Head Injury Rehabilitation Ontario

APPLICATION FOR SERVICE
24 HR RESIDENTIAL

Tel: 905-523-8852 ext. 123 **Fax:** 905-523-8211
Email: admissions@hiro.ca **Web:** www.hiro.ca

TO BE COMPLETED BY **APPLICANT / REFERRAL SOURCE**

Veuillez communiquer avec nous pour obtenir la version française de la demande de services.

ELIGIBILITY CRITERIA

Please review the following criteria for 24HR residential services.

The applicant must:

- ❑ have a diagnosis of an acquired brain injury, as confirmed by a physician;
- ❑ be eighteen years of age or older;
- ❑ not be diagnosed with a progressive or degenerative disease/disorder;
- ❑ not be diagnosed with a developmental disability, in-utero/at birth ABI, or pediatric (<16) ABI;
- ❑ demonstrate capacity for functional rehabilitation, defined as:
    - Generally oriented to person and place (may not be oriented to time, or to their exact location – e.g. "I'm at home" vs. the city or address)
    - Basic self-awareness (e.g. able to notice if incontinent, to select appropriate clothes for the weather, etc.)
    - Follows 1 to 2 step commands
    - Can sustain attention for longer than 15 minutes (if motivated)
    - Responds to compensatory strategies and/or demonstrates some retention of new learning
    - Able and willing to tolerate constant daily prompting for independent participation in life tasks, and structured rehabilitation programming 1+ hour(s) per day

  OR

    - None of the above – The applicant has a goal to identify suitable non-pharmaceutical or physical restraint options for managing behaviour.
- ❑ be willing to relocate to the Hamilton/Niagara area;
- ❑ be insured under OHIP;
- ❑ not have active substance abuse issues or use non-prescribed marijuana;
- ❑ be medically and psychiatrically stable, including:
    - not require that nursing care be available on site 24 hours a day;
    - not require sliding scale medication;
    - not require internal catheterization;
    - not being reliant on tube-feeding long-term;
    - not using hospital-only administered medications;

  Applicants with additional medical, physical or psychiatric needs will be considered on a case-by-case basis.

If the applicant meets the eligibility criteria listed above, please proceed to the next page to complete the application.

PERSONAL INFORMATION

Applicant's Name: _____ ☐ Male ☐ Female ☐ Other
(first name) (last name)

Health Card Number: _____/_____ Expiry Date: _____
Applicant must have a valid physical copy of their health card version code DD/MM/YYYY

Date of Birth: _____ Date of Application: _____
DD/MM/YYYY DD/MM/YYYY

Current Living Situation:

☐ House/Apartment ☐ Supported Housing ☐ Residential Care Facility ☐ Hospital ☐ Long Term Care Facility ☐ Unsheltered

☐ Other: _____

Address: _____
Number Street City Postal Code Apartment(Intercom #)

Home Telephone: _____ Cell Phone: _____

Email Address: _____

If/when discharged from HIRO, please identify anticipated discharge location: _____

Marital Status: ☐ Single ☐ Married/Common Law ☐ Separated/Divorced ☐ Other:_____

Primary Language: ☐ English ☐ French ☐ Other: _____ Interpreter Required: ☐ Yes ☐ No

Decision Maker (Property): Name _____ Telephone:_____

Designation: ☐ Self ☐ Substitute Decision Maker ☐ Power of Attorney ☐ Public Guardian & Trustee ☐ Statutory Guardian
**Power of Attorney, Public Guardian & Trustee, Statutory Guardian and/or capacity assessments or documents must be attached.*

Decision Maker (Personal Care): Name _____ Telephone:_____

Designation: ☐ Self ☐ Substitute Decision Maker ☐ Power of Attorney ☐ Public Guardian & Trustee ☐ Statutory Guardian
**Power of Attorney, Public Guardian & Trustee, Statutory Guardian and/or capacity assessments or documents must be attached.*

BRAIN INJURY INFORMATION

Date of Brain Injury: _____
DD/MM/YYYY

Cause of Injury: _____
(anoxia, assault, motor vehicle accident, fall etc.)

