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		Date of birth (dd-mm-yyyy) - -
Pronouns	Gender ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to say ☐ Other		
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 ☐ Single ☐ Married/Common Law ☐ Separated/Divorced ☐ Other	Current living situation ☐ Alone ☐ With Relative(s) ☐ With Non-Relative(s) ☐ Other	Accomodation ☐ House ☐ Residential Care Facility ☐ Apartment Building ☐ Supported Housing ☐ Long Term Care Facility ☐ Hospital ☐ Other	
Is your rent geared to income? If Yes please enter Subsidy Provider or Housing Corporation ☐ No ☐ Yes		Are you a resident of Ontario? If yes, how long? ☐ No ☐ Yes	
Citizenship ☐ Canadian ☐ Permanent Resident ☐ Other	Language spoken / Interpreter required ☐ No ☐ 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

☐ Aneurysm	☐ Anoxia	☐ Assault	☐ Fall	☐ Other
☐ Motor Vehicle Accident	☐ Stroke	☐ Tumor	☐ Infection	

Issues Identified

☐ Orientation	☐ Motivation/ Initiation	☐ Impulsive	☐ Organization/ Planning	☐ Verbal Aggression
☐ Memory	☐ Pain	☐ Irritability	☐ Nervousness	☐ Other
☐ Fatigue	☐ Sadness	☐ Concentration	☐ Insight	
☐ Physical Aggression	☐ Self harm	☐ Perseveration	☐ 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? ☐ Yes ☐ No ☐ Contact Person

5 TYPE OF SERVICES REQUESTED (select all applicable)

☐ Residential ☐ Day Services ☐ Case Management ☐ Supported Independent Living (SIL)

☐ Seniors Services ☐ Concussion ☐ Caregiver Services ☐ Other

6 MEDICAL INFORMATION

Seizures - If yes, describe

☐ No ☐ Yes

Administering Medication(s)	Wheelchair
☐ Self ☐ With help from others ☐ No medication prescribed	☐ 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	Current Substance Abuse	Substance Abuse Treatment Recommended
☐ No ☐ Yes ☐ History not available	☐ No ☐ Yes ☐ Not known	☐ No ☐ Yes

Previous Psychiatric History - If yes, describe

☐ No ☐ Yes

Current Psychiatric Status	Psychiatric Consult Notes
	☐ Included ☐ Report to follow ☐ 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-yyy)	Contact Information (name, position, phone number, email, fax)
	- -	
	- -	
	- -	
	- -	
	- -	
	- -	
	- -	
	- -	

8 SOCIAL INFORMATION

Highest Education Achievement

☐ Grade School ☐ High School ☐ College ☐ University ☐ 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)

☐ Independently ☐ With Assistance

Transportation Support

☐ Transhelp ☐ Wheel-Trans ☐ Care-a-van ☐ Family

☐ Self ☐ Other

Transportation Number

Previous or Current Involvement with the Criminal Justice System? If yes provide details

☐ No ☐ Yes

9 FINANCIAL INFORMATION

Please Specify Source(s) of Income

☐ Ontario Disability Support Program (ODSP)
☐ Workplace Safety Insurance Board (W.S.I.B.)
☐ Inheritance
☐ Employment Insurance (E.I.)
☐ Structured Settlement
☐ Old Age Security (OAS)
☐ Full Time Employment
☐ Ontario Works (OW)
☐ Long Term Disability (private)
☐ Veterans Affairs Canada
☐ Insurance Settlement
☐ Canadian Pension Plan (C.P.P.)
☐ Part Time Employment
☐ Other

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

☐ Yes ☐ 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

☐ Yes ☐ 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	Please print name	Date (dd-mm-yyyy)
X		- -
Witness	Please print name	Date (dd-mm-yyyy)
X		- -

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