



Attendant Care Service Application Form

PHYSICAL CONDITION/FUNCTIONING

What is the **primary** disability that caused you to apply for Attendant Care Services?

What is the diagnosis date? _____

When was your last OT/PT assessment? _____

INCOME

Have you received income from an insurance settlement related to your disability that disqualifies you for a government-funded program?

ATTENDANT CARE REQUIREMENTS

How many hours of service do you require daily? (circle one)

Less than 1 ½ hours

1 ½ - 3 hours

3 – 4 hours

SERVICE	√	SERVICE	√
TRANSFERS		GENERAL HYGIENE	
Into/out of bed		Bath/shower	
Onto/off toilet/commode		Bed Bath	
BOWEL AND BLADDER		Grooming	
Bladder - condom catheter		Peri-care	
Bladder -indwelling catheter		Menstrual care	
Bladder -intermittent catheter		Incontinence care	
Bladder -night bag		MEALS AND DRINKS	
Bowel (<i>circle all that apply</i> – enema, suppository, digital stimulation) frequency		Cooking	
Ileo-conduit care		Special diet	
Bed pans/Urinal		Cutting up food	
DRESSING & UNDESSING		Feeding	
Lower body		Splints	
Upper body		Drinks	
Outer wear		G-Tube Feeding	
Buttons/zippers hooks		MISCELLANEOUS	
Assist with prosthesis on/off		Medication	
SKIN CARE		TV/radio/stereo	
Turns at night		Locks/keys	
Skin Care		Money-handling	
Skin checks		Windows; open/close	
RESPIRATION		Doors	
		Range of motion exercises	
		Communication, incl. telephone	



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ESCORT/SUPPORT	√	HOUSEKEEPING (dusting, vacuuming, laundry, etc)	√
Grocery shopping		No	
Personal shopping		Yes	
Banking		Partial	
Medical/dental appointments		NURTURING Number of Children: Age of Children:	
Requires escort on accessible bus			
Assist with booking transportation			
Other			

REFERRING AGENCY CONTACT INFORMATION

Contact Name: _____
(last) *(first)*

Agency Name and Address:

(street and number) *(city)* *(postal code)*

Tel & Ext: _____ **Fax:** _____ **Email:** _____

Would you like to be informed once arrangements have been made to conduct the assessment? **Yes / No**
(circle one)

Coordination/collaboration with applicant's CCAC contracted services is requested. **Yes / No**
(circle one)

If the referring agency is the CCAC, please forward a RAI as soon as possible.

PHYSICIAN CONTACT INFORMATION

Primary

Name: _____ **Tel.:** _____

Address: _____
(Street and number) *(City)* *(Postal code)*

Specialist

Name: _____ **Tel.:** _____

Address: _____
(Street and number) *(City)* *(Postal code)*



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√ **Identify what program you are applying for**

Attendant Care Outreach _____ Elaine House Respite _____ Nurturing _____
Attendant Care Respite _____ Supportive Housing _____

Supportive Housing (if you are applying for this program please complete the housing choice list)

It is the policy of the Association that if the applicant refuses the apartment in either of their first 2 choices for Supportive Housing, their applications will be placed in a refused services hold file for 6 months from the date of refusal. The applicant will then have the option to reapply and have their application reactivated from the hold file.

Please identify 1st and 2nd housing location choices. When a vacancy occurs the Association will only select the applications that have selected the areas where the vacancy is available.

Identify your 1st choice with 1

Identify your 2nd choice with 2

You can identify other options if you are interested.