REFERRAL INFORMATION

Who is making the referral? ☐ Myself (if self, move to next section) ☐ Family Member ☐ Friend

☐ Community Service Provider ☐ Case Manager ☐ Lawyer

Name: _____ Position/Relationship: _____

Telephone:_____ Fax: _____ Email: _____

RELEVANT TREATMENT HISTORY (including current services)

Program/ Facility/ Hospital or Agency	Contact Information (name, position, phone number, email, fax)	Dates Involved

SUPERVISION NEEDS

Please select the appropriate level of supervision needs required for the applicant in each category:

Supervision Needs	Low	Medium	High
Medical Considerations Frequency and intensity of medical concerns (e.g., Seizures, panic attacks, self-harm, choking risk, suicide risk, prosthetic care). *Consider: mental wellness*.	☐ • Low frequency (monthly); • Intensity - minor intervention to manage; may require up to 15 minutes; • never requires EMS intervention); • Co-morbidities have been stable for > 1 year OR no co-morbid concerns	☐ • Moderate frequency (weekly); • Intensity - moderate intervention to manage; may require up to 30 minutes; • rarely requires EMS intervention); • Co-morbidities fluctuate, but support is present	☐ • High frequency (> weekly) • Intensity - high intervention to manage; may require up to 1 hour; • may require EMS intervention); • Co-morbidities fluctuate, but support is present
Passive Supervision e.g., Napping, watching television, sedentary leisure in room. *Consider: Un/intentional self-harm risk, confusion, disorientation.*	☐ Safe to be unsupervised for up to 1 hour or more	☐ Requires a check-in every 30 minutes	☐ Requires constant checks (including video monitoring) 24 hours per day
Behaviours and Emotional Support Frequency of prompting and cuing; substance seeking; elopement; manipulation. *Consider: Physical, environmental, verbal, or sexual behaviours.*	☐ Occasional (0-49% of the time) and/or low intensity (immediate reconciliation of 1 person)	☐ Often (50-75% of the time) and/or moderate intensity (may require up to 30 minutes of 1 person to de-escalate)	☐ Always (76-100% of the time) and/or High intensity/immediate risk of harm; may require 2+ people to de-escalate
Personal Care Needs Direct care assistance (e.g., toileting, hygiene and peri-care, dressing, transfers, showering) for the client. *Consider: Continence.*	☐ May require support for morning and night routines and/or requires 0-2-person assistance for any personal care	☐ Requires direct personal care at moderate frequency (e.g. every 4-6 hours) and/or requires 1-2-person assistance for any personal care	☐ Requires direct personal care at a high frequency (e.g. every 2 hours) and/or requires 3-person assistance at any time
Social and Congregate Considerations *Consider: Are antecedents to behaviour often social in nature? Is overstimulation in a home setting triggering? Do they seek conflict? Are they physically imposing or difficult to redirect when escalated? Do they need isolation or quiet space? Do they disrupt others?*	☐ Mildly irritated by others and/or disrupts others occasionally (0-49% of the time) and/or requires redirection by staff	☐ Moderately irritated by others and/or disrupts others often (50-75% of the time) and/or requires redirection by staff	☐ Highly irritated by others and/or disrupts others always (76-100% of the time) and/or efforts to redirect are challenging

PERSONAL CARE NEEDS

HIRO is a long-stream rehabilitation facility, and we are staffed accordingly.

Personal care services are limited to the following:

- No sliding scale medications;
- No regular access to nursing;
- No mechanical restraints, security guards, or seclusion rooms to manage behaviours;
- Cannot require 3-person assistance for any ADLs, or transfers;
- Applicant must be independent in bed mobility and/or wheelchair positioning (if applicable);
- Applicant must be able to self-propel/locomote independently (or with standby supervision) up to 9 meters;
- Applicant must be able to tolerate being "up" (in wheelchair, if applicable) for the majority of a day.

CUSTODIAL CARE NEEDS

Please select the appropriate level of care needs required for the applicant in each category and provide any/all equipment required to complete the task:

Tasks	Equipment	Independent	Set Up Only	Prompts / Cues	1-Person assistance	2-Person assistance	3+ Person assistance
Transfers and Mobility							
Mobilize 9m Indoors		☐	☐	☐			
Community Mobility		☐	☐	☐	☐	☐	
Lie to sit (bed)		☐	☐	☐	☐	☐	
Sit to stand		☐	☐	☐	☐	☐	
Toilet transfer		☐	☐	☐	☐	☐	
Bath transfer		☐	☐	☐	☐	☐	
Car transfer		☐	☐	☐	☐	☐	
Personal Care							
Un/Dressing		☐	☐	☐	☐	☐	
Hair Care & Shaving		☐	☐	☐	☐	☐	
Toenail Care		☐	☐	☐	☐	☐	
Fingernail Care		☐	☐	☐	☐	☐	
Oral Care		☐	☐	☐	☐	☐	
Hand hygiene		☐	☐	☐	☐	☐	
Showering		☐	☐	☐	☐	☐	
Feeding	Specialty Diet:	☐	☐	☐	☐	☐	
Medication		☐	☐	☐	☐	☐	
Bowel Hygiene	Yes☐ No☐ Overnight Incont.☐	☐	☐	☐	☐	☐	
Urine Hygiene	Yes☐ No☐ Overnight Incont.☐	☐	☐	☐	☐	☐	
Menstrual Care		☐	☐	☐	☐	☐	

