

ATTENDANT SERVICE APPLICATION CENTRE (ASAC)

(Formerly Project Information Center, PIC)

(TORONTO & YORK REGION - ATTENDANT OUTREACH & SUPPORTIVE HOUSING ATTENDANT SERVICES, TRANSITIONAL PROGRAMS)

APPLICANT (√): () New Application () Update	OFFICE USE: Date Received:	ID#:
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PLEASE NOTE: THIS INFORMATION IS BEING COLLECTED FOR THE PURPOSE OF FACILITATING YOUR APPLICATION FOR ATTENDANT SERVICES AND SHALL ONLY BE RELEASED IN ACCORDANCE WITH THE TERMS SET OUT IN THIS APPLICATION OR AS THE CENTRE FOR INDEPENDENT LIVING IN TORONTO (C.I.L.T.) INC. - ATTENDANT SERVICE APPLICATION CENTRE (ASAC) MAY BE REQUIRED BY LAW.

PLEASE CHECK (√) AND MAKE SURE YOU MEET THE FOLLOWING ELIGIBILITY REQUIREMENTS BEFORE YOU COMPLETE THE APPLICATION:

YES (√)	No (√)	ELIGIBILITY REQUIREMENTS (Must complete)
		You have a valid Ontario Health Card (OHIP).
		You are 16 years of age or older
		You have a permanent physical disability .
		You require personal care i.e. bathing, dressing, toileting, and transferring. [Except MILE Program]
		You must be able to direct your own services . <i>This means you are able to take responsibility for yourself; understand your support service requirements; and provide instructions to an attendant on how to carry out activities or procedures which are necessary in meeting your service needs.</i>

IF YOU DO NOT MEET THE ABOVE ELIGIBILITY REQUIREMENTS, YOUR APPLICATION FOR ATTENDANT SERVICES WILL NOT BE ACCEPTED AND WILL BE RETURNED.

I. APPLICANT INFORMATION

First name:	Last name: <small>(Match names on your Health Card)</small>
ONTARIO HEALTH CARD NUMBER: <small>(Without this number, your application cannot be processed and will be returned to you.)</small>	
Date of Birth: Month: Day: Year:	Gender: () Male () Female

PHONE:	Home: ()	Cell: ()	Work: ()
Other phone:	Fax:	Email:	

CURRENT ADDRESS: Name of institution (if applicable)		
Street:	Apt No. / Unit No.:	
City:	Province:	Postal Code:

PERMANENT ADDRESS: () Same as Current Address	Name of institution:	
Street:	Apt No. / Unit No.:	
City:	Province:	Postal Code:

MAILING ADDRESS: () Same as Current Address () Same as Permanent Address	Name of institution:	
Street:	Apt No. / Unit No.:	
City:	Province:	Postal Code:

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ALTERNATE CONTACT INFORMATION (Optional)			
First name:		Last name:	
Relationship:			
Name of organization (if applicable)			
ADDRESS: Street:			Apt No./ Unit No.:
City:		Province:	Postal Code:
PHONE:	Home: ()	Work: ()	Cell: ()
Fax:		Email:	

IF SOMEONE ASSISTS YOU WITH FILLING OUT THIS APPLICATION, PLEASE COMPLETE (Optional)			
First name:		Last name:	
Relationship:			
Name of organization (if applicable)			
ADDRESS: Street:			Apt No./ Unit No.:
City:		Province:	Postal Code:
PHONE:	Home: ()	Work: ()	Cell: ()
Fax: ()		Pager:	Email:

II. CURRENT SOURCES OF SERVICES - Check (✓) all applicable below		
Are you currently receiving personal care or personal support services? () No () Yes, please indicate below		
PERSONAL CARE / SUPPORT SERVICES	NAME OF ORGANIZATION	
() Attendant Outreach Service		
() Supportive Housing Attendant Services		
() Transitional and life skills program		
() Direct Funding Program for Attendant		
() Community Care Access Centre(CCAC)		
() Community agency		
() Volunteer, family, friend, church group:		
() Others:		
OTHER SOURCES OF SERVICES	NAME OF ORGANIZATION	TYPES OF SERVICES
() Long term care / Nursing Home		() Personal Care
() Acute\Rehab\Complex Continuing Care		() Nursing
() Out-Patient Services		() Physiotherapy
() Senior Services		() Occupational Therapy
() Mental Health & Addictions		() Social Work
() Developmental Services		() Physician
() Private care		() Homemaking (e.g. housekeeping, cooking)
() Community Care Access Centre(CCAC)		() Others:
() Others:		

