MARCH OF DIMES CANADA | LA MARCHE DES DIX SOUS DU CANADA

Service Application –Brain Injury

This form is consistent with Policy BI 02 01

Purpose

March of Dimes Canada (MODC) collects personal information for a variety of purposes including the delivery of services, fundraising, quality management, research, billing and meeting legal and regulatory requirements.

MODC utilizes several safeguard measures to protect personal information and keep it confidential and will not share any personal information with any third parties unless it is directly related to the delivery or enhancement of the services that MODC provides or unless a Canadian law requires it.

Personal information that is no longer required to fulfill the identified purposes will be destroyed, erased, or made anonymous. MODC has guidelines and procedures to prevent unauthorized access and to govern the destruction of personal information.

The full MODC Personal Information Protection (Privacy) Policy is available on the MODC website or by request.

Consent

I fully understand the reasons March of Dimes Canada (MODC) has requested my personal information and I give consent to MODC to use my personal information for the purposes outlined. I also understand that I may withdraw my consent at any time, subject to legal or contractual obligations and reasonable notice, and that MODC will inform me of the implications of such withdrawal.

Client Name [active SDM where authorized] *(please print)*:	Signature:	Date: *(mm/dd/yy)*
Witness Name * *(please print)*:	Signature:	Date: *(mm/dd/yy)*
Supervisor/Program Manager/ Designate Name *(please print)*:	Signature:	Date: *(mm/dd/yy)*

* Only required when Client is unable to sign on their own

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PLEASE NOTE:
This application form is only to be used to apply for MODC Brain Injury Services. Should you also be interested in Attendant Services programs, you can download an application at https://www.marchofdimes.ca/en-ca/programs/acsh/attendantcare/Pages/default.aspx or contact your local MODC office.

Applicant Name:	**Office Use Only**
Date:	**Client #:**

March Of Dimes Canada Community Support Services Living Office List

You may apply to more than one office and/or location. A separate application will have to be completed for Attendant Services and Brain Injury Programs. Please select all applicable locations/offices below:

***If an applicant declines an offer to one or more of their selected locations/offices, they will be removed from that location/office's waiting list and the date of decline will become the new date of application for all remaining applicable locations/offices.**

LEGEND

AS – Attendant Services **BI – Brain Injury** **OAS – Outreach Attendant Services**
OS – Outreach Services **SHP – Supportive Housing Program** **CCH – Congregate Care Home**
Bdrm – Bedroom

LOCATIONS	OFFICES
☐ **Central Ontario** Community Support Services Office Oak Ridges 13311 Yonge St, Suite 202 Richmond Hill, ON L4E 3L6 (905) 773-7758 x 6216 **1-800-567-0315 x 6216** Fax: (905) 773-5176	☐ **Simcoe Region: BI Community Outreach Groups** 136001 ☐ **York Region: BI Community Outreach Groups** 136001 ☐ **York /Simcoe: York-Simcoe Brain Injury Services** OS 119011 ☐ **Newmarket: Heritage East** SHP BI 136004 1 bdrm, shared 2 bdrm ☐ **York Region:** BI OS 136002
☐ **Toronto Central** Community Support Services 125 Mill Street, Ste 313 Toronto, ON M5A 1G9 **(437) 216-9480**	☐ **Toronto: Cooperage St.**, BI SHP 118008 1 bdrm
☐ **East Ontario** Community Support Services Office 6 Glenn Wood Place Brockville, ON K6V 2T3 1-888-252-9008 x6408 Fax: (613) 342-7636	☐ **Brockville/Smiths Falls:** BI 132002

