PEEL CHESHIRE HOMES (BRAMPTON) INC.
156 Murray Street, Brampton, Ontario L6X 3L7 Tel.: (905) 450-5185 Fax: (905) 450-7457

Sydney Thibault, Outreach Manager
Tel Number: (905) 450-8495
Fax Number: (905) 450-7457

Attendant Outreach Services – Intake / Referral Form

Referral Contact Information

Referral by: _____

(Social Worker, Self, Guardian, Hospital, Relative, Spouse etc.)

Telephone Number: **Ext:** **Date:**

Email Address *(to confirm receipt of referral):*

Applicant Information

First Name: **Last Name**:

Gender: ☐ male ☐ female ☐ other **Age**: _____ **Valid Health Card**: ☐ yes ☐ no

Current Address: *Street and Unit #:* *Postal Code:*

Street Name:

City:

Description of Physical Diagnosis *(or diagnoses)*:

Telephone Number: **Language(s) Spoken**:

Applicant Eligibility

(*Please check all that apply*)

1.	Applicant is at least 16 years of age or older.	
2.	Applicant is insured under the Health Insurance Act of Ontario.	
3.	Applicant has a **permanent physical disability** and requires physical assistance with activities of daily living in order to accomplish tasks safely and within a reasonable time.	
4.	Applicant requires assistance with **personal care** (e.g. bathing, continence care, grooming, dressing, etc.).	
5.	Applicant can clearly direct their own personal support and homemaking services.	
6.	Applicant is able to have any medical/professional needs met by the existing community health network (e.g. community care access centers) on a visitation basis.	
7.	Applicant is not able to have their needs met through current service providers.	
8.	Applicant is residing in **BRAMPTON**, Ontario.	

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Service Request *(please note: personal care is required for eligibility)*

☐ **Personal Care** ☐ **Light Housekeeping** ☐ **Laundry**

☐ **Meal Preparation** ☐ **Other** *(please list):*

Preferred Service Time
(please note: service duration is 1.5 hours in either the AM or PM window Monday-Friday; preference is not guaranteed)

☐ **AM** *(8:00am – 4:00pm)* ☐ **PM** *(2:00pm-10:00pm)* ☐ **No Preference**

Current Sources of Service

Number of Hours/Week:	**Type of Service** *(nursing, PSW, etc.)*	**Name of Service Provider:**

Is there anything we should know before coming for a home visit that could put an employee at risk? (e.g. pets, smoking, others)

Next Steps: An email confirmation will be sent to the referral source indicating whether the applicant is eligible, ineligible, or whether more information is required within 7 days of receipt of the referral. The applicant will be mailed a letter indicating eligibility or ineligibility and placed on our waitlist if applicable within 7 days of receipt of the referral.

Note: If the applicant does not meet ALL the eligibility criteria, DO NOT FAX this form