

ATTENDANT SERVICES - PROJECT INFORMATION CENTRE
APPLICATION FOR ATTENDANT SERVICES IN TORONTO
 (ATTENDANT OUTREACH SERVICES, SUPPORTIVE HOUSING ATTENDANT SERVICES, TRANSITIONAL PROGRAMS)

| | | |
|---|-------------------------|------|
| APPLICANT (√): () New Application () Update | OFFICE USE: Date Rec'd: | ID#: |
|---|-------------------------|------|

PLEASE NOTE: THIS INFORMATION IS BEING COLLECTED FOR THE PURPOSE OF FACILITATING YOUR APPLICATION FOR ATTENDANT SERVICES AND SHALL ONLY BE RELEASED IN ACCORDANCE WITH THE TERMS SET OUT IN THIS APPLICATION OR AS THE CENTRE FOR INDEPENDENT LIVING IN TORONTO (C.I.L.T.) INC. - PROJECT INFORMATION CENTRE (PIC) MAY BE REQUIRED BY LAW.

PLEASE CHECK (√) AND MAKE SURE YOU MEET THE FOLLOWING ELIGIBILITY REQUIREMENTS BEFORE YOU COMPLETE THE APPLICATION.

- You have a valid Ontario Health Card (OHIP).
- You are at least 16 years of age.
- You have a PERMANENT PHYSICAL DISABILITY and require PHYSICAL ASSISTANCE with activities of daily living such as bathing, dressing, transferring and toileting.
- You must be able to clearly direct your own services.
- You must be able to have your health needs met by the existing community health network on a visitation basis.

IF YOU DO NOT MEET THE ABOVE ELIGIBILITY REQUIREMENTS, YOUR APPLICATION FOR ATTENDANT SERVICES WILL NOT BE ACCEPTED AND WILL BE RETURNED.

I. APPLICANT INFORMATION

| | | | |
|--|-----------|---|-----------------------|
| First name: | | Last name: | |
| Date of Birth (M / D / Y) : | | Gender: () Male () Female | Ethnicity (optional): |
| Languages spoken: | | Ethno-cultural preference (optional): | |
| ONTARIO HEALTH CARD NUMBER: | | <i>(Without this number, your application cannot be processed and will be returned to you.)</i> | |
| PHONE: | Home: () | Work: () | Cell: () |
| Fax: () | Pager: | Email: | |
| Other phone: | | | |
| CURRENT ADDRESS: Name of institution (if applicable) | | | |
| Street: | | Apt No. / Unit No.: | |
| City: | Province: | Postal Code: | |
| PERMANENT ADDRESS: () Same as Current Address | | Name of institution: | |
| Street: | | Apt No. / Unit No.: | |
| City: | Province: | Postal Code: | |
| MAILING ADDRESS: () Same as Current Address () Same as Permanent Address | | Name of institution: | |
| Street: | | Apt No. / Unit No.: | |
| City: | Province: | Postal Code: | |

ATTENDANT SERVICES - PROJECT INFORMATION CENTRE

Are you currently receiving services in your own home? () Yes () No

Are the services you currently receiving enable you to remain safely in your own home? () Yes () No

If NO, please explain: _____

| CURRENT SOURCES OF SERVICES | NAME OF ORGANIZATION | TYPES OF SERVICES | HRS./WK. |
|---|----------------------|-------------------|----------|
| () Attendant Outreach Service | | | |
| () Supportive Housing Unit | | | |
| () Transitional program | | | |
| () Community Care Access Centre(CCAC) | | | |
| () Community agency | | | |
| () Volunteer, family, friend, church group | | | |
| () Hospital or long term care facility | | | |
| () Other. (Please specify) | | | |

| CURRENT SOURCE OF INCOME | |
|--|---|
| () Employment () Ontario Disability Support Program () Old Age Security () Disability Insurance () Court Settlement () Canada Pension Plan – Disability | () Ontario Works (general welfare assistance) () Employment Insurance () Workplace Safety & Insurance Board () Personal Savings () Other; specify: |

