

**Purpose**

March of Dimes Canada (MODC) collects personal information for a variety of purposes including the delivery of services, fundraising, quality management, research, billing and meeting legal and regulatory requirements.

MODC utilizes several safeguard measures to protect personal information and keep it confidential and will not share any personal information with any third parties unless it is directly related to the delivery or enhancement of the services that MODC provides or unless a Canadian law requires it.

Personal information that is no longer required to fulfill the identified purposes will be destroyed, erased, or made anonymous. MODC has guidelines and procedures to prevent unauthorized access and to govern the destruction of personal information.

The full MODC Personal Information Protection (Privacy) Policy is available on the MODC website or by request.

**Consent**

I fully understand the reasons March of Dimes Canada (MODC) has requested my personal information and I give consent to MODC to use my personal information for the purposes outlined. I also understand that I may withdraw my consent at any time, subject to legal or contractual obligations and reasonable notice, and that MODC will inform me of the implications of such withdrawal.

<b>Applicant Name [active SDM where authorized] (please print):</b>	Signature:	Date: (mm/dd/yy)
<b>Witness Name * (please print):</b>	Signature:	Date: (mm/dd/yy)
<b>Supervisor/Program Manager/ Designate Name (please print):</b>	Signature:	Date: (mm/dd/yy)

\* Only required when applicant is unable to sign on their own



## Service Application –Brain Injury

This form is consistent with Policy BI 02 01

**PLEASE NOTE:**

This application form is only to be used to apply for MODC Brain Injury Services. Should you also be interested in Attendant Services programs, you can download an application at <https://www.marchofdimes.ca/en-ca/programs/acsh/attendantcare/Pages/default.aspx> or contact your local MODC office.

<b>Applicant Name:</b>	<b>Office Use Only</b>
<b>Date:</b>	<b>Client #:</b>

### March Of Dimes Canada Community Support Services Living Office List

You may apply to more than one office and/or location. A separate application will have to be completed for Attendant Services and Brain Injury Programs. Please select all applicable locations/offices below:

**\*If an applicant declines an offer to one or more of their selected locations/offices, they will be removed from that location/office’s waiting list and the date of decline will become the new date of application for all remaining applicable locations/offices.**

**LEGEND**

**AS – Attendant Services    BI – Brain Injury    OAS – Outreach Attendant Services**  
**OS – Outreach Services    SHP – Supportive Housing Program    CCH – Congregate Care Home**  
**Bdrm – Bedroom**

LOCATIONS	OFFICES
<input type="checkbox"/> <b>Central Ontario</b> Community Support Services Office Oak Ridges 13311 Yonge St, Suite 202 Richmond Hill, ON L4E 3L6  (905) 773-7758 x 6216 <b>1-800-567-0315 x 6216</b> Fax: (905) 773-5176	<input type="checkbox"/> <b>Simcoe Region: BI Community Outreach Groups</b> 136001 <input type="checkbox"/> <b>York Region: BI Community Outreach Groups</b> 136001 <input type="checkbox"/> <b>York /Simcoe: York-Simcoe Brain Injury Services OS</b> 119011 <input type="checkbox"/> <b>Newmarket: Heritage East SHP BI</b> 136004 1 bdrm, shared 2 bdrm <input type="checkbox"/> <b>York Region: BI OS</b> 136002
<input type="checkbox"/> <b>Toronto Central</b> Community Support Services 125 Mill Street, Ste 313 Toronto, ON M5A 1G9 <b>(437) 216-9480</b>	<input type="checkbox"/> <b>Toronto: Cooperage St., BI SHP</b> 118008 1 bdrm
<input type="checkbox"/> <b>East Ontario</b> Community Support Services Office 6 Glenn Wood Place Brockville, ON K6V 2T3  1-888-252-9008 x6408 Fax: (613) 342-7636	<input type="checkbox"/> <b>Brockville/Smiths Falls: BI</b> 132002



MARCH  
OF DIMES  
CANADA

LA MARCHÉ  
DES DIX SOUS  
DU CANADA

## Service Application –Brain Injury

This form is consistent with Policy BI 02 01

LOCATIONS	OFFICES
<p><input type="checkbox"/> <b>North Eastern Ontario</b> 96 Larch St., Unit 400 Sudbury, Ontario P3E 1C1</p> <p>BI Enquiries: (705) 671-3188</p> <p>Fax: (705) 671-6240</p>	<p><input type="checkbox"/> <b>Espanola/Manitoulin:</b> BI OS 135006</p> <p><input type="checkbox"/> <b>Elliot Lake:</b> BI 135006</p> <p><input type="checkbox"/> <b>Kirkland Lake/Temiskaming:</b> BI OS 135006</p> <p><input type="checkbox"/> <b>North Bay:</b> BI OS 135006</p> <p><input type="checkbox"/> <b>Sault Ste. Marie:</b> BI OS 135006</p> <p><input type="checkbox"/> <b>Sudbury:</b> BI OS 135006</p> <p><input type="checkbox"/> <b>Timmins:</b> BI OS 135006</p> <p><input type="checkbox"/> <b>Sudbury Day Centre:</b> BI 135005</p> <p><input type="checkbox"/> <b>Sudbury:</b> BI SHP 135009 1 bdrm</p> <p><input type="checkbox"/> <b>Sudbury Congregate Care:</b> 135011</p> <p><input type="checkbox"/> <b>Sault Ste. Marie Congregate Care:</b> 135008</p>