REHABILITATION GOALS

HIRO does not offer permanent housing. Please identify potential goals for rehabilitation, if admitted:

- ☐ Improve independence with basic Activities of Daily Living – e.g. toileting, showering, grooming etc. Improve
- ☐ independence with instrumental Activities of Daily Living – e.g. cooking, shopping, cleaning etc. Improve
- ☐ social and behavioural skills in a congregate environment
- ☐ Volunteering/School/Working
- ☐ Maintain sobriety
- ☐ Other: _____

FINANCIAL INFORMATION

Please specify public source(s) of income:

- ☐ Ontario Disability Support Program (ODSP)
- ☐ Ontario Works (OW)
- ☐ Canada Pension Plan (CPP)
- ☐ Old Age Security (OAS)
- ☐ Veterans Affairs Canada
- ☐ Employment Insurance (EI)
- ☐ Full Time Employment
- ☐ Part Time Employment

Monthly Income: _____

Please identify applicable private funding sources:

- ☐ Long Term Disability (Private)
- ☐ Motor Vehicle Insurance
- ☐ Workplace Safety Insurance Board (WSIB)
- ☐ Extended Health Benefits
- ☐ Settlement
- ☐ Other: _____

Please attach any third party or private insurer information, if applicable.
If involved in litigation, please attach relevant contact information (e.g. legal counsel, case management).

EMERGENCY CONTACT

Emergency Contact Name: _____
(first name) (last name)

Relationship: _____

Address: _____
Number Street City Postal Code Apartment(Intercom #)

Home Telephone: _____ Cell Phone: _____

Email Address: _____

ADDITIONAL INFORMATION

Please identify other services you have applied to:

HOUSING:

- ☐ Indwell
- ☐ March of Dimes
- ☐ Good Shepherd
- ☐ Christian Horizons
- ☐ Long Term Care (LTC)
- ☐ OTHER: _____

ABI SERVICES:

- ☐ Connect Communities
- ☐ Hamilton Brain Injury Association (HBIA)
- ☐ Hamilton Health Sciences (ABI Program)
- ☐ Brain Injury Community Re-entry (BICR)
- ☐ Brain Injury Association Niagara (BIAN)
- ☐ OTHER: _____

Please ensure the following are attached, if applicable:

- A scanned copy of valid Government-issued ID (**NOT** health card) or Birth Certificate. *Note: the physical ID must be in the Applicant's possession for admission consideration.*
- Decision maker paperwork *(Power of Attorney, Statutory Guardianship, and/or Public Guardian & Trustee*)
- Relevant medical consultation reports *(e.g. Neuropsychology, Occupational Therapy, Psychiatry etc.)*
- Current medication list
- Insurance or litigation paperwork/contact information

I, _____

Name of Applicant/Substitute Decision Maker/Power of Attorney

Certify that the above information is correct, to the best of my knowledge at the time of application.

_____ _____

Signature of Applicant/Substitute Decision Maker/Power of Attorney | Date (DD/MM/YYYY)

As the applicant or authorized Decision Maker, I consent for Head Injury Rehabilitation Ontario (HIRO) to receive this applicant's personal health information. I permit HIRO to disclose this applicant's personal health information, for the purposes of ABI service consultation, with the following personnel:

- HIRO's internal contract providers (e.g. Family Physician, Psychiatrist, Occupational Therapist, Physiotherapist etc.)
- Current care and/or shelter providers (e.g. hospital team, treatment team, residence etc.)
- Other system partners that may provide counsel to HIRO on the applicant's care and /or shelter (e.g. ABI System Navigator, Office of the Public Guardian & Trustee, Home and Community Support Services etc.)

_____ _____

Signature of Applicant/Substitute Decision Maker/Power of Attorney | Date (DD/MM/YYYY)

_____

Print Name

Personal health information will be protected by HIRO as per the Personal Health Information Protection Act (PHIPA). The applicant and/or their Decision Maker may withdraw consent at any time, by informing HIRO verbally or in writing.

Please return completed applications and relevant assessments/reports to:

Head Injury Rehabilitation Ontario
Attn: Admissions Department
508 – 225 King William St.
Hamilton, ON L8R 1B1

Fax: 905 523-8211

A Promise of Hope After ABI