| II. ALTERNATE CONTACT INFORMATION | | | |
|---|-----------|------------|--------------------|
| First name: | | Last name: | |
| Relationship: | | | |
| ADDRESS: Name of organization (if applicable) | | | |
| Street: | | | Apt No./ Unit No.: |
| City: | | Province: | Postal Code: |
| PHONE: | Home: () | Work: () | Cell: () |
| Fax: () | Pager: | Email: | |
| DID SOMEONE ASSIST YOU WITH FILLING OUT THIS APPLICATION? () No () Yes (If YES, please provide contact information below.) | | | |
| First name: | | Last name: | |
| Relationship: | | | |
| ADDRESS: Name of organization (if applicable) | | | |
| Street: | | | Apt No./ Unit No.: |
| City: | | Province: | Postal Code: |
| PHONE: | Home: () | Work: () | Cell: () |
| Fax: () | Pager: | Email: | |

III. DISABILITY INFORMATION

Select **ONE** main permanent physical disability that requires you to use attendant services (Do **NOT** choose more than **ONE**. List other additional disabilities at the bottom of this page):

| | |
|--|--|
| <input type="checkbox"/> Acquired Brain Injury | <input type="checkbox"/> Osteogenesis Imperfecta |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS) | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Arthritis/Rheumatic Conditions | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Friederich's Ataxia | <input type="checkbox"/> Spinal Muscular Atrophy |
| <input type="checkbox"/> Guillain-Barré Syndrome | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Huntington's Chorea | <input type="checkbox"/> Other (<i>Specify ONE only if it is NOT available from the list</i>): |
| <input type="checkbox"/> Multiple Sclerosis | _____ |
| <input type="checkbox"/> Muscular Dystrophy | |

Please describe how this disability affects your day-to-day functioning:

Was this disability:

Since Birth

Acquired (e.g. M.S.) Date: _____

Trauma (e.g. injury) Date: _____

Is your disability likely to:

Improve

Deteriorate

Remain Stable

Please explain: _____

OTHER DISABILITY:

Please list/describe any **other disabilities** or **medical conditions** that may affect delivery of your services (i.e., visual impairment/ blindness, hard of hearing/deafness, epilepsy, HIV/AIDs, etc):

IV. MEDICAL INFORMATION

Can your **medical** needs be met within the community; i.e., visiting nurses, etc.? () Yes () No

If NO, please explain: _____

Attendant services may include assisting you with medication. Please describe which **medications** you take at present including name, dosage and reason: (One line per drug)

FAMILY PHYSICIAN INFORMATION

| | | | |
|--|------------|--------------|----------|
| First name: | | Last name: | |
| ADDRESS: Name of institution (if applicable) | | | |
| Street: | | | Apt no.: |
| City: | Province: | Postal Code: | |
| PHONE: Work: () | Pager: () | Cell: () | |
| Fax: () | Email: | | |

VI. CURRENT LIVING SITUATION

WHAT IS YOUR CURRENT LIVING SITUATION (choose *ONE* only)

- Rehabilitation Hospital/Unit - Name: _____
- Chronic Care Hospital - Name: _____
- Children's Hospital- Name: _____
- Convalescent Hospital - Name: _____
- Nursing Home – Name: _____
- Long Term Care Homes / Home for the Aged – Name _____
- Living alone in Apartment/House
- Living alone with Dependent Child/Children – Their age range: _____
- Living with Parent/Step-Parents – Their age range: _____
- Living with Spouse/other Adult – Their age range: _____
- Living with Spouse/other Adult and Dependent Child/Children – Their age range: _____
- Living in Shared Housing or Supportive Housing Unit with Support Staff (i.e. 24 hour attendant services) – Name: _____
- Institution (e.g. large hospital, health centre) – Name: _____
- Transitional Program (with attendant services) – Name: _____
- Other. Please specify: _____

IS YOUR CURRENT LIVING SITUATION SUITABLE? :

- Yes
- No Please explain:
 - Living arrangements (i.e. living alone, elderly parents, personal difficulties etc.)
 - Architectural barriers (i.e. stairs, access to washroom, kitchen etc.)
 - Inadequate/lack of services
 - Geographic location (i.e. employment or educational opportunity, proximity to family)
 - Change in family size (i.e. children or other arrive or leave)
 - Other: Please specify: _____

APPLICANTS STAYING AT HOSPITAL / REHABILITATION UNIT MUST COMPLETE:

Name of Hospital: _____

Discharge date: _____

What is your mailing address when you are staying at hospital:

- Same as Current Address Same as Permanent Address Same as Mailing Address

OTHER ADDRESS: _____

PHONE: _____

What will be your living situation after you have discharged from hospital / rehabilitation unit?