## Service Application –Brain Injury

This form is consistent with Policy BI 02 01

Unless otherwise noted within a section, the information in this form is required so that we may assess your entitlement to Brain Injury Services. The information will be kept confidential and will only be provided to persons who require the information in order to consider your application or in order to provide service to you.

<b>For Office Use Only:</b>			
Customer Type: <input type="checkbox"/> Bill-to Customer <input type="checkbox"/> Referral Source (please specify):			
<b>*Indicates required fields</b>	Client #:	Disability Code:	Date Stamp: Initials:

### Applicant Information

Salutation (Optional)	<b>*First Name:</b>	<b>*Last Name:</b>
-----------------------	---------------------	--------------------

<b>Preferred Name:</b>	<b>Preferred Pronoun (optional):</b>
------------------------	--------------------------------------

**\*Street Address (#, street, suite):**

<b>*City/Town:</b>	<b>*Province (2-letter abbreviation):</b>	<b>*Postal Code:</b>
--------------------	---	----------------------

<b>*Home Phone:</b> ( )	<b>Fax:</b> ( )
-------------------------	-----------------

<b>Cell Phone:</b> ( )	<b>E-mail Address:</b>
------------------------	------------------------

<b>*Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer	<b>Marital Status:</b> <input type="checkbox"/> Married <input type="checkbox"/> Common-law <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
---	--

<b>*Birth Date (mm/dd/yy):</b>	<b>*Do you have a valid Ontario Health Card?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (Must show @ intake interview)	<b>* Health Card Expiry Date (mm/dd/yy) (OR)</b> <input type="checkbox"/> Red and White Card
--------------------------------	---	---

### Family Physician Information

**Name:**

<b>Address:</b>	<b>Phone #</b>
-----------------	----------------

### Emergency Contact Information

**Emergency Contact Name:**

<b>Relationship:</b>	<b>Emergency Contact Phone:</b>
----------------------	---------------------------------

**Emergency Contact Address:**

**Name of person completing referral:**

**Organization:**

**Relationship:**

**Address:**

**Phone:**

**Documentation Confirming Brain Injury:**  Enclosed  To be forwarded

**Type of Brain Injury Service being applied to for specific location:**

Sub-Program:  Outreach Services  Supportive Housing Program  Congregate Care Home  
 Groups

If applying to Supportive Housing Program, please specify number of bedrooms:

**Have you previously applied for March of Dimes Canada services:**  Yes  No  Not Sure

**If yes, when? (mm/dd/yy):** **And for what service?:**

**Language(s) Spoken:**  English  French  Sign language  Other: *(specify)*

What is your mother tongue?

If your mother tongue is not French or English, in which of Canada’s official languages are you most comfortable?  English  French

*(This data is collected for statistical purposes only and is not part of admission criteria)*

**Ethnicity:**  African  Asian  Indian / Pakistani  Other European  
 Native Canadian/American  Spanish/Portuguese  Other  Refuses/No Answer

**Disability / Medical History Information**

**Date of Injury (mm/dd/yy):**

**Nature / Type of Injury / Event**

Anoxia       Motor Vehicle Collision     Tumor                       Other:  
 Assault       Sports                       Viral Infection  
 Fall             Stroke                       Work-Related Injury

**Circumstances surrounding injury:**

**Have you ever been involved in a motor vehicle or work-related injury?**  Yes  No

**Previous Medical / Rehabilitation Facilities**

Facility Name	Length of Stay

**Please list / indicate any other disabilities or medical conditions that may affect delivery of your services:** (i.e., an unstable medical condition, diabetes, difficulty with swallowing, allergies, communicable diseases, special diet, heart disease)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Neuropsychological Assessments Completed:**  Yes  No

**Date Completed:** (mm/dd/yy)

**By Whom:**

**Address:**



**Service Application –Brain Injury**

This form is consistent with Policy BI 02 01

Phone: \_\_\_\_\_

Precautions related to above stated conditions: \_\_\_\_\_

**Current Medications**

Medication	Dosage	Reason

**Medication Administration:**

Self:  Yes  No Others:  Yes  No

Please describe: \_\_\_\_\_

**Seizures**

Do you experience Seizures:  Yes  No

If yes, date of last Seizure: \_\_\_\_\_

Please describe: \_\_\_\_\_

Do you have a DNR:  Yes  No

Documentation confirming DNR:  Yes  No

**Medical Information Prior to Brain Injury**

Please list any illnesses, injuries or diagnosis prior to injury, and any related hospitalizations, treatments, etc. *(If additional space is required, please attach separate sheet.)*

