

# APPLICATION FOR SERVICE



**Eligibility Criteria** - We may be able to help you if you meet the following eligibility criteria.

To be eligible for general services, the individual must:

- Have a primary diagnosis of an Acquired Brain Injury (ABI)\*
- Be 16 years of age and over
- Reside in the region of Peel, Halton, or Dufferin County (may waive this criterion should an individual be able to travel to Mind Forward locations)
- Be an active participant in achieving mutually agreed-upon goals
- Be medically stable
- Be free of psychiatric or behavioural symptoms of an order that would preclude the individual from being able to participate in mutually agreed-upon goals

\* The agency has adopted the World Health Organization's definition of ABI: "Damage to the brain, which occurs after birth and is not related to a congenital or a degenerative disease. These impairments may be temporary or permanent and cause partial or functional disability or psychosocial maladjustment" (Geneva 1996)

**MUST include all relevant brain injury medical and consult reports** - i.e. Neuro-imaging (MRI, CT scan), Neurology report, Emergency Room Reports and/or Hospital Admission/ Discharge Notes.

Processing of the referral will be significantly delayed if the above is not included.

## 1 APPLICANT'S PERSONAL INFORMATION - be sure to fully complete this section

Last name		First name		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (dd-mm-yyyy) - -
Health card number		Version Code		Expiry date (dd-mm-yyyy) - -	
Address		Apt. #	City	Province	Postal Code
Home telephone - -		Cell phone - -		E-mail address	
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married/Common Law <input type="checkbox"/> Separated/Divorced <input type="checkbox"/> Other		Current living situation <input type="checkbox"/> Alone <input type="checkbox"/> With Relative(s) <input type="checkbox"/> With Non-Relative(s) <input type="checkbox"/> Other		Accommodation <input type="checkbox"/> House <input type="checkbox"/> Residential Care Facility <input type="checkbox"/> Apartment Building <input type="checkbox"/> Supported Housing <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Hospital <input type="checkbox"/> Other	
Is your rent geared to income? If Yes please enter Subsidy Provider or Housing Corporation <input type="checkbox"/> No <input type="checkbox"/> Yes				Are you a resident of Ontario? If yes, how long? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Citizenship <input type="checkbox"/> Canadian <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Other		Language spoken		Interpreter required <input type="checkbox"/> No <input type="checkbox"/> Yes	First Nation Band Affiliation Status Number with Dept. of Indian Affairs

## 2 BRAIN INJURY INFORMATION

Date of Injury (dd-mm-yyyy) - -					
Cause of Injury <input type="checkbox"/> Aneurysm <input type="checkbox"/> Anoxia <input type="checkbox"/> Assault <input type="checkbox"/> Fall <input type="checkbox"/> Other <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Stroke <input type="checkbox"/> Tumor <input type="checkbox"/> Infection					
Issues Identified <input type="checkbox"/> Orientation <input type="checkbox"/> Motivation/ Initiation <input type="checkbox"/> Impulsive <input type="checkbox"/> Organization/ Planning <input type="checkbox"/> Verbal Aggression <input type="checkbox"/> Memory <input type="checkbox"/> Pain <input type="checkbox"/> Irritability <input type="checkbox"/> Nervousness <input type="checkbox"/> Other <input type="checkbox"/> Fatigue <input type="checkbox"/> Sadness <input type="checkbox"/> Concentration <input type="checkbox"/> Insight <input type="checkbox"/> Physical Aggression <input type="checkbox"/> Self harm <input type="checkbox"/> Perseveration <input type="checkbox"/> Communication					
Additional comments					

### 3 PERSONAL SUPPORT NETWORK AND EMERGENCY CONTACTS

Emergency contact last name	Emergency contact first name	Relationship	
Address	Apt. #	City	Province Postal Code
Home telephone - -	Work telephone - -	E-mail address	

Other contact last name	Other contact first name	Relationship	
Address	Apt. #	City	Province Postal Code
Home telephone - -	Work telephone - -	E-mail address	

### 4 REFERRING AGENT (Person making the request)

Who is making the referral?  
 Myself (if self-referral, please move on to next section)   
 Case Manager   
 Community Service Provider   
 Lawyer   
 Family Member/Friend

Name	Name of Agency	Position/Relationship
Phone number - -	E-mail address	Is the applicant aware of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No Contact Person

### 5 TYPE OF SERVICES REQUESTED (select all applicable)

- Residential   
 Day Services   
 Seniors Services (Mississauga-Halton only)   
 Supported Independent Living (SIL) (Mississauga-Halton only)  
 Case Management   
 Concussion   
 Caregiver Services   
 Other

### 6 MEDICAL INFORMATION

Seizures - If yes, describe  
 No     Yes

Administering Medication(s)  
 Self     With help from others     No medication prescribed

Wheelchair  
 Does not use a wheelchair     Manual     Electric

Assisted Transfers - If yes, describe  
 No     Yes

Assistive Devices/Medical Equipment - If yes state what is needed  
 No     Yes

Attendant Care - If yes, describe  
 No     Yes

Supervision or assistance with walking  
 No     Yes    If yes, does it apply to     Level surfaces     Stairs     Both