- Nursing Home – Name: _____
- Long Term Care Homes / Home for the Aged – Name _____
- Living alone in Apartment/House
- Living with Dependent Child/Children – Their age range: _____
- Living with Parent/Step-Parents – Their age range: _____
- Living with Spouse/other Adult – Their age range: _____
- Living with Spouse/other Adult and Dependent Child/Children – Their age range: _____
- Other. Please specify: _____

VII. ACCOMMODATION INFORMATION (Applicants of supportive housing and shared living must complete this page.)

HOUSING INFORMATION:

() I will be living alone

() I will not be living alone

() I will live with a person who requires attendant services.

He/She must apply separately to PIC. To link applicants so services are introduced for both at the same time, please provide co-applicants's name and phone number here:

Name: _____ Phone: _____

Does your current living situation have rent supplement? () Yes () No

Do you need subsidized housing? () Yes () No

If YES, have you applied to Housing Connections? () Yes Application date: _____
() No

ACCOMMODATION PREFERENCES: Please **check (√)** which types of accommodation you would accept. If you have preference, among those choices, please rank them in order of preference 1, 2, 3, 4, 5, etc..

| CHECK (√) | RANK | TYPES OF ACCOMMODATION |
|-----------|------|------------------------|
| | | Bachelor apartment |
| | | One bedroom |
| | | Two bedroom |
| | | Three bedroom |
| | | Four bedroom |
| | | Shared accommodation |
| | | Any |

APPLICANTS FOR TRANSITIONAL HOUSING MUST ANSWER:

Do you have accommodation to move to when the transitional program is completed?

() Yes Where: _____

() No Will you require assistance in seeking accommodation?

() Yes

() No

VIII. ATTENDANT SERVICES QUESTIONNAIRE

(The following questions are necessary for planning purpose and because of certain cost sharing agreements with the Federal Government. They in no way affect your priority for service)

| | |
|--|---|
| Check (√) | Can you direct your attendant services? This means that you are able to take responsibility for yourself and tell the attendant what you need and how to perform the task. |
| <input type="checkbox"/> Yes, I am able to direct attendants verbally or otherwise. Explain: _____ _____ | |
| <input type="checkbox"/> No. If the answer to this question is NO, you are not eligible for attendant services. Please contact us for a more appropriate referral. | |

| | |
|---|--|
| Rank | What project categories would you prefer (rank in order of preference from 1 to 3)? |
| <input type="checkbox"/> Supportive housing <input type="checkbox"/> Shared Living <input type="checkbox"/> Outreach programs | |

| | |
|---|--|
| Check (√) | Please indicate your preference of services with (√): |
| <input type="checkbox"/> I will take the first supportive housing unit available. <input type="checkbox"/> I will take the first outreach project available. <input type="checkbox"/> I would prefer a new service provider because I have difficulty with the following project: _____ _____ | |
| <input type="checkbox"/> I would like to change to the following project: _____ Reasons: <input type="checkbox"/> job <input type="checkbox"/> school <input type="checkbox"/> proximity to friends <input type="checkbox"/> proximity to family <input type="checkbox"/> Others, please specify _____ _____ | |
| <input type="checkbox"/> I recommend the following service provider as an excellent attendant service provider. _____ | |

| | |
|--|----------------|
| Community Activity | |
| Are you currently working? | Yes () No () |
| If NO, what are your goals? _____ | |
| Are you a volunteer | Yes () No () |
| Are you going to school? | Yes () No () |
| Other: Please specify: _____ | |
| How would attendant services affect your current level of community activity? _____ _____ | |

ATTENDANT SERVICES - PROJECT INFORMATION CENTRE

IX. ATTENDANT SERVICES PROJECTS (Refer to the PIC Directory for description of these projects)

A. SUPPORTIVE HOUSING ATTENDANT SERVICES:

Please check (✓) which supportive housing projects you wish to apply.