**Assistive Devices**

**Please indicate which, if any, of the following you use:**

- |   |  |
|---|--|
| <input type="checkbox"/> Canes / Crutches / Walker      | <input type="checkbox"/> Support Bars                    |
| <input type="checkbox"/> Wheelchair (electric / manual) | <input type="checkbox"/> Raised Toilet Seat              |
| <input type="checkbox"/> Scooter                        | <input type="checkbox"/> Lifts (Hoyer, ceiling tracking) |
| <input type="checkbox"/> G-Tube Feeding                 | <input type="checkbox"/> Trache                          |
| <input type="checkbox"/> Ventilator / breathing assist  | <input type="checkbox"/> Communication Devices           |
| <input type="checkbox"/> Braces                         | <input type="checkbox"/> Technical Aids (ie. Palm pilot) |
| <input type="checkbox"/> Bath seat bench                | <input type="checkbox"/> Other, please <i>specify</i> :  |

**Maintenance of devices indicated (including battery charging of electronic devices):**

**Social Information**

Living Conditions	Living Arrangements
<input type="checkbox"/> Home (Rented)	<input type="checkbox"/> Live alone
<input type="checkbox"/> Home (Owned)	<input type="checkbox"/> Live alone with dependent children
<input type="checkbox"/> Home (Family Or Friend)	<input type="checkbox"/> Live with parents or step-parents
<input type="checkbox"/> Children's Hospital	<input type="checkbox"/> Live with spouse or other adults
<input type="checkbox"/> Convalescent Hospital	<input type="checkbox"/> Live with spouse or other adults and dependent children
<input type="checkbox"/> Long Term Care Setting	<input type="checkbox"/> Live in Shared Housing with support staff
<input type="checkbox"/> Hospital (Please name):	<input type="checkbox"/> Other: <i>(please explain)</i>
<input type="checkbox"/> Institution	
<input type="checkbox"/> Other: <i>(please explain)</i>	

**Applicants who are now staying at hospital / rehabilitation unit**

Anticipated Discharge Date:

**What will your living situation be after you are discharged from hospital / rehab unit?**

**Decision Making**

**Do you have an Active Substitute Decision-Maker?**  Yes  No

**If yes, specify:**

<b>Power of Attorney for Personal care:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Legal Guardian</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Power of Attorney for Property:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Public Guardian/Trustee</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide documentation if one of the above applies to you.

**Has there been a capacity assessment:**  Yes  No

*If Yes, please provide copy with this application*



## Service Application –Brain Injury

This form is consistent with Policy BI 02 01

### Current Professional Services *(Please specify any assistive services that you currently receive)*

Service	Agency / Provider Name	Number of visits per week / month	Duration of each visit
Homemaking			
Physiotherapy			
Occupational Therapy			
Nursing			
Attendant Services			
Physicians (psychologists, psychiatrists, neurologists, etc)			
Other <i>(specify)</i> :			
Other <i>(specify)</i> :			

### Additional Professionals / Agencies Currently Involved

Service	Company / Firm	Contact	Phone
Adjuster			
Lawyer			
Case Manager			
Other			

**Please describe your current support from family and friends:**

---

**What activities do you currently enjoy doing?**

---



**Please indicate which of the following areas you wish to work on and set goals around. If an interest of yours is not listed, please add it under other:**

- |   |   |
|---|---|
| <input type="checkbox"/> Learning to direct your services | <input type="checkbox"/> Community Integration                              |
| <input type="checkbox"/> Behaviour Management             | <input type="checkbox"/> Finding schooling, work or volunteer opportunities |
| <input type="checkbox"/> Cognitive Skills                 | <input type="checkbox"/> Socialization                                      |
| <input type="checkbox"/> Communication Skills             | <input type="checkbox"/> Personal safety at home & in the community         |
| <input type="checkbox"/> Healthy Eating / Cooking         | <input type="checkbox"/> Making your home more accessible                   |
| <input type="checkbox"/> Leisure Activities               | <input type="checkbox"/> Physical fitness                                   |
| <input type="checkbox"/> Managing Finances                | <input type="checkbox"/> Other:   |

**Please list your Volunteer / Employment Record:**

**Highest grade / level attained:**

**If in school, name of school:**

**Additional Comments:**

---

---

---

---

---

---

---

---

---

---

**Privacy Statement**

March of Dimes Canada is committed to handling any personal information that we may collect concerning you and your family member(s) in a professional, respectful, and lawful manner. March of Dimes Canada collects, uses, and discloses personal information in accordance with this privacy statement and our privacy policy. The personal information about you and your family member(s) is used for the purposes of:

- i) contacting you about the status of your application(s)
- ii) obtaining feedback about March of Dimes Canada services you receive
- iii) providing information about March of Dimes Canada to you and others
- iv) complying with the laws and regulations that require the collection, use and disclosure of personal information in connection with the Brain Injury program

The personal information collected about you and your family member(s) includes information supplied by you in your application for funding assistance and any additional or updated information which we may collect from you in the future.