Communication Issues - If yes, describe  
 No     Yes

Other Medical Conditions (allergies, heart conditions, diet restrictions, etc) - If yes, describe  
 No     Yes

Pre-Injury History of Substance Abuse <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> History not available	Current Substance Abuse <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not known	Substance Abuse Treatment Recommended <input type="checkbox"/> No <input type="checkbox"/> Yes
Previous Psychiatric History - If yes, describe <input type="checkbox"/> No <input type="checkbox"/> Yes		
Current Psychiatric Status	Psychiatric Consult Notes <input type="checkbox"/> Included <input type="checkbox"/> Report to follow <input type="checkbox"/> Not available	

Family Physician	Telephone - -	Fax - -	
Address	City	Province	Postal Code

## 7 RELEVANT TREATMENT HISTORY (including current services)

Program/Facility/Hospital	Dates Involved (dd-mm-yyyy)	Contact Information (name, position, phone number, email, fax)
	- -	
	- -	
	- -	
	- -	
	- -	
	- -	
	- -	
	- -	

## 8 SOCIAL INFORMATION

Highest Education Achievement		
<input type="checkbox"/> Grade School	<input type="checkbox"/> High School	<input type="checkbox"/> College
<input type="checkbox"/> University	<input type="checkbox"/> Trade	
Name of Last Employer	Position	How long were you in this position?

Applicant will be travelling (Please note there are no transportation resources available for our programs)	
<input type="checkbox"/> Independently	<input type="checkbox"/> With Assistance
Transportation Support	Transportation Number
<input type="checkbox"/> Transhelp	<input type="checkbox"/> Wheel-Trans
<input type="checkbox"/> Self	<input type="checkbox"/> Care-a-van
<input type="checkbox"/> Other	<input type="checkbox"/> Family

Previous or Current Involvement with the Criminal Justice System? If yes provide details
<input type="checkbox"/> No <input type="checkbox"/> Yes

## 9 FINANCIAL INFORMATION

Please Specify Source(s) of Income		
<input type="checkbox"/> Ontario Disability Support Program (ODSP)	<input type="checkbox"/> Old Age Security (OAS)	<input type="checkbox"/> Insurance Settlement
<input type="checkbox"/> Workplace Safety Insurance Board (W.S.I.B.)	<input type="checkbox"/> Full Time Employment	<input type="checkbox"/> Canadian Pension Plan (C.P.P.)
<input type="checkbox"/> Inheritance	<input type="checkbox"/> Ontario Works (OW)	<input type="checkbox"/> Part Time Employment
<input type="checkbox"/> Employment Insurance (E.I.)	<input type="checkbox"/> Long Term Disability (private)	<input type="checkbox"/> Other
<input type="checkbox"/> Structured Settlement	<input type="checkbox"/> Veterans Affairs Canada	
Amount of income per month		
Do you have direct access to your income? If no, Name and Phone number of Substitute Decision Maker/Power of Attorney/ Public Guardian and Trustee, and attach supporting documentation		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you make your own personal decisions? If no, Name and Phone number of Substitute Decision Maker/Power of Attorney and attach supporting documentation		
<input type="checkbox"/> Yes <input type="checkbox"/> No		

## 10 ONGOING LITIGATION OR ONGOING CLAIM INFORMATION

Lawyer's Name	Company	Phone
		- -
Insurance Adjustor Name	Company	Phone
		- -
Rehabilitation Case Manager Name	Company	Phone
		- -

## 11 REQUIRED INFORMATION AND DOCUMENTATION CHECKLIST

The following information must be included (as indicated) to avoid any delays in processing your referral

- Patient's Address, Phone Number and E-mail       Patient's Health Card Number       Diagnosis  
 Date of Injury/Event       Type of Service requested

The following medical and rehabilitation documentation is required

- Neuro-imaging (MRI, CT scans)       Neurology Reports (if applicable)       Neuropsychological Assessment (if completed)  
 Psychiatric Consultation Notes or Mental Health reports (if completed)       Power of Attorney for Property (if applicable)       Power of Attorney for Personal Care (if applicable)  
 Hospital Admission/ Discharge Notes       Treatment History       Any other relevant treatment reports

## 12 AUTHORIZATION AND SIGNATURE – you must complete this section

I, \_\_\_\_\_ have or have had this application for service completed for me. I confirm that the above mentioned information is correct, to the best of my knowledge.

Signature of Applicant or Decision Maker X	Please print name	Date (dd-mm-yyyy) - -
Witness X	Please print name	Date (dd-mm-yyyy) - -

## RESPECTING YOUR PRIVACY

Respecting your privacy is a priority for Mind Forward Brain Injury Services.

Mind Forward complies with the Personal Health Information Act (PHIPA), 2004

*The information contained herein is confidential and no unauthorized person will have access to the information without the consent of the patient/client or substitute decision maker.*

## SUBMISSION INSTRUCTIONS

Please return (Mail, Fax or Email) completed applications and relevant assessments and reports to:

### Mind Forward Brain Injury Services

Attn: Intake Department  
176 Robert Speck Pkwy.  
Mississauga, ON, L4Z 3G1

Fax: 905 949-4019

Email: intake@mindforward.org