

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

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

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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 Provider			
() 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):

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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:	

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V. PHYSICAL INFORMATION

Height: _____ (cm)

Weight: _____ (kg)

Do you wear glasses/contacts? () Yes () No

Do you use a hearing aid? () Yes () No

Can you bear weight? () Yes () No () Partially

Do you require transfers? () Yes () No () Not applicable in my current situation

Do you require more than one assistant for transfers? () Always () Occasionally () Never

What type(s) of transfer do you use?

() Pivot - with minimal assistance

() Pivot - with full assistance

() Mechanically Assisted Transfer

() Two Person Lift

() Towel or Transfer Board

() Other, please specify: _____

ESSENTIAL COMMUNICATIONS:

Can you communicate verbally? () Yes () No () Partially / Sometimes

Do you need assistance to use the telephone? () Yes () No () Partially / Sometimes

Do you need assistance with other communication aids? () Yes () No () Partially / Sometimes

What communication systems / aids do you use?

() Bliss Board

() BOCAID

() Dynamyte system

() Other, please specify: _____

() Voice system

() Voice output devices

() Word board

() Voice activation software

() Voice amplifier

ASSISTIVE DEVICES: Please indicate (✓) which, if any, of the following you use:

() Canes/crutches/walker

() Electric wheelchair

() Manual wheelchair

() Scooter

() G-tube feeding

() Ventilator/breathing assist

() Maintenance of devices indicated (including battery charging of electronic devices)

() Other, please specify:

() Braces

() Bath seat / bath or shower bench

() Raised toilet seat

() Commode

() Ceiling track lift

() Portable mechanical lift (electric or manual)

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: _____
- 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 Service Living 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: _____
- 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 be living with another person
 Will this person require attendant services?
 () No
 () Yes **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 (<input type="checkbox"/>) No (<input type="checkbox"/>)
If NO, what are your goals?	_____
Are you a volunteer	Yes (<input type="checkbox"/>) No (<input type="checkbox"/>)
Are you going to school?	Yes (<input type="checkbox"/>) No (<input type="checkbox"/>)
Other: Please specify:	_____
How would attendant services affect your current level of community activity?	_____

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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
	OMOD - York University (For Students, staff & faculty)	4700 Keele Street
	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

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 St. Lawrence	30 St. Lawrence Street
	Participation House - Condo Project	11753 Sheppard Ave. E.

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C. OUTREACH ATTENDANT SERVICES

Please ensure that you reside in the service area listed. Alternatively, you may check "I will accept services from any of the following outreach service providers" and PIC will select those that serve your area.

I will accept services from any of the following 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	Certain areas in Downtown & Scarborough, see PIC Directory page 6

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.) (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 Outreach and Supportive Housing /Transitional attendant services, please check (✓) a box for each.)

(✓)	OUTREACH ATTENDANT SERVICES	(✓)	SUPPORTIVE HOUSING / TRANSITIONAL
	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
(The policy for attendant outreach requires that persons who need more than 90 hours per month to receive Ministry approval.)

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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			

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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

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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:			

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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: Project Information Centre c/o Centre for Independent Living in Toronto (CILT) Inc. 365 Bloor Street East, Suite 902 Toronto, Ontario, M4W 3L4	Contact information: Tel: 416-599-2458 ext. 223 Fax: 416-599-3555 Email: pic@cilt.ca Website: www.cilt.ca
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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.

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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.