APPLICATION FOR SERVICE

INSTRUCTIONS FOR COMPLETING APPLICATION FOR SERVICE

Upon receipt of your application and all required documentation, Pathways to Independence "Referral and Intake Committee" will review your request for service. The Committee (who meets monthly) will make recommendations regarding your request after which you will be notified in writing of the outcome.

To avoid a delay in processing your application, review the following checklist to ensure you have completed the necessary steps.

- Review criteria to ensure eligibility.
- Sign the Authorization to Release/Obtain Information. You or your Substitute Decision Maker must sign.
- Complete the Medical Status Form if you are unable to provide medical documentation to support your diagnosis of an acquired brain injury.
- Complete the Financial Disclosure section. The applicant or person legally responsible for financial decisions must sign.
- Please include all relevant documentation that supports the application and to assist in determining the needs and urgency.
- The applicant is encouraged to participate in the completion of this form as much as possible. This can be done in conjunction with a service provider and/or significant other. We would appreciate a copy of any documentation that supports the request and assists in identifying the specific needs of the applicant. Forms that are incomplete may be returned and will delay the application process

Dated Created: 2014-03-01
Date Modified: N/A

Pathways to Independence

APPLICATION FOR SERVICE FORM

PERSONAL INFORMATION			
First Name Last Name	Date of Birth (dd-mmm-yyyy)		Sex: ☐ Male ☐ Female
Address (Inc Apt#)	Home Phone Number		Alternate Phone Number
City	Province	Postal Code	Email Address
Region:			
Health Card Number			
Do you wear a medical alert bracelet? ☐ Yes ☐ No If yes what is your medical condition:			Marital Status
Current Living Situation: ☐ Alone ☐ With Other (specify) _____			
Accommodation: ☐ House ☐ Group Home ☐ Apartment Building ☐ Supportive Housing ☐ Rooming House ☐ Long Term Care Facility ☐ Hospital ☐ Other _____			
Citizenship: ☐ Canadian ☐ Permanent Resident ☐ Other			
Are you a resident of Ontario? ☐ Yes ☐ No If yes, how long? _____			
Language Spoken:			Interpreter Required: ☐ Yes ☐ No
First Nation Band Affiliation:			Status Number:
Religious Affiliation ☐ Yes ☐ No ☐ Unknown			Cultural Preference ☐ Yes ☐ No ☐ Unknown
BRAIN INJURY INFORMATION			
Date of Injury(dd-mmm-yyyy)	Cause of Injury (e.g. anoxia, assault, motor vehicle collision, fall, etc.)		
Family Physician			Treating Emergency Hospital

Dated Created: 2014-03-01
Date Modified: N/A

City	Province	Postal Code	City	Province	Postal Code
Telephone			Telephone		
Is there history of a previous injury/accident: ☐ Yes ☐ No					
If yes, please explain:					

PERSONAL SUPPORT NETWORK / EMERGENCY CONTACT			
Name	Relationship		Contact Person ☐ Yes ☐ No
Address (inc. apt #)			Home Phone
City	Province	Postal Code	Work Phone
Email Address			

REFERRING AGENT			
Name	Relationship		Contact Person ☐ Yes ☐ No
Address (inc. apt #)			Home Phone
City	Province	Postal Code	Work Phone

PROGRAM REQUESTED
Supported Independent Living Services
Community Services/Outreach
Day Program
Respite
Residential (24 hour)
Employment
What are the long term goals with this placement request:

Dated Created: 2014-03-01
Date Modified: N/A

REASON FOR REFERRAL
Applicant/SDM:
Referring Agency
Have you ever received Pathways Services ☐ Yes ☐ No List of Services and dates of service: _____ Date: _____ _____ Date: _____ _____ Date: _____ _____ Date: _____

TREATMENT HISTORY(if applicable) ☐ Yes ☐ No If Yes, please complete the following:		
Program/Facility/Hospital	**Dates Involved (dd-mmm-yyyy)**	**Contact Name and Phone Number**
Are you receiving or have you applied for other brain injury services? ☐ Yes ☐ No		
If yes, please provide contact names and phone number:		
Have you participated in a neuropsychological assessment? ☐ Yes ☐ No		
If yes, Name of Assessor:	Phone Number	

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Date Modified: N/A

NOTE: Medical, attendant care, rehabilitation and vocational reports are required (if available) such as: Neurosurgery, Neuropsychology, Speech Therapy, Physiotherapy, Occupational Therapy, Social Work, Psychology, Psychiatry, Assessment and Discharge Summaries. Please attach copies of any available reports to this application.

MEDICAL INFORMATION
Seizures ☐ Yes ☐ No If yes, please describe type and frequency:
Do you smoke? If yes please state how frequent and how many cigarettes.
If applicable, are your seizures under control? ☐ Yes ☐ No
Wheelchair ☐ Yes ☐ No ☐ Manual ☐ Motorized Transfers ☐ Independent ☐ Stand-by assistance ☐ Full assistance
Supervision or assistance with mobility: ☐ Yes ☐ No If yes, does it apply to ☐ level surfaces ☐ Stairs ☐ Both
Communication Issues ☐ Yes ☐ No If yes, please describe:
Cognitive Difficulties (memory, concentration) ☐ Yes ☐ No If yes, please describe:
Other physical conditions (allergies, diabetes, heart conditions, diet restrictions, etc.) ☐ Yes ☐ No If yes, please describe:
Have you ever experienced behavioral that is challenging, for example- mood disorder, anxiety, social isolation, anger management? ☐ Yes ☐ No If yes, please describe:

LIST OF MEDICATIONS (if you need more space please write on back of this page)		
Name of Medication	**Dosage**	**Times taken**

