APPLICATION FOR ATTENDANT SERVICE / ASSISTED LIVING

(for Personal Care/Attendant Outreach & Assisted Living (with housing)/ Supportive Housing services throughout the Champlain LHIN)

Is this a ( ) New Application or an ( ) Update?	*Office Use Only*: **Date Received**:

Please Note: this information is being collected for the purpose of facilitating your application for Attendant service/Assisted Living and shall be released in accordance with the terms set out in this application or as may be required by law.

PLEASE CHECK (☑) AND MAKE SURE YOU MEET THE FOLLOWING ELIGIBILTY REQUIREMENTS BEFORE YOU COMPLETE THE APPLICATION:

Yes ☑	ELIGIBILITY REQUIREMENTS (Must complete)
	You have a **valid Ontario Health Card** (OHIP).
	You are **16 years of age or older**.
	You have a **permanent health condition(s)**.
	You **require personal care** i.e. bathing/showering, dressing, toileting and transferring.

1 APPLICANT INFORMATION

First name:	**Last name**: (*Match names on your Health Card*)	
Ontario Health Card #:	*(Without this number, your application cannot be processed and will be returned to you)*	
Date of Birth: Month: Day: Year:	**Gender**: ( ) Male ( ) Female ( ) Trans ( ) Non-binary[1]	
Phone: Home ( )	Cell: ( )	Work: ( )
Other phone: Fax:	**E-mail:**	
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:**

[1] Non-binary refers to any gender that is not exclusively male or female.

ALTERNATE CONTACT INFORMATION (Optional) *(By completing this section, you give us permission to contact your Alternate Contact)*		
First Name:	**Last Name:**	
Relationship:		
Name of Organization: (*if applicable*)		
Address: Street:		**Apt No./Unit No**.:
City:	**Province:**	**Postal Code:**
Phone: Home: ( )	**Work**: ( )	**Cell**: ( )
Fax:	**E-mail**:	**Pager #**:
IF SOMEONE ASSISTS YOU WITH FILLING OUT THIS APPLICATION, PLEASE COMPLETE *(By completing this section, you give us permission to contact this person.)*		
First Name:	**Last Name:**	
Relationship:		
Name of Organization: (*if applicable*)		
Address: Street:		**Apt No./Unit No**.:
City:	**Province:**	**Postal Code:**
Phone: Home: ( )	**Work**: ( )	**Cell**: ( )
Fax:	**E-mail**:	**Pager #**:

2 SOURCES OF CURRENT SERVICES *Check (☑) all that apply*

Are you currently receiving personal care or personal support services? ( ) No ( ) Yes, please indicate below

PERSONAL CARE / SUPPORT SERVICES	**NAME OF ORGANIZATION**
☐Attendant Outreach Service	
☐Retirement Home	
☐Supportive Housing / Assisted Living Services (in a different city)	
☐Direct Funding Program for Attendant Services	
☐Home & Community Care (Champlain LHIN) personal support services	
☐Community agency / private care provider	
☐Volunteer, family, friend, church group	
☐Others:	
OTHER SOURCES OF SERVICES	**NAME OF ORGANIZATION**
☐ Out-Patient Services (eg. day hospital, dialysis, Adult Day Program)	
☐Mental Health & Addictions	
☐Developmental Services	
☐Home & Community Care (Champlain LHIN) - Professional services (nursing and/or therapies)	
☐Other:	

3 YOUR HEALTH CONDITION

Check (☑) ONE main permanent health condition that requires you to use Attendant services/Assisted Living Services. (***DO NOT check more than ONE***. *List additional health conditions below*):

☐Acquired Brain Injury (ABI)	☐Multiple Sclerosis
☐Amputation	☐Muscular Dystrophy
☐Amyotrophic Lateral Sclerosis (ALS)	☐Osteoporosis
☐Anxiety / Depression	☐Parkinson's
☐Arthritis / Rheumatic Conditions	☐Peripheral Vascular Disease
☐Bariatric	☐Spina Bifida
☐Cerebral Palsy	☐Spinal Cord Injury
☐Congestive Heart	☐Spinal Muscular Atrophy
☐COPD (Chronic Obstructive Pulmonary Disease)	☐Stroke
☐Dementia / Cognitive Decline	
☐Diabetes	If None of the Above, check 'Other' & specify:
☐Huntington's	☐Other:
	(***Specify ONE***): _____

ADDITIONAL HEALTH CONDITIONS / DISABILITIES:

Please list/describe any additional health conditions that may affect delivery of your services (i.e. visual impairment; deafness; epilepsy; transmissible diseases; etc.):

COMMUNICATION INFORMATION:

Do you need an interpreter? ☐ No ☐ Yes If yes, language spoken: _____

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?