| CHECK (✓) | NAME OF THE PROJECT | ADDRESS |
|---|---|--|
| | Access Apartments - York Square/Plaut Manor | 2468 & 2480 Eglinton Avenue W. |
| | Access Apartments - Aldebrain | 2155 Lawrence Avenue E. |
| | Access Apartments - St. Mark's | 7 The Donway E. |
| | Bellwoods Centres - Mimico Co-op | 1 Summerhill Road |
| | Bellwoods Centres - Shaw Street | 300 Shaw Street |
| | Bellwoods Centres - Dundas | 1082 Dundas Street W. |
| | Clarendon Foundation - Broadway | 8, 10, 12 Broadway Avenue |
| | Clarendon Foundation - Henry Lane/The Esplanade | 25, 49 Henry Lane Terrace; 140 The Esplanade |
| | Nucleus Housing - Trimbee Court | 30 Denarda Street |
| | Nucleus Housing - Humberview Co-op | 2100 Weston Road |
| | OMOD - McCaul | 22 McCaul Street |
| | OMOD - Bloor | 341 Bloor Street West |
| | PACE Independent Living - Bathurst/Prince Charles | 3270 Bathurst Street |
| | PACE Independent Living - Caboto Terrace | 3050 Dufferin Street |
| | PACE Independent Living - Windward Project | 34 Little Norway Crescent |
| | Three Trilliums - Elm Street | 25 Elm Street |
| | Three Trilliums - Walton Place | 835 Birchmount Road |
| | Tobias House - Carlton Ave | 84 Carlton Street |
| | Tobias House - Jarvis Street | 460 Jarvis Street |
| | Tobias House - Coxwell Ave | 695 Coxwell Avenue |
| ENHANCED SUPPORT PROJECT (see PIC Directory page 15) | | |
| | PACE Independent Living - Bello Horizonte) | 1500 Keele Street |
| SPECIALIZED PROJECT (Attendant services are not provided) (see PIC Directory page 15) | | |
| | NABORS - Chord Co-op | 43 & 53 Goldwin Avenue |
| | NABORS - Courtyards Co-op | 10 Broadway Avenue |
| YORK UNIVERSITY – STUDENTS, STAFF & FACULTY ONLY (see PIC Directory page 9) | | |
| | OMOD - York University | 4700 Keele Street |

B. SHARED LIVING ATTENDANT SERVICES:

Please check (✓) which shared living projects you wish to apply.

| CHECK (✓) | NAME OF THE PROJECT | ADDRESS |
|-----------|-------------------------------------|------------------------|
| | North Yorkers - Bayview & Sheppard | 2880 Bayview Avenue |
| | OMOD - Meynell House | 30 St. Lawrence Street |
| | Participation House - Condo Project | 11753 Sheppard Ave. E. |

ATTENDANT SERVICES - PROJECT INFORMATION CENTRE

C. ATTENDANT OUTREACH SERVICES

Please ensure that you reside in the service area listed. Alternatively, you may check "I will accept services from any of the following attendant outreach service providers".

I will accept services from any of the following attendant outreach service providers. OR

Please check (✓) which outreach projects you wish to apply.

| CHECK (✓) | NAME OF THE PROJECT | SERVICE AREA |
|-----------|---------------------------------|--|
| | Access Apartments | West to East Toronto, north of Eglinton Avenue. |
| | Bellwoods Centres | Entire city of Toronto |
| | Canadian Paraplegic Association | Entire city of Toronto. |
| | Canadian Red Cross | East York, North York, York, Scarborough, Etobicoke |
| | PACE Independent Living | East of Weston Road, from south to north Toronto |
| | Three Trilliums | Between Yonge St. & Roncesvalles Ave. and St. Clair Ave. & Lakefront |

D. TRANSITIONAL & LIFE SKILLS PROGRAMS:

Please check (✓) which transitional projects you wish to apply.