Cluster Supportive Housing

49 Coulter Street Barrie (all units have wheel-in showers)

1 bedroom _____

2 bedrooms _____

380 Duckworth Street Barrie (all units have wheel-in showers)

1 bedroom _____

2 bedrooms _____

Support Service Living Units

101 Kozlov Street Barrie (some units have wheel in showers)

1 bedroom only _____

193 Edgehill Barrie (some units have wheel-in showers)

1 bedroom only _____

125 Fittons Road Orillia (all units have wheel-in showers)

1 bedroom _____

2 bedrooms _____

Congregate Living Home

88 Cook Street Barrie

1 bedroom with common living area _____

Cluster Supported Living

This model does not offer housing

Town of Midland _____

Town of Collingwood _____



Attendant Care Service Application Form

Physician Report

RELEASE BY PATIENT

Patient's Name: _____

I hereby authorize my physician to release any medical information to the Simcoe County Association for the Physically Disabled.

Date: _____ Patient's Signature: _____

Your patient has applied for Attendant Care services. The information you provide will assist us in appropriately assessing the application. To be considered for this program the applicant must meet the following minimum criteria;

1. **Be able to direct own care**
2. **Have a permanent physical disability**
3. **Have all medical and clinical needs met in the community**
4. **Require personal care**

<u>Medical Diagnosis of Disability</u>	<u>Date of Onset</u>	<u>Total Duration of Condition</u>
1) _____	_____	_____
2) _____	_____	_____

Does your patient have any clinical needs? If yes, are the clinical needs being met in the community?

Does your patient have a history of mental illness and/or addictions? If yes, is your patient receiving the necessary treatment? _____

Medical Prognosis of Disability (Check where applicable and explain prognosis):

Stable Improving Deteriorating Uncertain

Explain:

Do you feel your patient is capable of administering his or her own medication? Yes No

If No, who will take responsibility for administering their medications?

Name: _____

Relationship: _____



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Physician Report

<u>Current Medications</u>	<u>Dosage</u>	<u>Frequency</u>
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____

Is your patient currently receiving therapy or treatments? Please specify (nursing, occupational therapy, physical therapy)

Does your patient have any medical problems that we should be made aware of?

General Health of Patient (check where applicable):

Good Fair Poor

How often has the patient been admitted to hospital in the last 12 months?

Allergies: _____

Do you feel that with non-medical support service available in the activities of daily living (mobility, eating, sleeping, washing and grooming, toileting, housekeeping, laundry and shopping, and essential communication) your patient is physically able to live in the community? Yes No

Explain _____



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Physician Report

Is the patient free of any communicable or infectious disease? Yes No

Is your patient?

Orientated to time and place Yes No

Experiencing short term memory loss Yes No

Experiencing long term memory loss Yes No

How well adjusted do you feel your patient is to their disability? _____

IMPORTANT NOTE TO PHYSICIAN:

Would you please ensure that your patient has had a medical examination within the past 12 months. **If assistance is required for any special procedures (Bowel Routine, Bladder Routine, Trac, G-Tube Feedings) a doctor's order is required in order for assistance to be provided by the Association.**

This report will remain confidential. Please return the completed form to the address below.

PLEASE PRINT OR TYPE:

Physician's Name _____

Address: _____

Telephone: _____ Date: _____

Signature of Physician: _____

Please return your report by mail or fax:

The Simcoe County Association *for the* Physically Disabled

1102-44 Cedar Pointe Drive, Barrie, Ontario L4N 5R7

Fax #: (705) 737-1874



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RELEASE OF INFORMATION

Name: _____

Date: _____

I _____ hereby authorize the release and sharing of information from the following persons and/or agencies referred to below to disclose my personal information to representatives of the Simcoe County Association for the Physically Disabled.

Family Physician _____

Specialist _____

CCAC _____

Discharge Planner _____

Care Provider _____

Family members _____

Landlord _____

Other, please specify _____

Signature: _____

Witness: _____

Date: _____



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The Simcoe County Association *for the* Physically Disabled
1102-44 Cedar Pointe Drive, Barrie, Ontario L4N 5R7

Intake Department

Phone#: (705) 737-3263 Ext. 232

Fax #: (705) 737-1874

OFFICE USE ONLY

Program _____ Area _____

Initials

Application Date _____
DD MM YR

Status Notification Sent _____
DD MM YR

Assessment Date _____
DD MM YR

Reassessment Date _____
DD MM YR