☐ Paper and pen ☐ Other: _____

☐ Alphabet / symbol board

☐ Speech generating device, such as Dynavox, Pathfinder.

OTHER NEEDS:

Thinking about your lifestyle and personal goals will help you understand and communicate your needs. These may include the need for other community-based services. Check ☑ below if you would like information on how you might access additional supports **now**.

Disclaimer: Depending on your preferred service provider, services may not include any/all of these supports.

☐ Accompaniment to medical appointments	☐ Homemaking (light housekeeping)
☐ Assistance with groceries / errands	☐ Hospice / palliative care
☐ Caregiver support	☐ Meals on Wheels
☐ Diner's Club / 'LunchAbility'	☐ Snow removal (driveway/walkway)
☐ Foot care / nail care	☐ Social recreation / Adult Day Programs
☐ Help with hearing loss	☐ Transportation to medical appointments
☐ Help with vision problems	

4 SERVICE NEEDS

*** Applicants must have personal care needs. Please check (☑) all the tasks that apply to you

SERVICES	CHECK ☑	SERVICES	CHECK ☑
ASSISTANCE WITH ADVANCED ACTIVITIES OF DAILY LIVING *(Please complete Supplement A)*	☐	**DRESSING & UNDRESSING** Lower body Upper body Buttons/zippers/hooks Brace prosthesis	 ☐ ☐ ☐ ☐
ASSISTANCE WITH SERVICE DOG	☐	**GENERAL HYGIENE** Bath / shower Grooming Peri-care Menstrual care (sanitary pads)	 ☐ ☐ ☐ ☐
BARIATRIC ASSISTANCE *(Please complete Supplement B)*	☐	**MEALS & DRINKS** Meal preparation Assistance with eating & drinking G-tube feeding	 ☐ ☐ ☐
BLADDER ASSISTANCE	☐	**MEDICATION ASSISTANCE**	☐
BOWEL ASSISTANCE	☐	**NURTURING ASSISTANCE** *(Please complete Supplement D)*	☐
BREATHING ASSISTANCE *(Please complete Supplement C)*	☐	**TRANSFERS:** Pivot Lift, mechanical transfer Re-positioning / Turns at night Transfer board	 ☐ ☐ ☐ ☐

ASSISTIVE DEVICES / EQUIPMENT: Please indicate ☑ which, if any, of the following you use:

☐ Bath seat / bench	☐ G-tube feeding	☐ Scooter
☐ Braces	☐ Hearing aids	☐ Ventilator
☐ Cane / crutches	☐ Hospital bed	☐ Walker
☐ Ceiling track lift	☐ Manual wheelchair	☐ Transfer pole
☐ Commode	☐ Power wheelchair	☐ Other. Please specify:
☐ CPAP or BiPAP	☐ Portable mechanical lift (electric or manual)	_____
☐ Glasses / corrective lenses	☐ Raised toilet seat	
☐ Grab bars in the bathroom		

Please tell us, what is really important to you?

5 CURRENT LIVING ARRANGEMENT

WHAT IS YOUR CURRENT LIVING ARRANGEMENT? Check (☑) ONE below.

☐ Living alone in Apartment / House
☐ Living alone with Dependent Child/Children
☐ Living with Parent / Step-Parents
☐ Living with Spouse / other Adult
☐ Living with Spouse / other Adult and Dependent Child/Children
☐ Other, please specify: _____

Is this living situation permanent or temporary?

( ) Permanent Please go to Section VI, Health Service Providers / Services (page 6)
( ) Temporary Please continue on this page.

Check ☑ one below	NAME OF ORGANIZATION
☐Rehabilitation Hospital / Unit	
☐Chronic Care Hospital	
☐ Convalescent Hospital	
☐ Other Hospital or Health Care Facility	
☐ Long Term Care Home / Facility	

What is your mailing address while you are staying there?	
☐ same as Current Address (page 1) ☐ same as Permanent Address (page 1) ☐ same as Mailing Address (page 1)	Other Phone: Other Address:

What will your living situation be AFTER you have been discharged?

