

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 <small>Month/Day/Year</small>		Gender	Marital status
Ontario Health Number			
Type of Physical Disability			
Date of Onset <small>Month/Day/Year</small>		Smoker Yes / No	
What is your first language?			
If your language is neither English nor French, in which official language are you most comfortable?			

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
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.

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