

Protection (Privacy) of Client Personal Information

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.



Attendant Services Service Application

This form is consistent with Policy AS 02 01

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

* Only required when Client unable to sign on own

PLEASE NOTE:

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

Applicant Name:	Office Use Only
Date:	
	Client #:

March of Dimes Canada Community Support Services 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 and 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.**

<u>LEGEND</u>	
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"/> Central Ontario Community Support Services Office Oak Ridges 13311 Yonge St, Suite 202 Richmond Hill, ON L4E 3L6	<input type="checkbox"/> Richmond Hill: Observatory Towers SHP AS 119005 1,2 bdrm
	<input type="checkbox"/> Markham: Kin Village SHP AS 119004 1,2,3 bdrm
	<input type="checkbox"/> Thornhill: SHP AS 119008 1,3 bdrm
	<input type="checkbox"/> York Region: OAS 119002

(905) 773-7758 x 6216
 1-800-567-0315 x 6216
 Fax: (905) 773-5176

Vaughan Congregate Care:
 CC AS 119009 1,3 bdrm

LOCATIONS	OFFICES
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Toronto Central
 Community Support Services
 151 Mill Street, Ste 313
 Toronto, ON
 M5A 4T8

 (416) 922-2881

Toronto: York University SHP AS 118006
 Toronto: Meynell House CC AS 118005
 Toronto: Stephanie McCaul
 SHP AS 118004 1 bdrm
 Toronto: Bloor St. SHP AS 118007 1 bdrm
 Toronto: Cooperage St.,
 AS SHP 118008 1,2,3 bdrm
 Toronto: Maple House SHP AS 118010
 **ALC program
 Toronto: OAS 118002

To apply to York Region Outreach Attendant Care or Supportive Housing Programs and Toronto Supportive Housing Programs, please download and complete the Attendant Services Application Centre (ASAC) application on the Centre for Independent Living Toronto (CILT) website at: <http://cilt.ca/programs-and-services/asac/asac-application-and-guide>

East Ontario
 Community Support Services Office
 6 Glenn Wood Place
 Brockville, ON
 K6V 2T3

 1-888-252-9008 x6408
 Fax: (613) 342-7636

Brockville: AS SHP 111004 1 bdrm
 Brockville-Leeds/Grenville/Lanark:
 OAS 111002
 Ottawa-Barrhaven: AS SHP
 111005 1, 2 bdrm
 Pembroke-Renfrew: OAS 111003



LOCATIONS	OFFICES
<p><input type="checkbox"/> Durham Ontario Community Support Services Office 1615 Dundas Street East, Suite 305 Whitby, ON K1N 2L1</p> <p>1-888-433-0240 Fax: (905) 576-8020</p>	<p><input type="checkbox"/> Durham: OAS 110003</p> <p><input type="checkbox"/> Whitby: Dryden Heights SHP AS 110005 1, 2 bdrm</p> <p><input type="checkbox"/> Oshawa: New Hope SHP AS 110004 1, 2 bdrm</p>
<p><input type="checkbox"/> North Eastern Ontario 96 Larch St., Unit 400 Sudbury, Ontario P3E 1C1</p> <p>AS Enquiries: (705) 254-1099 Fax: (705) 671-6240</p>	<p><input type="checkbox"/> Sault Ste. Marie: Cara SHP AS 114014 1 bdrm</p> <p><input type="checkbox"/> Sault Ste. Marie: Northern SHP AS 114003 1 bdrm</p> <p><input type="checkbox"/> Sault Ste. Marie: Seniors Program AS 114012</p> <p><input type="checkbox"/> Elliot Lake/Algoma: OAS 114006</p> <p><input type="checkbox"/> Sault Ste. Marie/Algoma: OAS 114007</p>



LOCATIONS	OFFICES
<p><input type="checkbox"/> Southern Ontario Community Support Services Office 3340 Schmon Parkway Unit 1E Thorold, ON L2V 4Y6</p> <p>(905) 687-8484, x250 1-800-263-4742 Fax: (905) 685-6651</p>	<p><input type="checkbox"/> Haldimand Norfolk Region: OAS 113004</p> <p><input type="checkbox"/> Niagara Falls: Stamford Kiwanis SHP AS 113007 1,2 bdrm</p> <p><input type="checkbox"/> Niagara-on-the-Lake: Niagara College OAS 113003</p> <p><input type="checkbox"/> Niagara Region: OAS 113003</p> <p><input type="checkbox"/> St. Catharines: Faith Lutheran SHP AS 113010 1,2 bdrm</p> <p><input type="checkbox"/> St. Catharines: Brock University OAS 113003</p> <p><input type="checkbox"/> St. Catharines: Ridley Terrace SHP AS 113009 1,2 + 3 bdrm</p> <p><input type="checkbox"/> St. Catharines: Scott Street SHP AS 113011 1, 2 bdrm</p> <p><input type="checkbox"/> Welland: Niagara College OAS 113003</p>
<p><input type="checkbox"/> South Central Ontario Community Support Services Office 20 Jarvis St. Hamilton, ON L8R 1M2</p> <p>(905) 528-4261, ext 4219 Fax: (905) 528-7762</p>	<p><input type="checkbox"/> Burlington / North Halton: OAS (112002-Halton N.)</p> <p><input type="checkbox"/> Hamilton: Central Place SHP AS 112006 1,2 bdrm</p> <p><input type="checkbox"/> Hamilton: Jason's House CC AS 112008</p> <p><input type="checkbox"/> Hamilton: OAS 112004</p> <p><input type="checkbox"/> Hamilton: St. John's Place SHP AS 112007 1,2 bdrm</p> <p><input type="checkbox"/> Hamilton: Villa Verdi SHP AS 112009 1,2 bdrm</p>



