APPLICATION FOR SERVICE

Acquired Brain Injury Services
Quinte Region

Lead • Grow • Innovate

Vision
"That all people enjoy a high quality of life as an accepted member of their chosen community"

Mission
"We support people in living their best lives"

We serve
"People with acquired brain injuries and/or developmental disabilities who may also have complex needs"

Values & Guiding Principles

- Create belonging & acceptance
- Nurture curiosity & creativity
- Empower people & teamwork
- Help, always
- Help everyone make a difference
- Create homes, not houses
- Value uniqueness, personal growth & independence

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INSTRUCTIONS FOR COMPLETING APPLICATION FOR SERVICE

Upon receipt of your application and all required documentation, the Pathways to Independence Intake Manager/Worker will review your request for service. Depending on the nature of the service request, the application/referral may be wait-listed until a resource becomes available, at which point you will be contacted for an intake meeting.

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

- Review criteria to ensure eligibility.
- It is the responsibility of the individual, the referral source or the emergency contact to communicate any changes to the information provided, including contact information.
- Substitute Decision Maker documentation must be provided to be considered.
- 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 on page 11.
- 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 family member or loved one.
- Any documentation that supports the request and assists in identifying the specific needs of the applicant is required. Forms that are incomplete may be returned and will delay the application process

Dated Created: 01-MAR-2014
Date Modified: 11-FEB-2025

APPLICATION FOR SERVICE FORM

PERSONAL INFORMATION			
First Name Last Name	Date of Birth:		Sex assigned at birth: Gender identity: (please note that this info is requested in order to provide support based on best practices)
Address (Incl. Apt#)	Preferred Phone Number		Alternate Phone Number
City	Province	Postal Code	Email Address
Legal Next of Kin (relationship to you):			
Health Card Number (with version code):			
Do you wear a medical alert bracelet? ☐ Yes ☐ No If yes what is your medical condition:			Marital Status
Current Living Situation: ☐ Alone ☐ With Other(s) (specify) _____ Accommodation: ☐ House ☐ Group Home ☐ Apartment Building ☐ Supportive Housing ☐ Rooming House ☐ Long Term Care Facility ☐ Hospital ☐ Other _____			
Citizenship: ☐ Canadian ☐ Permanent Resident ☐ Other, please describe _____			
Are you a resident of Ontario? ☐ Yes ☐ No If yes, how long? _____			
Language(s) Spoken:		Interpreter Required: ☐ Yes ☐ No	
First Nation Band Affiliation (if applicable):		Status Number:	
Religious Affiliation (if applicable):		Cultural Identity (if applicable, ie Japanese, African, etc.):	
Mother's Maiden Name:		Place/Hospital of Birth:	

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

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

SERVICE(S) REQUESTED (check any/all that apply)
Residential Group Living (24 hour) ☐
Day Program ☐
Respite ☐
Supported Independent Living ☐
Employment Support ☐
Please provide more details/reason for referral:
Are you currently or have you ever received services from Pathways in the past? Yes: ☐ No: ☐ List of Services received and dates: _____ Date: _____ _____ Date: _____
Are you receiving, or have you applied for Brain Injury Services from another provider? Yes: ☐ No: ☐ If yes, please provide Provider/Agency Name, Name of Contact Person, and phone number:

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ACQUIRED BRAIN INJURY (ABI) INFORMATION					
Date of Injury			Cause of Injury (e.g. anoxia, assault, motor vehicle collision, fall, etc.):		
Family Physician:			Treating Emergency Hospital:		
City:	Province:	Postal Code:	City:	Province:	Postal Code:
Telephone:			Telephone:		
Is there history of a previous injury/accident: ☐ Yes ☐ No					
If yes, please explain:					

DECISION MAKING – FINANCIAL & TREATMENT DECISIONS
Do you have a legal ***Guardian*** (legally authorized Guardianship of the Person and/or Property)? If yes, Guardianship of the Person ☐ Property ☐ both ☐ ? If yes, what is their name and contact information:
Do you have a ***Power of Attorney*** for Property and/or Personal Care? If yes, for Property ☐ Personal Care ☐ both ☐ ? If yes, what is their name and contact information:
Does a ***Public Guardian and Trustee*** assist you with financial and treatment decisions? If yes, for Financial ☐ Treatment ☐ both ☐ ? If yes, what is their name and contact information:
Do you have a family member who assists you with financial and treatment decisions? If yes, what is their relationship to you? (i.e. mother, sister, etc.) What other immediate family members are currently living?
Please note that all documentation related to Trusteeship, Guardianship and Power of Attorney is required prior to moving forward with this application.

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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.

ABI RELATED TREATMENT HISTORY (if applicable)		
Program/Facility/Hospital	**Dates Involved**	**Contact Name and Ph. Number**

DOCTOR & MEDICAL PROFESSIONAL INFORMATION		
Name of Doctor	**Practice**	**Address & Phone Number**
	Family Doctor/GP	
	Psychiatrist	
	Dentist	
	Optometrist	
	Neurologist	
	Other:	
	Other:	
	Other:	
Date of last physical:	**Date of last dental visit:**	**Date of last eye exam:**

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LIST OF MEDICATIONS (if you need more space please write on back of this document)		
Name of Medication	**Dosage** (please identify if med is a PRN)	**Times taken**
Are you able to self-medicate? ☐ Yes ☐ No		

