Updated: April '26

Head Injury Rehabilitation Ontario

APPLICATION FOR SERVICE
SUPPORTED APARTMENTS

Email: admissions@hiro.ca **Fax:** 905-523-8211
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 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 #)

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:

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

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: _____

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:

- ☐ 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: _____

MANDATORY FURNISHINGS

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

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

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

Head Injury Rehabilitation Ontario

MEDICAL STATUS FORM - RESIDENTIAL

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

TO BE COMPLETED BY **PHYSICIAN OR NURSE PRACTITIONER**

APPLICANT INFORMATION:

_____ _____/_____/_____ _____ _____
First Name/Last Name | Date of Birth (MM/DD/YYYY) | Height (cm) | Weight (lbs)

_____ _____
Address Street City Postal Code Unit # | Phone Number

Is the applicant's diagnosis an acquired brain injury? ☐ Yes ☐ No
*(If **NO**, this applicant is not eligible for HIRO's services; please discontinue this form)*

If yes, please specify the diagnosis: _____

Please list any other diagnostics relative to function (*e.g. mood disorders, cardiovascular or respiratory disease, metabolic diseases, autoimmune diseases, sleep disorders, neurological or neuromuscular disorders*):

_____

Does this applicant require any regulated nursing duties/controlled acts, including but not limited to: *(select all that apply and attach script(s)/directives)*

☐ Intra-muscular Injections ☐ Subcutaneous injections ☐ Bowel Stimulation ☐ Catheterization
☐ Wound Care ☐ Other: _____

CAPACITY FOR REHABILITATION:

Successful applicants to HIRO's 24 hour residential services must demonstrate some capacity for rehabilitation. Please identify this applicant's abilities int the following areas:

Orientation	☐ Yes – Oriented to person and place ☐ No – Not oriented to person, place, or time ☐ Uncertain
Comprehension	☐ Yes – Follows 1 to 2 step commands ☐ No – Cannot follow 1 to 2 step commands ☐ Uncertain
Memory Deficit	☐ Has working memory deficit (cannot retain basic / simple information >5 minutes) or cannot sustain attention more than 5 minutes ☐ Has short term memory deficit ☐ Has no significant memory deficit ☐ Uncertain
New Learning	☐ Yes – responds to compensatory techniques and/or demonstrates retention of new learning ☐ Potential to learn basic skills using repetition and/or compensatory strategies (e.g. timers, alarms, calendars) ☐ Unable to demonstrate any new learning, even with compensatory strategies ☐ Uncertain
Demonstrates some insight into referral for rehabilitation	☐ Has some insight into physical, cognitive, or behavioural deficits ☐ Admits to physical deficits or restrictions (e.g. hemiparesis, weakness, mobility issues, not allowed to drive or work), but may not recognize cognitive/ behavioural deficits ☐ Has no self-awareness or insight into any deficits ☐ Uncertain

CAPACITY FOR REHABILITATION *continued...*

Goals for rehabilitation	
	☐ Has some realistic life skills goals (e.g. meal preparation, showering, dressing) ☐ Has unrealistic/ambitious goals for recovery (e.g. expectation to regain full function after SCI or hemiparesis, independent living, return to work or driving) ☐ Requires exploration for non-pharmaceutical or non-physical restraint options for managing behaviours to improve quality of life ☐ No rehabilitation goals

MEDICAL HISTORY:

In considering this applicant's ***recent medical history*** *(i.e. within 7 years)*, please rank the frequency, intensity and stability of their condition(s), if applicable:

LEGEND			
FREQUENCY	Low: monthly or less	Moderate: weekly	High: > weekly
INTENSITY	Low: may require up to 15 minutes from an unregulated staff to manage; never requires EMS intervention	Moderate: may require up to 30 minutes from an unregulated staff to manage; may require EMS intervention	High: may require up to 1 hour from an unregulated staff to manage; likely requires EMS intervention
STABILITY	Low: Co-morbidities have been stable for > 1 year	Moderate: Co-morbidities fluctuate, but support is present *(e.g. medicine trials, partnerships, AA)*	High: Co-morbidities require further investigation

	FREQUENCY	INTENSITY	STABILITY	COMMENTS
Seizures	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	
Panic Attacks	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	
Self Harm	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	
Choking	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	
Falls	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	
Diabetes	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	

MEDICAL HISTORY *continued...*

	FREQUENCY	INTENSITY	STABILITY	COMMENTS
Urinary Tract Infection	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	
Chronic Pain	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	
Communicable Diseases *(TB, HIV, MRSA, Hepatitis)*	☐ Yes ☐ No			
Other	☐ Yes ☐ No			

ATTESTATION

☐ I, confirm that this Applicant is suitable to reside in a 24-hour care facility with no regulated staff, no nursing services, and no seclusion rooms (isolated confinement). All client emergencies are escalated to 911/emergency services.

☐ I, confirm this Applicant is not being queried for/diagnosed with a progressive or degenerative disease/disorder (e.g. dementia, malignant tumor/cancer etc.).

☐ I, confirm the Applicant is not diagnosed with an in-utero/at birth ABI, pediatric (<16) ABI, or developmental disability that severely impacted reaching developmental milestones in youth. *If the brain injury occurred under age 16, please consider a referral for Developmental Services Ontario.*

☐ I, confirm that this Applicant is medically cleared for the use of basic Crisis Intervention and Prevention techniques including physical holds, blocks, and escorts when necessary to safely manage imminent risk of harm.

Date completed: _____
(DD/MM/YYYY)

I, _____
PRINT First Name/ Last Name/ Profession/ Designation

Certify that the above information is complete and accurate to the best of my knowledge at the time of application.

_____
Signature

Physician/Nurse Practitioner Contact information:

Address: _____

_____

_____

Telephone: _____

CPSO #/ Registration #:_____

What is your relationship to this applicant?

☐ Family Physician

☐ Walk-In Physician

☐ Specialist/Consultant

☐ Other: _____

Please ensure the following are attached, if applicable:

❑ Current medication list
❑ Script(s)/directives for controlled acts

Please **return** completed form to:

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

Fax: 905 523-8211

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A Promise of Hope After ABI