| CHECK (✓) | TRANSITIONAL & LIFE SKILLS PROGRAMS |
|-----------|---|
| | Gage Transition to Independent Living - 100 Merton Street (<i>With attendant services</i>) |
| | Bellwoods Centres Community Connect Program - 300 Shaw Street (<i>With attendant service. Only those individuals currently in acute care, rehab, Complex Continuing Care hospitals or LTCH are eligible for this program.</i>) (<i>Applicants please complete page 14 of this application.</i>) |
| | Bellwoods Centres MILE Program - Home-based (<i>Applicants please complete page 14 of this application.</i>) |

X. ATTENDANT SERVICES LEVEL

Please indicate average level of attendant services required:

(If this application is for BOTH Attendant Outreach and Supportive Housing / Transitional program, please check (✓) a box for each.)

| (✓) | ATTENDANT OUTREACH SERVICES | (✓) | SUPPORTIVE HOUSING / TRANSITIONAL PROGRAM |
|-----|------------------------------|-----|---|
| | Less than 1 ½ hours daily | | Less than 1 ½ hours daily |
| | Between 1 ½ to 3 hours daily | | Between 1 ½ to 3 hours daily |
| | Between 3 to 4 hours daily | | Between 3 to 5 hours daily |
| | More than 4 hours daily | | Between 5 to 6 hours daily |
| | | | More than 6 hours daily |

OUTREACH ATTENDANT SERVICE APPLICANTS ONLY:

Approximately, how many days per month would you require service? _____ Days per month

(There is currently a ceiling of 90 hours of services per month.)

ATTENDANT SERVICES - PROJECT INFORMATION CENTRE

XI. ATTENDANT SERVICES CHECKLIST

Please check (✓) which services you require and specify types of assistance and hours of services per week:

| SERVICES | (✓) | SPECIFY TYPES OF ASSISTANCE | HRS/WEEK |
|------------------------------------|-----|-----------------------------|----------|
| 1. TRANSFERS | | | |
| a. Into/out of bed | | | |
| b. Onto/off toilet/commode | | | |
| 2. BOWEL AND BLADDER | | | |
| a. Bladder - condom catheter | | | |
| b. Bladder -indwelling catheter | | | |
| c. Bladder -intermittent catheter | | | |
| d. Bladder -night bag | | | |
| e. Bowel | | | |
| f. Ileo-conduit care | | | |
| g. Bed pans/Urinal | | | |
| 3. DRESSING & UNDESSING | | | |
| a. Lower body | | | |
| b. Upper body | | | |
| c. Outer wear | | | |
| d. Buttons/zippers hooks | | | |
| e. Corset brace prosthesis on/off | | | |
| 4. SKIN CARE | | | |
| a. Turns at night | | | |
| b. Skin Care | | | |
| 5. BREATHING ASSISTANCE | | | |
| a. Suctioning | | | |
| 6. GENERAL HYGIENE | | | |
| a. Bath/shower | | | |
| b. Bed Bath | | | |
| c. Grooming | | | |
| d. Peri-care | | | |
| e. Sanitary pads and tampons | | | |
| f. Adult Diapers | | | |
| 7. MEALS AND DRINKS | | | |
| a. Cooking | | | |
| b. Cutting up food | | | |
| c. Feeding | | | |
| d. Splints | | | |
| e. Drinks | | | |

ATTENDANT SERVICES - PROJECT INFORMATION CENTRE

| SERVICES | (✓) | SPECIFY TYPES OF ASSISTANCE | HRS/WEEK |
|------------------------|-----|-----------------------------|----------|
| 8. MISCELLANEOUS | | | |
| a. Doors | | | |
| b. Medication | | | |
| c. TV/radio/stereo | | | |
| d. Locks/keys | | | |
| e. Money-handling | | | |
| f. Windows; open/close | | | |
| g. Smoking | | | |
| | | | |
| | | | |
| | | | |

Indicate (✓) if and when services are needed. (NOT all Attendant Service Providers offer these supports)

| ESCORT/SUPPORT ACTIVITIES | Daily | Weekly | Bi-weekly | Monthly |
|--|-------|--------|-----------|---------|
| a. Grocery shopping | | | | |
| b. Personal shopping | | | | |
| c. Banking | | | | |
| d. Medical/dental appointments | | | | |
| e. Personal vehicle - van, car | | | | |
| f. Other-periodic assistance with isolated activities (i.e. personal correspondence) | | | | |
| g. Others, please specify: | | | | |
| | | | | |

Do you require assistance with housekeeping? () Yes () No () Partially

ATTENDANT SERVICES - PROJECT INFORMATION CENTRE

NURTURING ASSISTANCE: (Please complete this page if you need nurturing assistance)

Nurturing Assistance is a consumer-directed service that provides physical assistance to parents who have physical disabilities with caring of their young children. It is not babysitting or day care services.