ADDITIONAL MEDICAL INFORMATION
Do you have a diagnosed Seizure Disorder? Yes: ☐ No: ☐ If yes, please describe type and frequency: Are your seizures controlled with the help of medication? Yes: ☐ No: ☐
Have you participated in a neuropsychological assessment? Yes: ☐ No: ☐ If yes, please provide the report and the doctor's name:
Do you smoke? If yes, how many cigarettes per day?
Do you have any allergies? If yes, please list:
Do you have any dietary restrictions? If yes, please list:
Have you received a swallowing assessment? If yes, what were the results/what level were you rated at?
Do you have any other medical or physical conditions (diabetes, heart condition, etc.) If yes, please describe:

PHARMACY INFORMATION (only required if applying for Residential Care (Group Living or SIL)
Please provide the name and address of your current Pharmacy:

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PSYCHIATRIC
Do you have a psychiatric diagnosis? ☐ Yes ☐ No If yes, Date/Year of Diagnosis: _____ Diagnosis:
Psychiatric Consult Notes: ☐ Included ☐ Report to follow ☐ Not available

SUBSTANCE ABUSE			
Pre-Injury History of Substance Abuse:	☐ Yes	☐ No	☐ Not known
Current Substance Abuse:	☐ Yes	☐ No	☐ Not known
If Yes, Substance Abuse Treatment Recommended:	☐ Yes	☐ No	
Are you presently undergoing treatment for addictions?	☐ Yes	☐ No	

LEGAL
Is there any history of criminal charges/probation? ☐ Yes ☐ No If yes, please describe:

EDUCATION AND EMPLOYMENT		
Name of Last School Attended:	Address of School:	
Level Attained:	Year Completed:	
Name of Last Employer:	Position:	Length (yrs):

FAMILY
On a scale of 1-5 (1= not involved, 5= very involved), what is the degree of involvement of your family in your care? Please list all family members active in your life, not mentioned above (names, relationship, etc.):

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INFO BELOW IS REQUIRED ONLY IF APPLYING FOR RESIDENTIAL CARE (Group Living, SIL, Host Family)

FINANCIAL INFORMATION ***(must be completed by person responsible for financial matters)***

Check any/all sources of income:

- ☐ Full-time Employment
- ☐ Part-time Employment
- ☐ Ontario Disability Support Program (ODSP)
- ☐ Ontario Works (OW)
- *ODSP #/Worker Name:*
- ☐ Passport Funding – Amt: _____
- ☐ Canada Pension Plan
- ☐ Long Term Disability (Private)
- ☐ Workplace Safety Insurance Board (WSIB)
- ☐ Inheritance
- ☐ Investments
- ☐ Retirement Savings Plan (RRSPs)
- ☐ Old Age Security (OAS/GIS)
- ☐ Other: _____
- ☐ Insurance Settlement/Structured Settlement ***(more info required below)***

Lawyer's Name: (if applicable) _____

Company: _____ Phone: _____

Insurance Adjuster Name: (if applicable) _____

Company: _____ Phone: _____

Rehabilitation Case Manager Name: (if applicable)_____

Company: _____ Phone: _____

Total amount of income received per month:

Do you have direct access to your income?:

Will the monthly amount of income that you receive change at any point?

If yes, on what date?:

Do you have your own bank account?

Please provide the name and address of the Banking Institution:

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INTERESTS, ABILITIES & SUPPORT NEEDS (please provide details below for each need/ability)	
Vision	
Hearing	
Communication/Speech	
Receptive Skills (ability to understand communication from others)	
Expressive Skills (ability to explain their thoughts)	
Cognitive difficulties (ie. memory, etc.)	
Mobility Issues	
Assistive Devices Needed	
Diet/Eating patterns or Food Allergies	
Bathing support needed	
Sleeping patterns	
Swimming Abilities	
Sharps	
Ability to stay home alone / How many hrs/days max?	
Hobbies/Leisure	
Social – any significant friendships?	
Dislikes	
Fears	
Triggers/Causes of challenging behaviors	
Behavioural Strategies	
Other Important Information related to support needs and abilities	

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INTERESTS, ABILITIES AND SUPPORT NEEDS
What are your future goals?
What are your likes/dislikes?
How do you get along with peers?
How do you react to big changes in your life?
Do you ever get upset? What might cause you get upset and what do you do to show your frustration?
Do you have support needs related to challenging behavior? (ie. PRN, Crisis Plan, etc.)
SUPPORT NEEDS – MOBILITY (only required if you have issues with your mobility)
Do you use an assistive device to support your mobility? (i.e. motorized or manual wheelchair, walker, etc.) If yes, please describe:
Do you *require* supervision or assistance to support your mobility? If yes, which? Does it apply to all surfaces, stairs, or both?:
If applicable, do you require transfer assistance to your wheelchair? If yes, full-transfer or stand-by assistance?

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ATTESTATION (note that all individuals who have provided information must sign)	
By signing below, I declare that the above information is true and correct to the best of my knowledge.	
Name (print)	Relationship (self, spouse, worker, etc)
Signature	Date (dd-mmm-yyyy)
Name (print)	Relationship (self, spouse, worker, etc)
Signature	Date (dd-mmm-yyyy)
Name (print)	Relationship (self, spouse, worker, etc)
Signature	Date (dd-mmm-yyyy)

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Medical Status Form

(Must be completed by a medical doctor)

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

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

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

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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:

_____ _____

Signature (of medical doctor) Date:

_____ _____

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

_____

_____

Please return form to:

Andrew Wyatt, RSW (he/him)
Client Services Manager, Intake and Employment
Pathways To Independence
T (613) 962 2541 ext. 287
C (613) 438 7188
F (613) 962 6357
andreww@pathwaysind.com
www.pathwaysind.com

Link to Policy: Yes■ No☐ If "yes" please specify Policy Title: ABI Intake, Tracking and Creation of Client File

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