



# APPLICATION FOR SERVICE SUPPORTED APARTMENTS

Email: [admissions@hiro.ca](mailto:admissions@hiro.ca) Fax: 905-523-8211

Web: [www.hiro.ca](http://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 HIRO's **Supported Apartments**.

### 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;
- ☐ be willing to relocate to Hamilton;
- ☐ be insured under OHIP;
- ☐ not have active substance abuse issues or use non-prescribed marijuana;
- ☐ will disclose income for subsidy purposes
- ☐ be medically stable (and not require intramuscular injections, hospital-only administered medications, or access to nursing 24/7),  
*Clients requiring any intramuscular injections will be considered on a case-by-case basis.*
- ☐ be psychiatrically stable such that it will not interfere with participation in rehabilitation.

*If the applicant meets the eligibility criteria listed above,  
please proceed with completing the application.*

## REHABILITATION SERVICES INFORMATION

Please identify other services you have applied to:

### HOUSING:

Indwell  
March of Dimes  
Good Shepherd  
Christian Horizons

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: \_\_\_\_\_

## 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 #)
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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 REQUIREMENTS

To be considered for a HIRO Supported Apartment, the below requirements must be met.

### The applicant must:

#### Medical Considerations

- ☐ be independent in administering medications between 10:45pm-7:30am. Assistance in administering oral medications can be provided between the hours of 7:30AM – 10:45PM.

#### Passive Supervision

- ☐ be safe to be unsupervised between the hours of 11pm-7:30am
- ☐ be safe to be unsupervised for up to 2 hours at a time (daytime hours)

#### Behaviours and Emotional Support

- ☐ demonstrate daily motivation to participate in daily life tasks.

#### Personal Care Needs

- ☐ be independent in all personal care (mobility, transfers, toileting, showering, and feeding);
- ☐ be independent to transfer on/off a low toilet and enter/exit a tub-shower without a tub transfer bench. Our apartments all have tub-shower configurations with grab bars;
- ☐ not require a mobility scooter or electric wheelchair. Due to the size of the apartment, applicants requiring these mobility aids will not be eligible;
- ☐ have sufficient standing tolerance to prepare a basic meal in the galley kitchen, without a mobility device or chair;
- ☐ must be independent in simple instrumental activities of daily living (e.g. preparing tea or coffee, preparing a microwave meal or cold dish such as cereal, taking the garbage to the garbage chute, putting laundry in a laundry basket, and basic cleaning).

#### Capacity for Rehabilitation

- ☐ be oriented to person, place, and generally time;
- ☐ have basic self-awareness (e.g. able to notice if incontinent, if hungry, to select appropriate clothes for the weather etc.);
- ☐ follow multi-step commands;
- ☐ sustain attention for longer than 30 minutes;
- ☐ respond to compensatory strategies and/or demonstrates some retention of new learning;
- ☐ demonstrate a tolerance for 2-3 structured rehabilitation programming sessions per day (45-60 min per session) for 5-6 days per week.

HIRO does not offer permanent housing. The intended length of stay is up to four (4) years. Considerations for extension may be applied.

## REHABILITATION GOALS

Please identify potential goals for rehabilitation, if admitted:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Routine Development  | <input type="checkbox"/> Personal Hygiene (showering regularly etc.) | <input type="checkbox"/> Sleep Hygiene     |
| <input type="checkbox"/> Housekeeping         | <input type="checkbox"/> Meal Preparation or Nutrition               | <input type="checkbox"/> Shopping          |
| <input type="checkbox"/> Volunteering         | <input type="checkbox"/> Banking or Financial Skills                 | <input type="checkbox"/> Schooling         |
| <input type="checkbox"/> Working              | <input type="checkbox"/> Leisure Engagement                          | <input type="checkbox"/> Social Skills     |
| <input type="checkbox"/> Gym or Exercise      | <input type="checkbox"/> Bus Utilization Skills                      | <input type="checkbox"/> Maintain Sobriety |
| <input type="checkbox"/> Social/Group options | <input type="checkbox"/> Other: _____                                |  |

## FINANCIAL INFORMATION

Please specify public source(s) of income:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Ontario Disability Support Program (ODSP) | <input type="checkbox"/> Ontario Works (OW)      | <input type="checkbox"/> Canada Pension Plan (CPP) |
| <input type="checkbox"/> Old Age Security (OAS)                    | <input type="checkbox"/> Veterans Affairs Canada | <input type="checkbox"/> Employment Insurance (EI) |
| <input type="checkbox"/> Full Time Employment                      | <input type="checkbox"/> Part Time Employment    |  |

Monthly Income: \_\_\_\_\_

These apartments are offered in conjunction with City Housing Hamilton.

City Housing Hamilton requires the following items to process an application for tenancy:

- ☐ Notice of Assessment;
- ☐ Confirmation of income;
- ☐ 2 pieces of identification (one a Birth Certificate)

If you require assistance in obtaining these items, please contact HIRO for support.

Please identify applicable private funding sources:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Long Term Disability (Private) | <input type="checkbox"/> Motor Vehicle Insurance | <input type="checkbox"/> Workplace Safety Insurance Board (WSIB) |
| <input type="checkbox"/> Extended Health Benefits       | <input type="checkbox"/> Settlement              | <input type="checkbox"/> 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: \_\_\_\_\_

## MANDATORY FURNISHINGS

Clients will not be admitted without the following minimum furnishings and personal belongings:

- |   |  |
|---|--|
| <input type="checkbox"/> A single or double mattress  | <input type="checkbox"/> One set of bed linens ( <i>fitted sheet, pillowcase, and a top sheet and/or blanket</i> )                                 |
| <input type="checkbox"/> A bed-bug cover for mattress | <input type="checkbox"/> Clothes hangers or a small dresser  |
| <input type="checkbox"/> Bed frame                    | <input type="checkbox"/> At least one week of seasonal/appropriate clothing ( <i>including undergarments, coats and shoes</i> )                    |
| <input type="checkbox"/> One pillow                   | <input type="checkbox"/> Personal hygiene supplies ( <i>shampoo, conditioner, toothbrush, toothpaste and deodorant</i> )                           |
| <input type="checkbox"/> One bath towel               | <input type="checkbox"/> Basic utensils ( <i>plate, bowl, fork, spoon, and cup or mug</i> )  |
| <input type="checkbox"/> Toilet paper                 | <input type="checkbox"/> Basic cleaning supplies ( <i>e.g. broom, rags, garbage can, dish sponge, laundry soap, all-purpose cleaning product</i> ) |
| <input type="checkbox"/> A couch or chair             |  |
| <input type="checkbox"/> One bathmat                  |  |
| <input type="checkbox"/> Garbage bags                 |  |

**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)

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**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***