Do you require nurturing assistance? () Yes () No

If YES, please indicate number of children: _____ and specify their genders and age:

| | GENDER | AGE | NOTES (HEALTH CONDITION, ETC) |
|---|--------|-----|-------------------------------|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |

Indicate (√) if and when services are needed.

| NURTURING ASSISTANCE ACTIVITIES | YES | NO | SOMETIMES |
|---|-----|----|-----------|
| a. Bathing | | | |
| b. Grooming | | | |
| c. Dressing and undressing | | | |
| d. Holding | | | |
| e. Cuddling | | | |
| f. Changing diapers | | | |
| g. Lifting and carrying the child to the parent | | | |
| h. If mother is breastfeeding, assist with positioning | | | |
| i. If formula is used, prepare formula and bottles according to the parent's direction | | | |
| j. Feeding and assisting with feeding | | | |
| k. Assist with parent hand washing, position receiving blanket(s) | | | |
| l. Assist parent with burping child | | | |
| m. Washing/drying family dishes | | | |
| n. Baby's laundry | | | |
| o. Keeping baby's furniture (crib, change table, etc.) clean | | | |
| p. Dusting and cleaning baby's belongings | | | |
| q. Caring for baby's belongings | | | |
| r. Assistance in tidying other rooms as needed | | | |
| s. Organize child's play area to facilitate parent-child interaction | | | |
| t. Position baby with parent for play; assist in activity involving music, songs, dancing, clapping | | | |
| u. Accompany the parent and child to go for walks, pushing stroller | | | |
| v. Accompany the parent and child to go shopping, e.g., helping in and out of car seat | | | |
| w. Others, please specify: | | | |
| x. Others, please specify: | | | |

ATTENDANT SERVICES - PROJECT INFORMATION CENTRE

BELLWOODS CENTRES' COMMUNITY CONNECT AND MILE APPLICANTS, PLEASE COMPLETE

IMPORTANT: *If you have selected Bellwoods Centres' Community Connect and MILE Program, please complete this.*

COMMUNITY CONNECT PROGRAM: Supportive Housing at 300 Shaw Street (Attendant Services are provided)

The Community Connect Program is an up to 6-month or up to 14-month residential independence training program, with program coordination, designed to facilitate the individual's successful transition from institution to community through safe living education and 24/7 access to personal support services.

Please indicate (✓) which of the following safety areas you need to work on:

| | | | |
|---|--|---|--|
| Living Situation/Housing <i>Eg. seek accessible housing, change in living conditions</i> | | Medication <i>Eg. prescribed/non-prescribed drugs</i> | |
| Communication and Scheduling <i>Eg. telephone use/emergency number, learn to direct your services, ability to schedule, seek and training in use of AAC equipment</i> | | Kitchen <i>Eg. microwave, stove, food supply/storage</i> | |
| Mobility <i>Eg. seek equipment and/or training with walking/devices, wheelchair/ scooter/transfers, venturing outdoors</i> | | Household <i>Eg. meal preparation, shopping, money management</i> | |
| Personal Care <i>Eg. seek equipment and/or training in use of personal equipment, dress/undress, hair care</i> | | Environmental Hazards <i>Eg. manage clutter</i> | |
| Bathroom and Toilet <i>Eg. seek bathroom/toilet equipment, training in bath/shower method, non-slip aids, toileting transfer</i> | | Finances <i>Eg. budgeting, accessing ODSP and funding sources for equipment</i> | |
| Eating <i>Eg. feeding ,nutrition</i> | | Medical and Other Professional Assistance <i>Eg. accessing family physician, social work support, other</i> | |
| Community Services <i>Eg. accessing personal care/attendant services, shopping, mental health or addiction support</i> | | | |

