PARTICIPATION SUPPORT SERVICES
Formerly Participation House Brantford
your care, your home, your way

APPLICATION FOR SERVICES

Type of Service requested (check all that apply)

	Supportive Housing (10 Bell Lane)
	Supportive Housing (255 Colborne Street)
	Supportive Housing (Stedman)
	Attendant Care Outreach
	Respite (Aging at Home)
	Assisted Living and Community Collaborative (Home & Community Care Support Services)
	Transitional Care (must be referred from Home & Community Care Support Services)

Urgency of need of service:

	Crisis – within the next 2-3 days
	Urgent – within the next month
	Immediate – within 6 months
	Non-Urgent – 6 months or more

Date of Application:	
Applicant's Name:	
Address:	
Date of Birth:	
Male / Female (circle)	Marital Status:
Source of Income:	
Health Card Number:	ODSP:
Clinical diagnosis/reason for referral (if known):	

Current Placement if not at above address:

Box 2048, 10 Bell Ln, Brantford, ON N3T 5W5
t (519) 756-1430 • w pssbrantford.ca

RE-ACCREDITED FOCUS ACCREDITATION 2020 - 2024 ORGANIZATION

Ontario Health

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Telephone No:	
Date of Birth:	
Contact Person:	
Relationship:	
Address:	
Telephone #:	Email Address:

Referral Information:	
Name of person referring:	
Agency:	
Contact - Phone:	Email:
Date of last RAI assessment (if known):	

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RELEASE OF INFORMATION

I hereby grant permission to the Executive Director of **PARTICIPATION SUPPORT SERVICES** to obtain/give information from/to any social/medical/educational authorities for program or medical needs for the undersigned resident.

_____

_____

_____

_____

_____

_____

_____
Applicant Signature

_____
Date

_____
Witness Signature

_____
Date

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CLIENT PROFILE SHEET

Name:	**DOB:**
Home Address:	**Postal Code:**
	Phone:

Referral Source: ❑ Hospital ❑ HNHB Home and Community Care ❑ other_____

Contact Person: _____

Attachments : ❑ RAI HC/RAI CHA ❑ Care Plan ❑ other _____

Emergency/Family Contact: _____

Reason for Stay/ Goal: _____

_____

Discharge Destination: _____

HNHB Home & Community Care Referral Initiated: ❑ Yes, for: _____ ❑ n/a

Medical Information

H.C.	
Physician:	**Phone:**

Diagnosis:_____

_____

Allergies: _____

Medication & Treatment Orders : (attach orders and copy of MARS) ❑

Pharmacy: _____ **Phone:** _____

ODSP? ❑ Y ❑ N #_____

Other Allied Health Professionals Involved: _____

Agency/Provider :_____ **Phone:** _____

Care Plan to be completed on reverse

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Details / Description of Care Requirements

Mobility ❑ambulatory ❑ wheelchair	
Transfer ❑ independent ❑ transfer assist ❑ lift	
Diet ❑ independent eating ❑ must be fed	
Elimination ❑ continent ❑ incontinent	
Oral Care ❑ natural teeth ❑ dentures	
Skin Care/condition ❑ skin breakdown? ❑ history of breakdown	
Other:	
Other:	

Complete Upon Admission:

Date of Admission: _____ **Room:** _____

Anticipated Length of Stay: _____

Admitted By: _____