LOCATIONS	OFFICES
<input type="checkbox"/> South Western Ontario Community Support Services Office 1086 Modeland Road Building 1050 Sarnia, ON N7S 6L2 (519) 332-4702 x 5506 Fax: (519) 332-3961	<input type="checkbox"/> Chatham / Kent: OAS 117004 <input type="checkbox"/> Chatham Tecumseh: SHP AS 117010 1 bdrm <input type="checkbox"/> Chatham: Riverway SHP AS 117011 1 bdrm <input type="checkbox"/> Chatham: McNaughton SHP AS 117012 1 bdrm <input type="checkbox"/> Drayton: Conestoga Crest SHP AS 117009 1 bdrm <input type="checkbox"/> Sarnia / Lambton: OAS 117005 <input type="checkbox"/> Sarnia: Standing Oaks CCH AS 117015 <input type="checkbox"/> Sarnia: Guernsey Gardens S HP AS 117014 1 bdrm <input type="checkbox"/> Sarnia: Ozanam Manor SHP AS 117013 1 bdrm <input type="checkbox"/> Sarnia: Maxwell Park Place SHP AS 117016 1,2 bdrm <input type="checkbox"/> Wellington County: OAS 117003



LOCATIONS	OFFICES
<input type="checkbox"/> West Central Ontario Community Support Services Office 2227 South Millway, Suite 305 Mississauga, ON L5L 3R6 (905) 607-3463 Fax: (905) 607-9856	<input type="checkbox"/> Brampton/Caledon: OAS 116002 <input type="checkbox"/> Brampton: Fletcher’s View: SHP AS 116007 1 bdrm <input type="checkbox"/> Dufferin: OAS 116005 <input type="checkbox"/> Oakville: Oakville Supportive Living Centre SHP AS 116013 1,2 bdrm <input type="checkbox"/> Oakville: OAS 116004 <input type="checkbox"/> Mississauga: Britannia Place SHP AS 116010 1,2 bdrm <input type="checkbox"/> Mississauga: OAS 116003 <input type="checkbox"/> Mississauga: Surveyor’s Point SHP AS 116009 1,2 bdrm – 55 yrs + <input type="checkbox"/> Mississauga: Weaver’s Hill SHP AS 116011 1,2 bdrm <input type="checkbox"/> Mississauga: Windsor Hill SHP AS 116008 1,2,3 bdrm <input type="checkbox"/> Shelburne: SHP AS 116014 1 bdrm <input type="checkbox"/> Etobicoke: Seniors Supports for Daily Living Program AS 116015 – 65 yrs + <input type="checkbox"/> Mississauga: Seniors Supports for Daily Living Program AS 116012 – 65 yrs +

Unless otherwise noted within a section, the information in this form is required so that we may assess your entitlement to Attendant 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.

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

Applicant Information

<input type="checkbox"/> Mr.	*First Name:	*Last Name:
<input type="checkbox"/> Mrs.		
<input type="checkbox"/> Ms.		

Preferred Name:

Preferred Pronoun (optional):

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

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

Home Phone: ()	Fax: ()
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Cell Phone: ()	E-mail Address:
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*Gender:	Marital Status:
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married
<input type="checkbox"/> Other	<input type="checkbox"/> Common-law <input type="checkbox"/> Separated
<input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed



*Birth Date (mm/dd/yy):

*Do you have a valid Ontario Health Card?
[] Yes [] No
(Must show @ intake interview)

* Health Card Expiry Date (where applicable)

Emergency Contact Name:

Emergency Contact Relationship:

Emergency Contact Address:

Emergency Contact Phone:

Type of Community Support Service being applied to for specific location:

Program: [] Attendant Services

Sub-Program: [] Outreach Services [] Supportive Housing Program
[] Respite [] Congregate Care Home

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

Approximately how many hours per week of care are you requesting from MODC?:

[] Personal Care: _____

[] Homemaking (i.e. light housekeeping, laundry): _____

[] Other (specify): _____

Have you previously applied for Community Support Services:

[] Yes [] No [] Not Sure

If yes, when? (mm/dd/yy):

And for what service?:

Language(s) Spoken: [] English [] French [] Sign language
[] (ASL/LSQ) [] Other:

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

Contact Information for Consent Source (if other than self):

Name (first & last):

Active Substitute Decision-Maker:
 Power of Attorney for Personal Care
 Power of Attorney for Financial Care
 Next of kin/spouse