MILE PROGRAM: (Home-based)

The MILE Program provides ongoing independence training including

- Program coordination including accessing resources such as community services, accessible housing, personal care/mobility, equipment and maintenance, medical and other professional assistance and financial resources
- Skills development in home and community activities

Please indicate (✓) which of the following safety areas you need to work on:

| | | | |
|---|--|--|--|
| Living Situation/Housing <i>Eg. seek accessible housing, change in living conditions</i> | | Medication <i>Eg. prescribed/non-prescribed drugs</i> | |
| Communication and Scheduling <i>Eg. telephone use/emergency number, learn to direct your services, ability to schedule, seek and training in use of AAC equipment</i> | | Kitchen <i>Eg. microwave, stove, food supply/storage</i> | |
| Mobility <i>Eg. seek equipment and/or training with walking/devices, wheelchair/ scooter/transfers, venturing outdoors</i> | | Household <i>Eg. meal preparation, shopping, money management</i> | |
| Personal Care <i>Eg. seek equipment and/or training in use of personal equipment, dress/undress, hair care</i> | | Environmental Hazards <i>Eg. manage clutter</i> | |
| Bathroom and Toilet <i>Eg. seek bathroom/toilet equipment, training in bath/shower method, non-slip aids, toileting transfer</i> | | Finances <i>Eg. budgeting, accessing ODSP and funding sources for equipment</i> | |
| Eating <i>Eg. feeding ,nutrition</i> | | Medical and Other Professional Assistance <i>Eg. accessing family physician, social work support, other</i> | |
| Community Services <i>Eg. accessing personal care/attendant services, heavy housekeeping, shopping, home maintenance, grass cutting, snow shovelling, or mental health or addiction support</i> | | Leisure/Employment/ School/Volunteering <i>Eg. hobby/employment/school/volunteering/ safety, accessing resources</i> | |

XII. DECLARATION, CONSENT TO DISCLOSURE OF APPLICANT INFORMATION AND RELEASE FROM LIABILITY

I _____, of _____ declare that
Applicant's or authorized representative's name City, Province

the information contained in this application is complete and correct, to the best of my knowledge.

I hereby authorize the *Centre for Independent Living in Toronto (C.I.L.T.) Inc. - Project Information Centre (PIC)* to forward the information contained in the application and supporting documents to the attendant service providers listed in the PIC application and/or to the following agencies/individuals (e.g. spouse, parents, social worker, etc.) specifically for the purpose of discussing this application for attendant services and/or of receiving attendant services.

| NAME | PHONE NUMBER | RELATIONSHIP | ORGANIZATION (if applicable) |
|------|--------------|--------------|------------------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

I understand that any Attendant Service Provider listed in the PIC application is hereby authorized and directed to inform the Project Information Centre of assessment results or significant information that affects the provision of attendant services including the commencement or termination of my attendant services with that Attendant Service Provider.

I understand that all Attendant Service Providers will discuss the contents of this application with PIC and/or amongst (between) themselves for the purpose of making attendant services available to me more quickly.

I understand that any Attendant Service Provider listed in the PIC application will contact me for assessment.

I understand that by virtue of being deemed eligible for acceptance into the PIC database I agree to inform PIC of any changes affecting that eligibility, including providing PIC with information about:

- Any change of my address
- Any change in my family or other status that affects my housing requirements
- Any change in my disability and resulting change in attendant service requirements
- The commencement or termination of my attendant services by my selected attendant service providers
- My continued interest or need to remain "active" on the PIC database.

ATTENDANT SERVICES - PROJECT INFORMATION CENTRE

I ACKNOWLEDGE AND AGREE THAT THE *CENTRE FOR INDEPENDENT LIVING IN TORONTO (C.I.L.T.) INC. - PROJECT INFORMATION CENTRE (PIC)* NEITHER WARRANTS THE SERVICES PROVIDED BY ANY ATTENDANT SERVICE PROVIDER NOR ACCEPTS ANY LIABILITY OR RESPONSIBILITY FOR ANY HARM THAT I MAY SUFFER ARISING OUT OF OR CONNECTED IN WAY TO MY RECEIVING ATTENDANT SERVICES FROM AN ATTENDANT SERVICE PROVIDER.

