ESSEX COMMUNITY SERVICES

35 Victoria Ave, Unit 7
Essex, ON N8M 1M4
P: 519-776-4231 | F: 519-776-4966
ecs@essexcs.on.ca

Application for Community Support Services

OFFICE USE ONLY			Reference #	_____
Information given by:	☐ Client	☐ Third Party w/ permission of client	Nesda #	_____
	☐ n/a – POA or SDM in effect		Novus #	_____

GENERAL INFORMATION – all fields are mandatory

Name (as it appears on Ontario Health Card):

First | Middle | Last | "Goes by"

Address: _____ PO Box: _____ Apt. #: _____

Town: _____ Postal Code: _____

Mailing Address (if different from above): _____

Home Phone: _____ Other Phone: _____

Health Card Number: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ Current Age: _____
(month/day/year)

Languages Spoken: _____

Lives Alone? ☐ Yes ☐ No Lives with: _____

EMERGENCY CONTACTS – all fields are mandatory

1st Emergency Contact: _____ Relationship: _____

Home Phone: _____ Other Phone: _____

2nd Emergency Contact: _____ Relationship: _____

Home Phone: _____ Other Phone: _____

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REQUESTED SERVICE(S)

	Start Date (mmm/dd/yyyy)	Discharge Date (mmm/dd/yyyy)	Referred to other HSP? (specify)
☐Transportation – CareLink	___ / ___ / ___	___ / ___ / ___	☐ _____
☐Meals on Wheels	___ / ___ / ___	___ / ___ / ___	☐ _____
☐Home Maintenance	___ / ___ / ___	___ / ___ / ___	☐ _____
☐Foot Care	___ / ___ / ___	___ / ___ / ___	☐ _____
☐Visiting – Social & Safety	___ / ___ / ___	___ / ___ / ___	☐ _____
☐Adult Day Program	___ / ___ / ___	___ / ___ / ___	☐ _____
☐Congregate Dining	___ / ___ / ___	___ / ___ / ___	☐ _____
☐ Other: _____	___ / ___ / ___	___ / ___ / ___	☐ _____
☐ Other: _____	___ / ___ / ___	___ / ___ / ___	☐ _____
☐ Other: _____	___ / ___ / ___	___ / ___ / ___	☐ _____

ELIGIBILITY CRITERIA – select one (if "Disabled" choose from options)

☐ Senior (55+)

☐ Disabled: Permanently ☐ Describe: _____
Temporarily ☐ Describe: _____
Expected Duration: _____

Requires Certificate of Disability? ☐ No ☐ Yes: _____
Date Certificate Received

Requires Service Animal? ☐ No ☐ Yes: _____

☐ Other Specify: _____

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PAYMENT METHOD

☐ Cash OR ☐ Invoice - **if yes please complete info below**

☐ Client OR ☐ C/O: _____

If billing address different than page one please specify:

_____
House # Street Name Apt. #

_____
Town Prov. Postal Code

_____
Phone E-Mail

SOURCE OF REFERRAL – select one

☐ Internal ☐ Family/friend ☐ CCAC: _____ ☐ Doctor/NP

☐ Saw Vehicle ☐ Brochure/flyer ☐ Hospital: _____

☐ Other: _____

OFFICE USE ONLY

Notes:

_____
_____
_____
_____
_____
_____

Screener Complete ☐ *Screener Date:* _____

CHA Complete ☐ *CHA Date:* _____

Reassessment Date: _____

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HEALTH, MOBILITY, COGNITIVE & CHRONIC DISEASE ASSESSMENT

The following information is required to help us complete your client records. Please circle your answer to the following questions:

1.	Would you consider yourself to be independent when making decisions regarding daily tasks – for example, when to get up, what to eat, or which clothes to wear?		Yes	No	
2.	Would you consider yourself independent to: bathe, manage personal hygiene, dress, and move around the house?		Yes	No	
3.	Do you get short of breath?		Yes	No	
4.	How would you rate your health?	Excellent	Good	Fair	Poor
5.	Does a condition or disease make mood or behaviours unstable?		Yes	No	
6.	Are you experiencing an episode or flare up of a recurrent problem?		Yes	No	
7.	In the last three (3) days have you felt sad, depressed or hopeless?		Yes	No	
8.	Does your primary helper express feelings of distress, anger or depression?		Yes	No	
9.	Do close family or friends feel overwhelmed by your illness?		Yes	No	

Are you registered with a family doctor? ☐Yes ☐ No Name: _____ Phone: _____

Hearing	☐ Good	☐ Fair	☐ Poor	☐ Aided	☐ Hearing Impairment
Vision	☐ Good	☐ Fair	☐ Poor	☐ Aided	☐ Visual Impairment

Have you been diagnosed with or suffer from any of the following health conditions or diseases, or do you have any other health conditions or concerns we should be aware of?

