



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 #: _____ Ver: _____

Phone: _____

Gender: Female Male Non-Binary

Please print and return by - Fax: 705-737-1874, Email: intake@ilssimcoe.ca

Or mail to: ILS, 1102-44 Cedar Pointe Drive, Barrie, ON L4N 5R7

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

Which program are you applying for?

Attendant Care Outreach Services

Supportive Housing Services

Diagnosis of Permanent Physical Disability

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:

Coordinator Name: _____

Signature: _____