LOCATIONS	OFFICES
☐ **North Eastern Ontario** 96 Larch St., Unit 400 Sudbury, Ontario P3E 1C1 BI Enquiries: (705) 671-3188 Fax: (705) 671-6240	☐ **Espanola/Manitoulin:** BI OS 135006 ☐ **Elliot Lake:** BI 135006 ☐ **Kirkland Lake/Temiskaming:** BI OS 135006 ☐ **North Bay:** BI OS 135006 ☐ **Sault Ste. Marie:** BI OS 135006 ☐ **Sudbury:** BI OS 135006 ☐ **Timmins:** BI OS 135006 ☐ **Sudbury Day Centre**: BI 135005 ☐ **Sudbury:** BI SHP 135009 1 bdrm ☐ **Sudbury Congregate Care:** 135011 ☐ **Sault Ste. Marie Congregate Care:** 135008

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Unless otherwise noted within a section, the information in this form is required so that we may assess your entitlement to Brain Injury Services. The information will be kept confidential and will only be provided to persons who require the information in order to consider your application or in order to provide service to you.

	For Office Use Only:			
	Customer Type: ☐ Bill-to Customer ☐ Referral Source *(please specify)*:			
***Indicates required fields**	Client #:	Disability Code:	Date Stamp:	Initials:

Applicant Information

☐ **Mr.** ☐ **Mrs.** ☐ **Ms.**	***First Name:**	***Last Name:**
Preferred Name:		**Preferred Pronoun (optional):**

***Street Address *(#, street, suite)*:**

***City/Town:**	***Province** *(2-letter abbreviation)*:	***Postal Code:**
***Home Phone:** ( )	**Fax:** ( )	
Cell Phone: ( )	**E-mail Address:**	
***Gender:** ☐ Male ☐ Female ☐ Other ☐ Prefer not to answer	**Marital Status:** ☐ Married ☐ Common-law ☐ Single ☐ Separated ☐ Divorced ☐ Widowed	
***Birth Date** *(mm/dd/yy):*	***Do you have a valid Ontario Health Card?** ☐ Yes ☐ No (Must show @ intake interview)	***** Health Card Expiry Date** (where applicable)

Family Physician Information

Name:	
Address:	**Phone #**

Emergency Contact Information

Emergency Contact Name:	
Relationship:	**Emergency Contact Phone:**
Emergency Contact Address:	

Name of person completing referral:

Organization:

Relationship:

Address:

Service Application –Brain Injury

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Phone:

Documentation Confirming Brain Injury: ☐ **Enclosed** ☐ **To be forwarded**

Type of Brain Injury Service being applied to for specific location:

Sub-Program: ☐ Outreach Services ☐ Supportive Housing Program ☐ Congregate Care Home ☐ Groups

If applying to Supportive Housing Program, please specify number of bedrooms:

Have you previously applied for March of Dimes Canada services: ☐ Yes ☐ No ☐ Not Sure

If yes, when? *(mm/dd/yy)*: **And for what service?:**

Language(s) Spoken: ☐ English ☐ French ☐ Sign language ☐ Other: *(specify)*
What is your mother tongue?
If your mother tongue is not French or English, in which of Canada's official languages are you most comfortable? ☐ *English* ☐*French*

(This data is collected for statistical purposes only and is not part of admission criteria)

Ethnicity: ☐ African ☐ Asian ☐ Indian / Pakistani ☐ Other European ☐ Native Canadian/American ☐ Spanish/Portuguese ☐ Other ☐ Refuses/No Answer

Disability / Medical History Information

Date of Injury *(mm/dd/yy):*

Nature / Type of Injury / Event

☐ Anoxia	☐ Motor Vehicle Collision	☐ Tumor	☐ Other:
☐ Assault	☐ Sports	☐ Viral Infection	
☐ Fall	☐ Stroke	☐ Work-Related Injury	

Circumstances surrounding injury:

Have you ever been involved in a motor vehicle or work-related injury? ☐ Yes ☐ No

Previous Medical / Rehabilitation Facilities

Facility Name	Length of Stay

Please list / indicate any other disabilities or medical conditions that may affect delivery of your services: (i.e., an unstable medical condition, diabetes, difficulty with swallowing, allergies, communicable diseases, special diet, heart disease)