☐ Living alone in Apartment / House
☐Living alone with Dependent Child / Children
☐ Living with Parent / Step-Parents
☐ Living with Spouse / other Adult
☐ Living with Spouse / other Adult and Dependent Child/Children
☐ Other Hospital or Health Care Facility. Name: _____
☐ Long Term Care Home / Nursing Facility. Name: _____
☐Other, please specify: _____

Discharge date: ☐ **Unknown**

Additional Discharge Information:

6 HEALTH SERVICE PROVIDERS / SERVICES

Please select all services / providers you wish to apply for:

Check ☑	TRANSITIONAL SERVICE – CITY OF OTTAWA ONLY
☐	RITE© (Rediscovering Independence through Training & Education). A short-term service, using a coordinated care approach, available to those who have applied and are waiting for services and those preparing to return home from acute care, in-patient rehabilitation, respite or a convalescence stay.

ATTENDANT OUTREACH SERVICE (provided in your home, place of work or place of education)		
Check ☑	**SERVICE PROVIDERS**	**SERVICE AREA**
☐	Carefor Health & Community Services	City of Cornwall; Stormont-Dundas & Glengarry region.
☐	Groupe Action	Prescott – Russell & Rockland region.
☐	March of Dimes Canada	Leeds, Lanark and Renfrew County
☐	VHA Health & Home Support	City of Ottawa and area

SHARED LIVING SERVICE (Group Homes)		
Check ☑	**SERVICE PROVIDERS**	**SERVICE AREA**
☐	Parkway House	2475 Regina Street, Ottawa, ON
☐	PHSS	East Ottawa / Orleans
☐	VHA Health & Home Support	88 Forestview Crescent, Ottawa, ON

SUPPORTIVE HOUSING SERVICE (Personal care + Apartments)		
Check ☑	**SERVICE PROVIDERS**	**SERVICE AREA**
☐	Carefor Health & Community Services	☐ 330 Fourth Street East, Cornwall, ON ☐ 15 Edward Street, Cornwall, ON ☐ 1026 Laurier Street, Rockland, ON ☐ 700 Mackay Street, Pembroke, ON (Mackay Centre)
☐	Carleton-Algonquin Attendant Services (*for post-secondary students living in residence only*)	☐ Algonquin College, Ottawa, ON ☐ Carleton University, Ottawa, ON
☐	Personal Choice Independent Living (PCIL)	☐ 520 Bronson Avenue (French), Ottawa, ON ☐ 181 Forestglade Crescent, Ottawa, ON ☐ 1604 Pullen Avenue, Ottawa, ON
☐	March of Dimes Canada	3001 Jockvale Road, Ottawa, ON
☐	VHA Health & Home Support	☐ 145 Clarence Street, Ottawa, ON ☐ 464 Metcalfe Street, Ottawa, ON (non-smoking) ☐ 2410 Southvale Crescent, Ottawa, ON ☐ 141 Twyford Avenue, Ottawa, ON

PLEASE NOTE:

1. **We will make three (3) attempts to reach you to offer service. If we are unable to reach you or your alternate contact, your application will become inactive and securely destroyed.**
2. **When you accept an offer of service from any of the providers to which you have applied, you will no longer be on the waiting list for any other service provider. If you wish to move to another service provider later on, you will have to re-apply.**

7 ACCOMMODATION INFORMATION
(Supportive Housing applicants MUST complete this section)

WHAT WILL YOUR LIVING SITUATION BE WHEN YOU ARE IN HOUSING?

☐ I will be living alone.
☐ I will **not** be living alone.
☐ I will bring my pet.
☐ I will live with a person who requires personal care. They must apply separately for services.
To link applicants so that services are introduced for both at the same time, please provide the co-applicant's name and phone number here:

Name: _____ Phone: _____

IS YOUR PERMANENT LIVING SITUATION SUITABLE?

☐ Yes
☐ No Please explain:
- ☐ Living arrangements (i.e. living alone, living with elderly parents, personal difficulties, etc.)
- ☐ Architectural barriers (i.e., space is inaccessible with 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: _____

ACCOMMODATION PREFERENCES:

Please Note: all service providers offer site-based support services. Some providers are also the landlord for the site (ie apartment or room) while other providers offer preferred access to the site because of their relationship with the landlord.