☐ Aggression	☐ Allergies:_____		☐ Anxiety Attacks
☐ Arthritis	☐ Asthma	☐ Balance Problems	☐ Bipolar Disorder
☐ Cancer	☐ Cerebral Palsy (CP)	☐ CHF	☐ COPD
☐ Delusions	☐ Dementia	☐ Depression	☐ Developmental Delay
☐ Diabetes	☐ Dialysis	☐ Disorientation	☐ Dizzy Spells
☐ Epilepsy	☐ Epi-Pen	☐ Fibromyalgia	☐ Haemophilia
☐ Hallucinations	☐ Heart Attack	☐ Hypertension	☐ Hypotension
☐ Kidney Disease	☐ Medic Alert Tag/Bracelet	☐ Memory Loss	☐ Mental Illness
☐ Multiple Sclerosis (MS)	☐ Non-Verbal (Aphasia)	☐ Osteoporosis	☐ Panic Attacks
☐ Portable Feeding Tube	☐ Portable Oxygen	☐ PTSD(Post-Traumatic Stress)	☐ Renal Disorder/Failure
☐ Safety Risk to Self or Others	☐ Seizures	☐ Stroke	☐ Tourette's Syndrome
☐ Verbal Outbursts	☐ Wandering Risk	☐ Other: _____	

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TRANSPORTATION – CareLink HEALTH TRANSIT • TRANSPORT-SANTÉ

Do you use any of the following mobility aids or assistive devices?

☐ Cane ☐ Walker ☐ Folding Wheelchair ☐ Transfer Wheelchair
☐ Standard Wheelchair ☐ Bariatric Wheelchair ☐ Large Wheelchair ≥30" ☐ Scooter
☐ Combined weight of person + chair ≥ 700 lbs.
☐ Independent/Ambulatory – no mobility aids or assistive devices

Do You Require an Attendant in Order to Travel? ☐ No ☐ Yes

Is the Transportation for Dialysis? ☐ No ☐ Yes – **please complete info below**

Main Location: ☐ Windsor Regional Hospital – Ouellette Campus
☐ Satellite Renal Dialysis Clinic – 300 Tecumseh Rd. E., Ste. 330
☐ Leamington District Memorial Hospital Satellite

Days Transportation is Required: M Tu W Th F Sa Su

Appointment Time: _____ a.m./p.m. to _____ a.m./p.m.
start end

Alternate Location: ☐ Windsor Regional Hospital – Ouellette Campus
☐ Satellite Renal Dialysis Clinic – 300 Tecumseh Rd. E., Ste. 330
☐ Leamington District Memorial Hospital Satellite

Days Transportation is Required: M Tu W Th F Sa Su

Appointment Time: _____ a.m./p.m. to _____ a.m./p.m.
start end

MEALS ON WHEELS - ECS will refer to appropriate agency

Desired day(s) of MOW delivery: M Tu W Th F Sa* Su* 7 days/wk*

Meal Requirement: ☐ Regular ☐ Diabetic ☐ Low Fat ☐ No Salt Added ☐ Other: _____

Texture Modification: ☐ None ☐ Chopped ☐ Pureed ☐ Liquefied

Food Allergies: ☐ No ☐ Yes: _____

Food Sensitivities: ☐ No ☐ Yes: _____

Dislikes: ☐ No ☐ Yes: _____

Delivery Instructions: _____

_____

Pets: ☐ No ☐ Yes Smoker: ☐ No ☐ Yes

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VISITING – SOCIAL & SAFETY

Preferred day(s) of calls: M Tu W Th F

Preferred time of calls: ☐ Mornings ☐ Afternoons

Any reminders required: ☐ No ☐ Yes: _____

Special interests: _____

Comments/notes on family situation: _____

Preferred day(s) of visits: M Tu W Th F

Preferred time of visits: ☐ Mornings ☐ Afternoons

Are you a smoker? ☐ No ☐ Yes

Do you have any pets? ☐ No ☐ Yes (specify: _____)

Is your driveway, walkway and home clear of debris, in good repair and well lit? ☐ Yes ☐ No

Is the general state of common rooms (living room, kitchen) clean and sanitary? ☐ Yes ☐ No

Is your home in a rural or remote area? ☐ Yes ☐ No

Please list hobbies, interests or other information to help find a suitable volunteer visitor for you:

_____

_____

Do you understand that Friendly Visiting is not a homemaking, personal support worker, nor a transportation service? ☐ Yes ☐ No

If required or deemed necessary will you allow an agency staff member to visit you at your home to verify the information above? ☐ Yes ☐ No

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ADULT DAY PROGRAM - ECS will refer to appropriate agency

Desired day(s) of attendance: M Tu W Th F 5 days/week

Transportation: ☐ CareLink Transportation (complete "Transportation" section & fax copy to most appropriate CareLink agency)

☐ Family/other to transport

Is there a Power of Attorney (POA) or Substitute Decision Maker (SDM) currently in effect? ☐ No ☐ Yes If yes, who: _____
↳ ☐ POA for Personal Care
↳ ☐ POA for Property

