



765 Brennan Road
 Sudbury ON P3C 1C4
 P 705-673-0655
 F 705-673-6682
 www.ican-cerd.com
 info@ican-cerd.com

ICAN Application for Services

We are committed to protecting the privacy, confidentiality and security of all personal information entrusted to us.

Client Personal Information

Name:		
Address:		
City/Province:	Postal Code:	
Phone (home):	Phone (cell):	
Date of Birth: <small>Month/Day/Year</small>	Gender:	Marital status:
Ontario Health Number:		
Type of Physical Disability:		
Date of Onset: <small>Month/Day/Year</small>		
Preferred language	Smoker Yes / No	

Please give a brief description of the following:

Reason for Application:

Referral Contact Information (if other than client)

<input type="checkbox"/> Next of KIN (family, relative) <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Other: _____	<input type="checkbox"/> Advocate <input type="checkbox"/> Case Manager/Health Care Professional
Last Name, First Name:	Agency/Organization:
Relationship:	Bus. Phone:
Fax number:	E-Mail:

ELIGIBILITY CRITERIA

To be eligible for ICAN Services, answers to the questions below must be Yes.		Yes	No
1	Client must have a permanent physical disability and require personal support services on a continuing basis in order to remain in the community		
2	Client must be sixteen years of age or older		
3	Client must possess a valid Ontario Health Card		
4	Client must be able to have medical/professional needs met by existing community health network		
5	Client must be capable or potentially capable of directing own services		
6	Client must be able to live safely unattended (because assistance is by appointment)		

If a RAI Assessment is available please forward a copy and do not complete the section on Physical and Functional Assessment.

Skip pages 3 & 4.

Physical Assessment:

Code: **1** - Functioning okay **2** - Requires Technical Aid **3** - Problem

Eye Sight	1	2	3	_____
Hearing	1	2	3	_____
Communication	1	2	3	_____

Functional Assessment:

Code: **1** - Independent **2** - Some Assistance Required **3** - Complete Assistance Required

Indoor Mobility

With Mechanical Aid	1	2	3	_____
Without Mechanical Aid	1	2	3	_____
Stairs	1	2	3	_____
Wheelchair	1	2	3	_____

Outdoor Mobility

With Mechanical Aid	1	2	3	_____
Without Mechanical Aid	1	2	3	_____
Stairs	1	2	3	_____

Transfers

With Mechanical Device	1	2	3	_____
Without Mechanical Device	1	2	3	_____
Dressing	1	2	3	_____
Reposition in bed	1	2	3	_____
Repositioning in w/c	1	2	3	_____

Washroom Assistance

Bladder Continent Incontinent
Bowel Continent Incontinent

Please list procedure for bladder/bowel care including equipment used and indicate level of assistance required.

Code: **1** - Independent **2** - Some Assistance Required **3** - Complete Assistance Required

Performance Hygiene

Shower/Tub	1	2	3	_____
Sponge Bath	1	2	3	_____
Care for Skin Breakdown	1	2	3	_____

Personal Grooming

Hair	1	2	3	_____
Shaving	1	2	3	_____
Mouth Care/Teeth	1	2	3	_____

Meal Preparation

Breakfast	1	2	3	_____
Lunch	1	2	3	_____
Supper	1	2	3	_____
Assistance with eating	1	2	3	_____

Please state how housekeeping, laundry and grocery shopping are currently being managed

Housekeeping	1	2	3	_____
Laundry	1	2	3	_____
Grocery shopping	1	2	3	_____

Person completing this form (if not applicant)

Name: _____

Address: _____

Telephone: _____

Relationship
to applicant: _____

I confirm to the best of my ability that the above information
accurately reflects my situation.

Signature
of Applicant: _____

Witness: _____

Date: _____

Please return completed form to:

ICAN - Independence Centre and Network

By mail or in person to:

765 Brennan Road, Sudbury ON P3C 1C4

or

By e-mail to: info@ican-cerd.com

or

By fax to: 705-673-6682