Neuropsychological Assessments Completed: ☐ **Yes** ☐ **No**

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Date Completed: *(mm/dd/yy)*	**By Whom:**
Address:	
Phone:	
Precautions related to above stated conditions:	

Current Medications

Medication	Dosage	Reason

Medication Administration:

Self: ☐ Yes ☐ No **Others:** ☐ Yes ☐ No

Please describe:

Seizures

Do you experience Seizures: ☐ **Yes** ☐ **No**

If yes, date of last Seizure:

Please describe:

Do you have a DNR: ☐ **Yes** ☐ **No**

Documentation confirming DNR: ☐ **Yes** ☐ **No**

Medical Information Prior to Brain Injury

Please list any illnesses, injuries or diagnosis prior to injury, and any related hospitalizations, treatments, etc. *(If additional space is required, please attach separate sheet.)*

Assistive Devices

Please indicate which, if any, of the following you use:

- ☐ Canes / Crutches / Walker
- ☐ Wheelchair (electric / manual)
- ☐ Scooter
- ☐ G-Tube Feeding
- ☐ Ventilator / breathing assist
- ☐ Braces
- ☐ Bath seat bench
- ☐ Support Bars
- ☐ Raised Toilet Seat
- ☐ Lifts (Hoyer, ceiling tracking)
- ☐ Trache
- ☐ Communication Devices
- ☐ Technical Aids (ie. Palm pilot)
- ☐ Other, please *specify:*

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

Social Information

Living Conditions	Living Arrangements
☐ Home (Rented)	☐ Live alone
☐ Home (Owned)	☐ Live alone with dependent children
☐ Home (Family Or Friend)	☐ Live with parents or step-parents
☐ Children's Hospital	☐ Live with spouse or other adults
☐ Convalescent Hospital	☐ Live with spouse or other adults and dependent children
☐ Long Term Care Setting	☐ Live in Shared Housing with support staff
☐ Hospital (Please name):	☐ Other: *(please explain)*
☐ Institution	
☐ Other: *(please explain)*	

Applicants who are now staying at hospital / rehabilitation unit

Anticipated Discharge Date:

What will your living situation be after you are discharged from hospital / rehab unit?

Decision Making

Do you have an Active Substitute Decision-Maker? ☐ Yes ☐ No

If yes, specify:

Power of Attorney for Personal care: ☐ Yes ☐ No **Legal Guardian** ☐ Yes ☐ No

Power of Attorney for Property: ☐ Yes ☐ No **Public Guardian/Trustee** ☐ Yes ☐ No

Please provide documentation if one of the above applies to you.

Has there been a capacity assessment: ☐ Yes ☐ No

If Yes, please provide copy with this application

Current Professional Services *(Please specify any assistive services that you currently receive)*

Service	Agency / Provider Name	Number of visits per week / month	Duration of each visit
Homemaking			
Physiotherapy			
Occupational Therapy			
Nursing			
Attendant Services			
Physicians (psychologists, psychiatrists, neurologists, etc)			
Other *(specify)*:			
Other *(specify)*:			

Additional Professionals / Agencies Currently Involved

Service	Company / Firm	Contact	Phone
Adjuster			
Lawyer			
Case Manager			
Other			

Please describe your current support from family and friends:

What activities do you currently enjoy doing?