I ALSO AGREE THAT I WILL RELEASE AND HOLD HARMLESS THE *CENTRE FOR INDEPENDENT LIVING IN TORONTO (C.I.L.T.) INC. - PROJECT INFORMATION CENTRE (PIC)*, TOGETHER WITH ITS EMPLOYEES, DIRECTORS AND OFFICERS, AS WELL AS THE ATTENDANT SERVICE PROVIDERS LISTED IN THE PIC APPLICATION, FROM ALL LIABILITY FOR ANY HARM OR ANY DAMAGES THAT I MAY SUFFER AS A RESULT OF THE RELEASE OR DISCLOSURE, IN ACCORDANCE WITH THE TERMS OF THIS CONSENT, BY THE *CENTRE FOR INDEPENDENT LIVING IN TORONTO (C.I.L.T.) INC. - PROJECT INFORMATION CENTRE (PIC)* OR BY THE ATTENDANT SERVICE PROVIDERS LISTED IN THE PIC APPLICATION OF PERSONAL INFORMATION ABOUT ME.

I hereby declare that I fully understand the terms of this agreement and that I have been afforded the opportunity to get legal advice prior to the signing of this document.

Signature of Applicant

Signature of Witness

Name of Applicant

Name of Witness

Date of Signature

Date of Signature

| | |
|---------------------|---|
| PLEASE NOTE: | This information is collected, and personal privacy protected, under the Province of Ontario's <u>Personal Health Information Protection Act, 2004</u> , the <u>Freedom of Information and Protection of Privacy Act</u> , and the Federal <u>Access to Information Act</u> . |
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| Please mail or deliver the form to: | Contact information: |
| Project Information Centre c/o Centre for Independent Living in Toronto (CILT) Inc. 365 Bloor Street East, Suite 902 Toronto, Ontario, M4W 3L4 | Tel: 416-599-2458 ext. 223 Fax: 416-599-3555 Email: pic@cilt.ca Website: www.cilt.ca |

Note: Fax is not a secure way to send personal information. If your faxed application is not clear or if some pages are missing, we will return it to you without putting you on the waiting list.

ATTENDANT SERVICES - PROJECT INFORMATION CENTRE

CHECKLIST

Please use this checklist to make sure you have completed the required information. If your application is incomplete, we will return it back to you without putting you on the waiting list.

PLEASE CHECK (✓) APPROPRIATE BOXES:

| COMPLETED | NOT APPLICABLE | PAGE NO. | SECTIONS |
|-----------|----------------|----------|---|
| | | 1 | ELIGIBILITY REQUIREMENTS CHECKLIST |
| | | 1 - 2 | I. APPLICANT INFORMATION (i.e. Current Source of Services & Income) |
| | | 2 | II. ALTERNATE CONTACT INFORMATION |
| | | 3 | III. DISABILITY INFORMATION |
| | | 4 | IV. MEDICAL INFORMATION (i.e. Family Physician Information) |
| | | 5 | V. PHYSICAL INFORMATION (i.e. Transfer, Communication, Assistive Devices) |
| | | 6 | VI. CURRENT LIVING SITUATION |
| | | 7 | VII. ACCOMMODATION INFORMATION (i.e. Accommodation Preference) |
| | | 8 | VIII. ATTENDANT SERVICES QUESTIONNAIRE |
| | | 9-10 | IX. ATTENDANT SERVICES PROJECTS |
| | | 10 | X. ATTENDANT SERVICES LEVEL |
| | | 11-12 | XI. ATTENDANT SERVICES CHECKLIST |
| | | 13 | NURTURING ASSISTANCE |
| | | 14 | BELLWOODS CENTRES' COMMUNITY CONNECT & MILE PROGRAMS |
| | | 15-16 | XII. DECLARATION, CONSENT TO DISCLOSURE & RELEASE FROM LIABILITY |

NOTE:

Please keep a copy of your application for your information and for updating your application in the future. It is ***your responsibility*** to keep your application up to date. If your contact information changes, inform us right away. ***Your application will become inactive if we cannot contact you.***

This is ***your application***. Physical assistance may be used to record your responses, but family members, professionals or others may not make submissions on your behalf.