If your service provider is not the landlord, you will have to enter into a separate legal tenant-landlord relationship with the building's landlord.

Please check ☑ which types of accommodation you would accept. If you have a preference from among your choices, please rank them in order of preference (1,2,3,4,5, etc.)

Check ☑	Rank	Type of Accommodation
☐		Bachelor apartment
☐		One (1) bedroom
☐		Two (2) bedroom
☐		Three (3) bedroom
☐		Shared accommodation

Can you afford full market rent? ( ) Yes ( ) No

PLEASE NOTE: *the eligibility criteria for the size of the subsidized unit (i.e. rent geared to income) often depends on the number of people in the household. For example, a single person would not typically qualify for a two bedroom unit.*

8 DECLARATION, CONSENT TO DISCLOSE APPLICANT INFORMATION AND RELEASE FROM LIABILITY

I _____ (Applicant's name) declare that the information contained in this application is correct and complete, to the best of my knowledge.

I authorize VHA Health & Home Support ('VHA') and my preferred provider agency(s) to collect and share my personal information with the individuals / organizations listed in this application. I also authorize VHA and my preferred provider agency(s) to contact the following agencies and/or individuals specifically for the purpose of discussing this application for services and/or about receiving services, and consent to the disclosure of my personal health information on this form to the following individuals:

☐ My Caregiver: _____ _____
Name *Phone number*

☐ Home & Community Care at the Champlain LHIN

☐ Other, please specify: _____

_____ _____
Name *Phone number*

I understand that this application and the information contained within it will be securely maintained within the Champlain Common Waitlist for Services until such time as I request my application be removed from the Waitlist and/or until such time as I accept an offer to receive services.

I understand that any service provider agency listed in this application may contact me for assessment.

I understand that the health service providers listed in this application may discuss the contents of this application amongst themselves for the purpose of making services available to me more quickly.

I understand that I am responsible to inform VHA Health & Home Support of any changes affecting my eligibility for services, including providing VHA with information about:

- Any change of my contact information
- Any change in my family or other status that affects my housing requirements
- Any change in my health condition and resulting change in service needs
- The start or end of my services by my selected service provider
- My continued interest or need to remain "active" on the Common Waitlist for these services.

I acknowledge and agree that VHA Health & Home Support neither warrants the services provided by any service provider nor accepts any liability or responsibility for services provided, by a health service provider agency, nor any harm that I may suffer arising out of or connected in any way to my receiving services.

I also agree that I will release and hold harmless VHA Health & Home Support, together with its employees, Directors and Officers, as well as the health service providers listed in this 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 VHA Health & Home Support or by the health service providers listed in the 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 OBTAIN LEGAL ADVICE PRIOR TO THE SIGNING OF THIS DOCUMENT. I UNDERSTAND THAT I CAN REFUSE TO SIGN THIS CONSENT FORM, HOWEVER, VHA HEALTH & HOME SUPPORT MAY BE UNABLE TO PROCESS MY APPLICATION AS A RESULT.

_____	_____
Signature / Mark of Applicant	*Signature of Witness*
_____	_____
Name of Applicant	*Name of Witness*
_____	_____
Date of Signature / Mark	*Date of Signature*

Please Note: This information is collected, and Personal Health Information protected, under the Province of Ontario's **Personal Health Information Protection Act** (2004).

Mail or deliver your application to:	**Contact information**:
Champlain Attendant /Assisted Living Services Network (CAASN) c/o VHA Health & Home Support 700-250 City Centre Avenue, Ottawa, ON K1R 6K7	Telephone: 613-238-8420 or 1-877-818-0884 Fax: 613-238-1306 E-mail: info@vhaottawa.ca Website: www.vhaottawa.ca

Please Note: *you can submit your application directly via the website or you can mail, fax or e-mail it. If your application is unclear, unreadable or if pages are missing, we will return your application without putting you on the waitlist for services.*

Please keep a copy of your application for your information, and for purposes of updating it in the future.

It is your responsibility to keep your application up-to-date. If your contact information changes, please provide the updated information right away. **Your application will become inactive if VHA or health service providers cannot contact you.**

This is your application. Physical assistance may be used to record your responses, but family members, health professionals and others cannot make submissions on your behalf.