Condo  
 Other \_\_\_\_\_

A. NUMBER OF BEDROOMS: \_\_\_\_\_

B. NUMBER OF BATHROOMS: \_\_\_\_\_ ½ Bath \_\_\_\_\_

C. TYPE OF BASEMENT  Finished  Unfinished  Full  Partial  None

D. HOW IS THE HOME HEATED  Gas     Electric  Wood     Other \_\_\_\_\_

E. DOES YOUR HOME HAVE: SMOKE DETECTORS [ ]

: CARBON MONOXIDE DETECTOR [ ]

: FIRE EXTINGUISHERS [ ]

: YARD FACILITIES [ ]

: LAUNDRY FACILITIES [ ]

**2. HOW WILL THE CLIENT(S) HAVE ACCESS TO THE FOLLOWING:**

A. BATHROOM FACILITIES [ ] SHARED [ ] SEPARATE

B. KITCHEN/DINING [ ] SHARED [ ] SEPARATE

C. LIVING ROOM/REC ROOM [ ] SHARED [ ] SEPARATE

**3. ACCOMMODATIONS FOR CLIENT(S):**

FURNISHED BEDROOM ( including a single bed, dresser, closet )

A. LOCATION OF BEDROOM:  Basement  Ground Level  First Floor  Second Floor

**IF BEDROOM IS LOCATED IN BASEMENT SECONDARY SEPARATE EXIT NECESSARY**

**4. ARE YOU PREPARED TO MODIFY YOU HOME FOR ACCESSIBILITY ?**  Yes  No

**EXPLAIN** \_\_\_\_\_  
\_\_\_\_\_

**5. IS THERE OPPORTUNITY FOR CLIENT COMMUNITY PARTICIPATION, IE. CHURCHES, SHOPS, LIBRARY, RECREATION, ETC.?** ( Please Give Details ): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HEALTH AND SAFETY MEASURES**

- OUT DOOR SMOKING AREA (If necessary)
- BATHROOMS UP TO CODE (proper ventilation, privacy etc.)
- HARMFUL MEDICATIONS STORED IN SAFE APPROVED PLACE  
(IE. LOCKED CONTAINER/CUPBOARD)
- ANY WEAPON, FIREARMS, AIR RIFLES ETC. ARE MADE INOPERABLE AND INACCESSIBLE AND  
ARE KEPT IN A SECURED AREA IN ACCORDANCE WITH SAFE STORAGE PRACTICES/  
LEGISLATION
- CORROSIVE AND HAZARDOUS MATERIALS ARE LABELLED AND KEPT IN A SAFE AREA
- HOME AND VEHICLE INSURANCE (**Form Attached**)  
**(Insurance is strongly advised to ensure that resources have all necessary risk coverage)**
- FIRST AID SUPPLIES / STORM KIT
- EVACUATION AND EMERGENCY PLANNING (Form Attached)**
  - Emergency and relevant telephone numbers clearly posted (911, Doctors, Hospital, workers, family)
  - Associate Family Providers will report to Residential Coordinator as soon as possible regarding any serious incident involving a client

**OTHER:**

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**ALCOHOL/SUBSTANCE USE**

1. A. Do you or anyone in your household use tobacco? YES [ ] NO [ ]  
A. If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

B. Do you or anyone in your household use alcohol? YES [ ] NO [ ]  
A. If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

3. Do you or anyone in your household have an alcohol or drug problem? YES [ ] NO [ ]

A. If yes, has treatment been received in the past. YES [ ] NO [ ]

2. Are you or anyone in your household currently using medically prescribed drugs? YES [ ] NO [ ]

NAME: \_\_\_\_\_ USE: \_\_\_\_\_  
NAME: \_\_\_\_\_ USE: \_\_\_\_\_  
NAME: \_\_\_\_\_ USE: \_\_\_\_\_  
NAME: \_\_\_\_\_ USE: \_\_\_\_\_

3. If there is a history of an addiction problem with you or in your household, will you give permission to obtain a consultation with your family's addiction counsellor? YES [ ] NO [ ]

**DISABILITY**

1. Do you have any disability that significantly impedes your ability to provide the necessary support and physical care to a person with a mental disability/illness? YES [ ] NO [ ]

A. If you have a disability, are you prepared to submit a medical reference related to your ability to perform functions of care? YES [ ] NO [ ]

**PSYCHIATRIC ISSUES**

1. Do you have a psychiatric disorder that has required hospitalization in the past. YES [ ] NO [ ]

2. Do you have a history of a psychiatric disorder or are you currently under "outpatient" psychiatric care / Hillsborough / McGill Day Treatment or QEH / Other? YES [ ] NO [ ]

**CRIMINAL RECORDS**

1. Is there anyone in your home who has ever been convicted of a criminal act, including physical or sexual abuse, or juvenile crime? YES [ ] NO [ ]

A. If YES, please describe in detail

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2. Has there ever been a case of domestic violence within your home? YES [ ] NO [ ]

3. Is every member in your home over the age of 18 years prepared to undergo a criminal record check and provide documentation? YES [ ] NO [ ]

**(Form Attached)**

4. Have you ever undergone an investigation by a child welfare or adult protection agency to determine if someone in your care were in need of protection? YES [ ] NO [ ]

**ACCEPTANCE OF FAMILY VISITS**

1. Will you accept and respect the need to maintain ties with the client's family and friends? YES [ ] NO [ ]

Comments: \_\_\_\_\_

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**CO-OPERATION WITH THE RESIDENTIAL CO-ORDINATOR**

1. Are you prepared to work in co-operation with the Residential Co-ordinator and share in the responsibility of the care and treatment of any client placed in your home? YES [ ] NO [ ]

2. Are you willing to participate in all aspects of assessment and preparation to better prepare and enable you to provide family care? (I.e. Education sessions, on-going home and family care assessments & visits, client case plans) YES [ ] NO [ ]

3. Do you accept the need to maintain confidentiality? (This involves the need to be discreet with information available and only sharing it with individuals on a need-to-know-basis) YES [ ] NO [ ]

4. Are you willing to sign an Oath of Confidentiality? YES [ ] NO [ ]

**(Form Attached)**

5. Are you willing for this agency to share you information as needed to a clients family as outlined on the Associate Family Profile YES [ ] NO [ ]

## ASSOCIATE FAMILY PROFILE

NAME: \_\_\_\_\_

SPOUSE/PARTNER: \_\_\_\_\_

CHILDREN: (#) \_\_\_\_\_

NAMES: \_\_\_\_\_

AGE: \_\_\_\_\_

OTHERS RESIDING IN THE HOME: \_\_\_\_\_

PETS: \_\_\_\_\_

COMMUNITY: \_\_\_\_\_

RELIGION: \_\_\_\_\_

HOBBIES: \_\_\_\_\_

\_\_\_\_\_

TRAINING: \_\_\_\_\_

SMOKING: YES [ ]    INDOORS [ ]    OUTDOORS [ ]  
                  NO [ ]

ADDITIONAL INFORMATION:

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