Dated Created: 2014-03-01
Date Modified: N/A

Do you self-medicate? ☐ Yes ☐ No		

PSYCHIATRIC

Do you have a psychiatric diagnosis? ☐ Yes ☐ No

If yes, Date/Year of Diagnosis: _____ (dd-mmm-yyyy)

Nature of Diagnosis:

Psychiatric Consult Notes: ☐ Included ☐ Report to follow ☐ Not available

SUBSTANCE ABUSE / LEGAL

Pre-Injury History of Substance Abuse: ☐ Yes ☐ No ☐ History not available

Current Substance Abuse: ☐ Yes ☐ No ☐ Not known

If Yes, Substance Abuse Treatment Recommended: ☐ Yes ☐ No

Are you presently undergoing treatment for addictions? ☐ Yes ☐ No

Is there any history of criminal charges/probation? ☐ Yes ☐ No

If yes, please describe:

EDUCATION AND EMPLOYMENT

Dated Created: 2014-03-01
Date Modified: N/A

Name of Last School Attended:	Address of School:	
Level Attained:	Year Completed:	
Name of Last Employer:	Position:	How long?

FINANCIAL INFORMATION ***This section must be completed by the applicant or person responsible for financial matters.***

Check Source Of Income:

☐ Ontario Disability Support Program (ODSP) ☐ Ontario Works (OW)

☐ Old Age Security (OAS) ☐ Canadian Pension Plan (C.P.P.)

☐ Workplace Safety Insurance Board (W.S.I.B.) ☐ Long Term Disability (private funding)

☐ Lawyer's Name: **(if applicable)** _____

Company: _____ Phone: _____

☐ Insurance Adjuster Name: **(if applicable)** _____

Company: _____ Phone: _____

☐ Rehabilitation Case Manager Name: **(if applicable)**_____

Company: _____ Phone: _____

☐ Insurance Settlement ☐ Structured Settlement ☐ Inheritance ☐ Part Time Employment

☐ Full Time Employment ☐ Income Generating Assets - please describe: _____

Amount of income per month: _____ Do you have direct access to your income? ☐ Yes ☐ No

If no, Name and Phone Number of Substitute Decision Maker/Power of Attorney:_____

Do you make your own personal decisions? □ Yes □ No
If no, Name and Phone Number of Substitute Decision Maker/Power of Attorney:

PERSONAL INFORMATION

Describe what your typical day is like?

Dated Created: 2014-03-01
Date Modified: N/A

What are your likes and dislikes?
Do you ever get upset? What things cause you get upset and what do you do to show your frustration.
Supervision or assistance with mobility: ☐ Yes ☐ No If yes, does it apply to □ level surfaces ☐ Stairs ☐ Both
Communication Issues ☐ Yes ☐ No If yes, please describe:
Cognitive Difficulties (memory, concentration) ☐ Yes ☐ No If yes, please describe:
Other physical conditions (allergies, diabetes, heart conditions, diet restrictions, etc.) ☐ Yes ☐ No If yes, please describe:
Have you ever experienced behavioral that is challenging, for example- mood disorder, anxiety, social isolation, anger management? ☐ Yes ☐ No If yes, please describe:

Dated Created: 2014-03-01
Date Modified: N/A

I, _____ certify that the above mentioned information is correct, to the best of my knowledge.

_____ _____

Signature Date (dd-mmm-yyyy)

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize _____

(Name of organization releasing information)

To release to, and/or obtain from:

Dated Created: 2014-03-01
Date Modified: N/A

Information from relevant client records, in accordance with the policy(ies) of the originating organization regarding:

_____ _____

(Name of Client) (D.O.B – dd-mmm-yyyy)

The required information to disclosed/obtain shall include written and verbal information regarding diagnosis, rehabilitation and support services needs as outlined in my application for services.

This authorization shall be valid from _____ to _____ and does not permit further disclosure without my specific written consent

_____ _____ _____ _____

(Applicant) Date (dd-mm-yyyy) Witness Date (dd-mmm-yyyy)

_____ _____

(Substitute Decision Maker) Date (dd-mmm-yyyy)

Medical Status Form

(Must be completed by a medical doctor)

_____ is applying to Pathways to Independence Acquired Brain Injury Services.
(Name and date of birth)

In order to process the above named persons application, this form must be completed in full.

This form is to be completed by a medical doctor and submitted with your application if you do not have any other medical documentation to support your diagnosis of an acquired brain injury.

Physical Status

Dated Created: 2014-03-01
Date Modified: N/A

Does the applicant require assistive devices? ☐ Yes ☐ No

If YES, please describe:

Does the applicant require attendant care? ☐ Yes ☐ No

If YES, please explain:

Are there any physical conditions that should be known? ☐ Yes ☐ No

If YES, please describe:

Medications

Name of Medication	Dosage	Reason	Side Effects

Diagnosis

Is the applicant's **primary** diagnosis an acquired brain injury? ☐ Yes ☐ No

If NO, please specify primary diagnosis:

Is the injury progressive or degenerative in nature? ☐ Yes ☐ No

Please specify diagnosis:

Is there a secondary and/or a dual diagnosis? ☐ Yes ☐ No

If YES, please specify:

Date of Application:_____

(dd-mmm-yyyy)

Dated Created: 2014-03-01
Date Modified: N/A

_____ _____

Physician's Signature or Stamp: Date (dd-mmm-yyyy)

Link to Policy: Yes ☐ No ■ If "yes" please specify Policy Title: _____

Please return form to:

Dawn Bedard
Manager, Intake & Planning
289 Pinnacle St, Belleville ON K8N 3B3
T 613.962.2541 **C** 613-827-2761
dawnb@pathwaysind.com **www.pathwaysind.com**

Date Printed: _____
(dd/mmm/yyyy)

Dated Created: 2014-03-01
Date Modified: N/A