**Additional Applicant Information**

*(The data in this section is collected for statistical purposes only and is not part of admission criteria)*

**Education:**

- |  |                                   |  |  |   |
|--|-----------------------------------|--|--|---|
| <input type="checkbox"/> Grade 6 or less | <input type="checkbox"/> Grade 9  | <input type="checkbox"/> Grade 12              | <input type="checkbox"/> Community College | <input type="checkbox"/> Bachelor's             |
| <input type="checkbox"/> Grade 7         | <input type="checkbox"/> Grade 10 | <input type="checkbox"/> High School Diploma   | <input type="checkbox"/> Law Degree        | <input type="checkbox"/> Master's               |
| <input type="checkbox"/> Grade 8         | <input type="checkbox"/> Grade 11 | <input type="checkbox"/> Business/Trade School | <input type="checkbox"/> Doctorate         | <input type="checkbox"/> Do not wish to comment |

**\*Annual personal income range: (check only one)**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> under \$5,000     | <input type="checkbox"/> \$20,000 - 24,999 | <input type="checkbox"/> \$40,000 - 44,999 | <input type="checkbox"/> Do not wish to comment |
| <input type="checkbox"/> \$5,000 - 9,999   | <input type="checkbox"/> \$25,000 - 29,000 | <input type="checkbox"/> \$45,000 - 49,999 |   |
| <input type="checkbox"/> \$10,000 - 14,999 | <input type="checkbox"/> \$30,000 - 34,999 | <input type="checkbox"/> \$50,000 - 54,999 |   |
| <input type="checkbox"/> \$15,000 - 19,999 | <input type="checkbox"/> \$35,000 - 39,999 | <input type="checkbox"/> \$55,000 or over  |   |

**\*Annual household income range: (check only one)**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> under \$5,000     | <input type="checkbox"/> \$20,000 - 24,999 | <input type="checkbox"/> \$40,000 - 44,999 | <input type="checkbox"/> Do not wish to comment |
| <input type="checkbox"/> \$5,000 - 9,999   | <input type="checkbox"/> \$25,000 - 29,000 | <input type="checkbox"/> \$45,000 - 49,999 |   |
| <input type="checkbox"/> \$10,000 - 14,999 | <input type="checkbox"/> \$30,000 - 34,999 | <input type="checkbox"/> \$50,000 - 54,999 |   |
| <input type="checkbox"/> \$15,000 - 19,999 | <input type="checkbox"/> \$35,000 - 39,999 | <input type="checkbox"/> \$55,000 or over  |   |

**Personal Income Source(s):**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Employment      | <input type="checkbox"/> Savings/Trust       | <input type="checkbox"/> Private Pension    | <input type="checkbox"/> Disability Veterans Allowance |
| <input type="checkbox"/> Spousal Support | <input type="checkbox"/> Canada Pension Plan | <input type="checkbox"/> Insurance Benefits | <input type="checkbox"/> Employment Insurance          |
| <input type="checkbox"/> WSIB            | <input type="checkbox"/> Family Benefits     | <input type="checkbox"/> Company Pension    | <input type="checkbox"/> Other (i.e., ODSP)            |
|  |  |   | <input type="checkbox"/> Do not wish to comment        |

**Declaration and Signatures**

In the event that the applicant is only able to provide verbal consent, the signature of a witness is required. The Witness, when required, acknowledges that the applicant has confirmed that the Supervisor/Designate has explained each clause of this document to him or her and that the applicant appears to have fully understood this document.

This form may be signed by either the applicant or their active Substitute Decision-Maker (SDM). Where there is a signature of an active SDM, March of Dimes must have documentation validating status as a Substitute Decision-Maker on file.

I, \_\_\_\_\_ have reviewed this Brain Injury Service Application and agree that the contents of this application are a true and accurate reflection of my needs.

In the event that March of Dimes Canada is unable to reach me regarding placement on the waitlist, I agree that staff may contact my referral source and/or the emergency contact person for assistance in locating me.

<b>Name of applicant/Active substitute decision-maker (print name):</b>	<b>Signature:</b>	<b>Date (mm/dd/yy):</b>
<b>Name of Witness (if applicable – please print):</b>	<b>Signature:</b>	<b>Date (mm/dd/yy):</b>