Home Phone: ()	Business Phone: () Ext.	Alternative Phone: () Ext.
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Cell Phone: ()	E-Mail Address:
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Contact Information for Referral Source (if other than self)

Referred by:	Agency:
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Phone Number: () Ext.	Fax Number: ()
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Address:

City:	Province:	Postal Code:
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Cell #: ()	E-mail Address:
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*Primary disability:	Secondary disability:
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***Reason for primary disability:**
 Aging
 Congenital
 Acquired
 Accident at Work
 Accident at Home
 Motor Vehicle Accident
 Assault
 Fall Non-Sports Related
 Sports

***Date of onset of primary disability (mm/dd/yy):**

Other Health Concerns:

- 1)
- 2)
- 3)



Please list any assistive devices that you currently use:

1)	6)
2)	7)
3)	8)
4)	9)
5)	10)

Living Conditions	Living Arrangements
<input type="checkbox"/> Home (Rented) <input type="checkbox"/> Home (Owned) <input type="checkbox"/> Home (Family Or Friend) <input type="checkbox"/> Children's Hospital <input type="checkbox"/> Nursing Home <input type="checkbox"/> Rehabilitation Hospital <input type="checkbox"/> Chronic Care Hospital <input type="checkbox"/> Home For The Aged <input type="checkbox"/> Institution	<input type="checkbox"/> Live alone <input type="checkbox"/> Live alone with dependent children <input type="checkbox"/> Live with parents or step-parents <input type="checkbox"/> Live with spouse or other adults <input type="checkbox"/> Live with spouse or other adults and dependent children <input type="checkbox"/> Live in Shared Housing with support staff <input type="checkbox"/> Other:

Current Professional/Attendant 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			
Brain Injury Services			
Other <i>(specify)</i> :			

What type of transfer(s) do you currently use? (Check all that apply):

- Transfer Unassisted Pivot – with minimal assistance
 Pivot – with full assistance Two-Person Lift
 Transfer belt/board/disk Mechanical Lift
 Supervision Required Other (specify):

Have current assessments been completed for your service?

- Yes No

Are we authorized to receive a copy of these assessments for current service? Yes No

(If Yes, ensure that “Authorization to Obtain and/or Release Information” form [CSS 02-xx] is signed)

Please complete the charts below by placing an X in the appropriate boxes

Type of Assistance	No assistance required	Some assistance required	Full assistance required (staff)
<p>Transfers: Chair to chair In/out of bed In/out shower/tub On/off toilet/commode One-person assist with lift One-person assist without lift Two-person assist with lift Supervision Required Comments:</p>	<input type="checkbox"/> 	<input type="checkbox"/> 	<input type="checkbox"/>
<p>Positioning/Turning: One-person assist with lift One-person assist without lift Supervision Required Comments:</p>	<input type="checkbox"/> 	<input type="checkbox"/> 	<input type="checkbox"/>
<p>Walking: Please specify:</p>	<input type="checkbox"/> 	<input type="checkbox"/> 	<input type="checkbox"/>
<p>Bowel and Bladder: Bladder - condom catheter Bladder - indwelling catheter Bladder - intermittent catheter Bowel - suppositories Bowel - digital stimulation</p>	<input type="checkbox"/> 	<input type="checkbox"/> 	<input type="checkbox"/>



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Stoma care Bedpan/urinal Diaper change Comments:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Basic Hygiene: Washing hands and/or face Pericare Mouth Care Hair Care Comments:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Bathing and Showering: Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing/Undressing: Lower body Upper body Footwear Buttons/zippers/hooks Braces/prosthesis Comments:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Skin Care: Repositioning at night Special skin care/treatments Comments:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Meal Preparation: Cooking Cutting up food Eating/feeding Splints	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>



Straw/drinks Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light Housekeeping/Household Management: Dusting Mop/sweep/vacuum Dishes Laundry Garbage Making/changing bed Comments:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Respiratory Care Lung augmentation exercise (assistive coughing/ ambubag) O ₂ assistance Trach care Trach suction CPAP (Continuous Positive Airway Pressure) BIPAP (Bilevel Positive Airway Pressure) Ventilator Comments:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Miscellaneous Assisted Exercise/Range of Motion(ROM) TV/radio/stereo	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>



Attendant Services Service Application

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Locks/keys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Windows open/close	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assistive aids (setup/shut down)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Verbal Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Battery charging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telephone assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal vehicle (assist in/out)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Privacy Statement

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

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

Declaration and Signatures

In the event that the Applicant is only able to provide verbal consent, the signature of a witness is required.

March of Dimes Canada' approval process requires that there be documentation validating status of Substitute Decision Maker (SDM) submitted during approval process.

I, _____ have reviewed this Community Support Service Application and agree that the contents of this application are a true and accurate reflection of my needs.

Name of applicant/active substitute decision maker (print name):	Signature:	Date (mm/dd/yy):
* Name of Witness (if applicable – please print):	Signature:	Date (mm/dd/yy):

* The Witness acknowledges that they have explained each clause of this document to the applicant and that the Applicant appears to have fully understood.