Is there an Advanced Directive of DNR? ☐ No ☐ Yes

Have you ever been diagnosed with or treated for Tuberculosis (TB)? ☐ No ☐ Yes

* Additional information and forms to be collected and completed by ADP staff

FOOT CARE

* Patient Information Chart to be completed by Foot Care Nurse

☐ Office/Clinic visits Please select preferred Clinic location:
☐ Amherstburg ☐ Essex
☐ Harrow ☐ Lakeshore
☐ Leamington ☐ McGregor
☐ Tecumseh ☐ Windsor

☐ Home visits (not available in all communities)

Comments: _____

_____

_____

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CONSENT/AUTHORIZATION FOR SERVICES

I authorize Essex Community Services (ECS) to provide the services requested. I also authorize ECS to forward my contact information to other organizations for services requested by me but not offered by ECS. I understand that all information gathered is confidential and that I may withdraw my consent at any time.

In case of emergency, I give permission to ECS staff to:

a) Notify the emergency contacts listed within this application for services;
b) Release pertinent information to medical personnel selected by staff to transport, hospitalize, secure proper treatment or surgery;
c) Share information with other service/health provider(s) to provide assistance.

I agree to pay any expense incurred during the medical emergency (i.e., ambulance).

I agree not to seek damages for any action taken by employees of ECS, its volunteers or agents in their efforts to obtain proper medical treatment or emergency services.

SHARING OF YOUR PERSONAL HEALTH INFORMATION
COMMUNITY CARE INFORMATION MANAGEMENT (CCIM) ASSESSMENT PROJECTS

The Assessment Projects include a Common Assessment Project (CAP) in the following community care sectors:

- **Community Support Services (CSS)**
- Community Mental Health (CMH)
- Long-Term Care Homes (LTCH)
- Community Care Access Centres (CCAC)

The CCIM Assessment Project Stream also includes the Integrated Assessment Record (IAR) project. Through the IAR, health service providers who are providing care to the same client can access previous assessment information to support collaborative care planning and service delivery.

Objectives of CAP:

- Support implementation of common assessment tools within each of these sectors, along with related standards and business processes, that enable client-focused delivery of care
- Provide secure access to information through the automation of assessment data management to aid benchmarking, policy development and sector planning
- Facilitating the secure sharing of assessments through consistent privacy-protective practices

I, _____, hereby understand that my Personal Health Information will be a part of the Integrated Assessment Record which allows for seamless care across various health service providers.

Client Signature: _____ Date: _____

POA/SDM Signature: _____ Date: _____

☐ Verbal consent/authorization received over telephone by client or POA/SDM or third party with client's permission

ECS Staff Signature: _____ Date: _____

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Transportation Service Rules & Consent/Authorization for Services

This agreement is between CareLink, its member organizations, and

Name: _____ Phone: _____

Address: _____

Please review the rules for accessing services and riding on CareLink vehicles:

- Respect for fellow passengers is a must.
- No smoking, violence or profanity allowed.
- Appropriate clothing and footwear is required at all time.
- Pick-up and drop-off locations must be confirmed at time of booking.
- Requests for additional stops cannot be made en route and must be made at the time of booking.
- It is the responsibility of the rider to be at their designated pick-up location at the time the bus is scheduled to arrive. In the event you are late the driver will wait only five (5) minutes past your scheduled time. If you are not at your designated location two (2) times your privileges to ride the system will come under review.
- The driver is not allowed to escort riders beyond the front door of their destination.
- Anyone caught stealing will be escorted off the vehicle promptly, the police will be contacted and you will not be permitted to ride again.
- CareLink and its member organizations are not responsible for lost or stolen items on the vehicle – please do not leave your personal items or valuables unattended.
- Anyone suspected of being or caught intoxicated and/or under the influence of and/or with alcohol, illegal substances and/or related paraphernalia on their person will not be permitted to enter the vehicle and/or will be escorted off the vehicle promptly, the police will be contacted and you will not be permitted to ride again.
- CareLink and its member organization staff have the final say in all matters regarding the safety of its passengers, staff, attendants and the operation of its vehicles.
- All incidents will be recorded and forwarded to the most responsible CareLink member organization's Administration on the appropriate documentation form.

I hereby authorize CareLink and its member organizations to provide transportation services and have read and understand the rules as outlined above. I understand that all information gathered is confidential and consent to the collection, use and disclosure of my personal information. I give permission to CareLink to share my information with other service providers in order to help me receive services, including emergency care, not offered directly by CareLink member organizations. I agree not to seek damages for any actions taken by CareLink member organizations, its staff, board, volunteers or other agents in their efforts to obtain assistance, treatment or emergency care. I understand that I may withdraw my consent at any time.

Client Signature: _____ Date: _____

POA/SDM Signature: _____ Date: _____

☐ Verbal consent/authorization received over telephone by client or POA/SDM or third party with client's permission

CareLink Staff Signature:_____ Date: _____

Office Use Only – CareLink Member Organization Responsible for Registration: ☐ ACS ☐ CSC ☐ ECS ☐ LAF ☐ SECC

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