Updated: June '25

Head Injury Rehabilitation Ontario

APPLICATION FOR SERVICE
OUTREACH SERVICES

Email: admissions@hiro.ca **Fax:** 905-523-8211
Web: www.hiro.ca

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

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

ELIGIBILITY CRITERIA

Please review the following criteria for HIRO's Outreach 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 developmental disability, in-utero/at birth ABI, or pediatric (<16) ABI;
- ❑ demonstrate capacity for functional rehabilitation;
- ❑ be insured under OHIP;
- ❑ be located in the Hamilton, Burlington, Brant, Haldimand and Norfolk regions
- ❑ be medically and psychiatrically stable such that it will not interfere with participation in rehabilitation
- ❑ not have active substance use challenges that would influence participation in rehabilitation regularly;
- ❑ be independently responsible for managing personal care needs (i.e. independent in personal care or receives professional services/social support to complete custodial care needs);
- ❑ be 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);
- ❑ have basic self-awareness (e.g. able to notice if incontinent, to select appropriate clothes for the weather, etc.);
- ❑ respond to compensatory strategies and/or demonstrates some retention of new learning;
- ❑ be able and willing to tolerate structured rehabilitation programming 1+ hour(s) per session.

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: _____

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

MEDICAL / EMERGENCY CONSIDERATIONS

List any/all medical or emergency considerations HIRO staff should be aware of (e.g. allergies, seizures, panic attacks, behaviours, etc.):

REHABILITATION GOALS

Please check off any or all potential goals:

- ☐ Meal preparation and/or cooking
- ☐ Shopping
- ☐ Cleaning and laundry
- ☐ Managing appointments and health concerns
- ☐ Building a routine
- ☐ Driving or bus utilization
- ☐ Home maintenance and/or gardening
- ☐ Passive Leisure (e.g. reading, crafts)
- ☐ Active Leisure (e.g. sports, renovations, going to the gym)
- ☐ Finance Management
- ☐ Other:
- ☐ Sleep Hygiene
- ☐ Social skills and friendships
- ☐ Volunteering
- ☐ Schooling
- ☐ Learning more about my brain injury
- ☐ Working
- ☐ Childcare tasks
- ☐ Sobriety and/or addictions
- ☐ Emotional and mood support

COMMUNICATION CONSIDERATIONS

If you have alternative communication needs, please select from the below (checkbox):

- ☐ Enlarged font
- ☐ Loud/clear audio
- ☐ Picture-based system (e.g. PECS)
- ☐ Text to audio
- ☐ None
- ☐ Other: _____

Please identify your preferred method of communication:

- ☐ Text
- ☐ Email
- ☐ Phone call
- ☐ Video Conferencing – Zoom/Teams
- ☐ Other: _____

FINANCIAL INFORMATION

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:

ABI SERVICES:

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

Please ensure the following are attached, if applicable:

- Decision maker paperwork *(Power of Attorney, Statutory Guardianship, and/or Public Guardian & Trustee*)
- Relevant medical consultation reports *(e.g. Neuropsychology, Occupational Therapy, Psychiatry etc.)*
- 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