Attendant Care Service Referral Form

Name: ______________________________ DOB (M/D/Y): ______________________

Address: ______________________________ ☐ Indigenous (First Nations, Inuit, Metis)

______________________________ ☐ Francophone ☐ Veteran

☐ Lives Alone ☐ Lives with Family Health Card #: ______________________

Phone: ______________________________ Gender: ☐ Female ☐ Male ☐ Non-Binary

If this application does not meet our Eligibility Criteria, the referral will be returned to the referral source

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Which program are you applying for?

☐ Attendant Care Outreach Services

☐ Supportive Housing Services

Diagnosis of *Permanent Physical Disability*

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Must be confirmed by Physician

Eligibility Criteria

- ✓ Insured under the Health Insurance Act of Ontario
- ✓ 16 years of age or older
- ✓ Have a **permanent physical disability** which requires hands on assistance with:
  - Bathing & dressing
  - Bowel & bladder care
  - Transferring
- ✓ Be able to direct their own care by communicating:
  - Their individual needs
  - Time requested for assistance
  - How assistance is to be provided
- ✓ Have all medical & professional needs met by the existing community health care network *(E.g. Social Work, Nursing, Physiotherapy, etc.)*

Referring Source (please print): ______________________________

Phone #: ______________ Fax #: ______________ Date: ______________

Applicant consents to this referral? ☐Yes ☐No

Applicant consents to share personal information? ☐Yes ☐No

By checking yes, you acknowledge and agree that the ILS Support Team will have access to your personal health information for the purpose of care planning.

FOR ILS USE ONLY

ACCEPTS REFERRAL: ☐ YES ☐ NO

Reason for declined referral: ______________________________

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Coordinator Name: ______________________ **Signature:** ______________________