Please indicate which of the following areas you wish to work on and set goals around. If an interest of yours is not listed, please add it under other:

- ☐ Learning to direct your services
- ☐ Behaviour Management
- ☐ Cognitive Skills
- ☐ Communication Skills
- ☐ Healthy Eating / Cooking
- ☐ Leisure Activities
- ☐ Managing Finances
- ☐ Community Integration
- ☐ Finding schooling, work or volunteer opportunities
- ☐ Socialization
- ☐ Personal safety at home & in the community
- ☐ Making your home more accessible
- ☐ Physical fitness
- ☐ Other:

Please list your Volunteer / Employment Record:

Highest grade / level attained:	**If in school, name of school:**

Additional Comments:

Privacy Statement

March of Dimes Canada is committed to handling any personal information that we may collect concerning you and your family member(s) in a professional, respectful, and lawful manner. March of Dimes Canada collects, uses, and discloses personal information in accordance with this privacy statement and our privacy policy. The personal information about you and your family member(s) is used for the purposes of:

i) contacting you about the status of your application(s)
ii) obtaining feedback about March of Dimes Canada services you receive
iii) providing information about March of Dimes Canada to you and others
iv) complying with the laws and regulations that require the collection, use and disclosure of personal information in connection with the Brain Injury program

The personal information collected about you and your family member(s) includes information supplied by you in your application for funding assistance and any additional or updated information which we may collect from you in the future.

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Additional Applicant Information

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Education:

- ☐ Grade 6 or less
- ☐ Grade 7
- ☐ Grade 8
- ☐ Grade 9
- ☐ Grade 10
- ☐ Grade 11
- ☐ Grade 12
- ☐ High School Diploma
- ☐ Business/Trade School
- ☐ Community College
- ☐ Law Degree
- ☐ Doctorate
- ☐ Bachelor's
- ☐ Master's
- ☐ Do not wish to comment

***Annual personal income range:** *(check only one)*

- ☐ under $5,000
- ☐ $5,000 - 9,999
- ☐ $10,000 - 14,999
- ☐ $15,000 - 19,999
- ☐ $20,000 - 24,999
- ☐ $25,000 - 29,000
- ☐ $30,000 - 34,999
- ☐ $35,000 - 39,999
- ☐ $40,000 - 44,999
- ☐ $45,000 - 49,999
- ☐ $50,000 - 54,999
- ☐ $55,000 or over
- ☐ Do not wish to comment

***Annual household income range:** *(check only one)*

- ☐ under $5,000
- ☐ $5,000 - 9,999
- ☐ $10,000 - 14,999
- ☐ $15,000 - 19,999
- ☐ $20,000 - 24,999
- ☐ $25,000 - 29,000
- ☐ $30,000 - 34,999
- ☐ $35,000 - 39,999
- ☐ $40,000 - 44,999
- ☐ $45,000 - 49,999
- ☐ $50,000 - 54,999
- ☐ $55,000 or over
- ☐ Do not wish to comment

Personal Income Source(s):

- ☐ Employment
- ☐ Spousal Support
- ☐ WSIB
- ☐ Savings/Trust
- ☐ Canada Pension Plan
- ☐ Family Benefits
- ☐ Private Pension
- ☐ Insurance Benefits
- ☐ Company Pension
- ☐ Disability Veterans Allowance
- ☐ Employment Insurance
- ☐ Other *(i.e., ODSP)*
- ☐ Do not wish to comment

Declaration and Signatures

In the event that the Client is only able to provide verbal consent, the signature of a witness is required. The Witness, when required, acknowledges that the Client has confirmed that the Supervisor/Designate has explained each clause of this document to him or her and that the Client appears to have fully understood this document.

This form may be signed by either the Client or their active Substitute Decision-Maker (SDM). Where there is a signature of an active SDM, March of Dimes must have documentation validating status as a Substitute Decision-Maker on file.

I, _____ have reviewed this Brain Injury Service Application and agree that the contents of this application are a true and accurate reflection of my needs.

In the event that March of Dimes Canada is unable to reach me regarding placement on the waitlist, I agree that staff may contact my referral source and/or the emergency contact person for assistance in locating me.

Name of applicant/active substitute decision-maker *(print name)*:	**Signature:**	**Date** *(mm/dd/yy)*:
Name of Witness *(if applicable – please print)*:	**Signature:**	**Date** *(mm/dd/yy)*: