Attendant Care Service Referral/Request Form

Please print and return by
Fax 705 737-1874 , mail to: ILS,1102-44 Cedar Pointe Drive, Barrie, ON L4N 5R7
Or email to intake@ilssimcoe.ca

Name: _____

Date of Birth: _____
dd/mm/yyy

HC#: _____ Version Code: _____

Address: _____

Phone# ( ) _____

Live Alone ☐ With Family ☐

Do you Receive Services from any agency? Yes ☐ No ☐

Gender: Female ☐ Male ☐

Diagnosis of *Permanent Physical Disability*

Must be confirmed by Physician

Consent to Share Information Yes ☐ No ☐

Large Print Material Request: Yes ☐

IF THIS APPLICANT DOES NOT MEET OUR ELIGIBILITY CRITERIA THE REFERRAL WILL BE RETURNED TO THE REFERRAL SOURCE

Program

Attendant Outreach Services ☐

Supportive Housing Services ☐

Referral Completed By _____

Agency Phone # _____

Email _____

Fax # _____

Date _____

☐Include most recent Inter RAI Assessment

☐Is Inter RAI Assessment Available on IAR

Eligibility Criteria

Be insured under the Health Insurance Act of Ontario

Be 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 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 on a visitation basis *(e.g. Social Work, Nursing, Physiotherapy, etc.)*

FOR ILS OFFICE USE ONLY

ACCEPTS REFERRAL: YES ☐ NO ☐

Reason for ineligibility :

ASSESSOR NAME: _____ **SIGNATURE:** _____

DATE: