ICAN INDEPENDENCE CENTRE AND NETWORK
CERD CENTRE ET RÉSEAU D'INDÉPENDANCE

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ICAN Application for Services

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

Client Personal Information

Salutation	First Name	Last Name
Address		
City/Province	Postal Code	
Phone (home)	Phone (cell)	
Date of Birth Month/Day/Year	Gender	Marital status
Ontario Health Number		
Type of Physical Disability		
Date of Onset Month/Day/Year	Smoker Yes No	
What is your mother tongue?		
If your language is neither English nor French, in which official language are you most comfortable?		

Please indicate which program you are applying to:

☐ Supportive Housing - Accessible Housing with Personal Support Services
☐ Outreach - Assistance in the home needed
☐ Exercise Program - Physical Activities
☐ Other: ____

Referral Contact Information (if other than client)

☐ Next of KIN (family, relative) ☐ Power of Attorney ☐ Other:____________________________	☐ Advocate ☐ Case Manager/Health Care Professional
First Name, Last Name	Agency/Organization
Relationship	Phone Number
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.

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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	____________________

BEHAVIOURAL SYMPTOMS

Instances when client exhibited behavioural symptoms.

If EXHIBITED, ease of altering the symptom when occurred.

0 - Did not occur in the last 3 days

1 - Occurred, easily altered

2 - Occurred, not easily altered

Behaviour	Code	Explanation
Wandering		
Verbally abusive behavioural symptoms		
Physically abusive behavioural symptoms		
Socially inappropriate/ disruptive behavioural		
Resists care		

COGNITIVE PATTERNS

Cognitive	Yes / No	Explanation
Memory recall ability		
Cognitive skills for daily decision making		
Indicators of delirium		
Addictions		

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

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

By fax to: 705-673-6682