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

**Kaitlyn Madensky, Outreach Manager**
**Tel Number: (905) 450-8495**
**Fax Number: (905) 450-7457**

# Attendant Outreach Services – Intake / Referral Form

## Referral Contact Information

**Referral Name and Title:** _____

*(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**:

**Sex**: ☐ 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 is 2 days/week for a duration of 1.5 hours in either the AM or PM window Monday-Saturday; preference is not guaranteed)*

☐ **AM** *(8:00am – 4:00pm)* ☐ **PM** *(1:00pm-9:00pm/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***