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III. DISABILITY INFORMATION

Check (✓) **ONE** main permanent physical disability that requires you to use attendant services
*(Do **NOT** check more than ONE. List other additional disabilities below):*

<input type="checkbox"/> Acquired Brain Injury <input type="checkbox"/> Amputation <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS) <input type="checkbox"/> Arthritis/Rheumatic Conditions <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Friederich's Ataxia <input type="checkbox"/> Guillain-Barré Syndrome <input type="checkbox"/> Huntington's <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Osteogenesis Imperfecta <input type="checkbox"/> Parkinson's <input type="checkbox"/> Polio <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Spinal Muscular Atrophy <input type="checkbox"/> Stroke If it is NOT available from the above list, check "Other" & specify <input type="checkbox"/> Other (<i>Specify ONE</i>): _____
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ADDITIONAL DISABILITIES / MEDICAL CONDITIONS:

Please list/describe any **additional disabilities** (include any disabilities listed above) or **medical conditions** that may affect delivery of your services (i.e. visual impairment; deafness; epilepsy; diabetes; transmissible diseases; etc.):

COMMUNICATION INFORMATION:

Do you need an interpreter? No Yes If yes, language spoken:

Can you communicate verbally? Yes No Partially / Sometimes

Do you need assistance to use the telephone? Yes No Partially / Sometimes

Do you need assistance with other communication aids? Yes No Partially / Sometimes

What communication systems / aids do you use?

ASSISTIVE DEVICES / EQUIPMENTS: Please indicate (✓) which, if any, of the following you use:

<input type="checkbox"/> Canes/crutches/walker	<input type="checkbox"/> G-tube feeding	<input type="checkbox"/> Braces
<input type="checkbox"/> Electric wheelchair	<input type="checkbox"/> Ventilator	<input type="checkbox"/> Ceiling track lift
<input type="checkbox"/> Manual wheelchair	<input type="checkbox"/> CPAP or BiPAP	<input type="checkbox"/> Portable mechanical lift (electric or manual)
<input type="checkbox"/> Scooter	<input type="checkbox"/> Bath seat	<input type="checkbox"/> Other, please specify:
<input type="checkbox"/> Commode	<input type="checkbox"/> Raised toilet seat	

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IV. CURRENT LIVING SITUATION

CURRENT LIVING ARRANGEMENT: CHECK (✓) ONE BELOW () Not Applicable

- () Living alone in Apartment/House
- () Living alone with Dependent Child/Children
- () Living with Parent / Step-Parents
- () Living with Spouse / other Adult
- () Living with Spouse / other Adult and Dependent Child/Children
- () Other, please specify:

APPLICANTS STAYING AT HOSPITAL, LONG TERM CARE, TRANSITIONAL PROGRAMS MUST ANSWER:

CHECK (✓) ONE BELOW	NAME OF ORGANIZATION
() Rehabilitation Hospital/Unit	
() Chronic Care Hospital	
() Convalescent Hospital	
() Other Hospitals or Health Care Facilities	
() Long Term Care Homes / Nursing Home	
() Transitional program with attendant services	

Discharge date: () Unknown () Not Applicable

Other Discharge Information:

Your mailing address when you are staying there:

- | | |
|---|---|
| <ul style="list-style-type: none"> () Same as Current Address on page 1 () Same as Permanent Address on page 1 () Same as Mailing Address on page 1 | <p>OTHER PHONE:</p> <p>OTHER ADDRESS:</p> |
|---|---|

Your living situation after you have been discharged:

- () Living alone in Apartment/House
- () Living alone with Dependent Child/Children
- () Living with Parent / Step-Parents
- () Living with Spouse / other Adult
- () Living with Spouse / other Adult and Dependent Child/Children
- () Other Hospitals or Health Care Facilities – Name: _____
- () Long Term Care Homes / Nursing Home – Name: _____
- () Transitional program with attendant services – Name: _____
- () Other, please specify:

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V. ATTENDANT SERVICES PROJECTS *(Refer to the ASAC Application Guide for description of these projects)*

Please select all projects you wish to apply for.

CHECK (✓)	SUPPORTIVE HOUSING - TORONTO	ADDRESS
	Access Independent Living Services - York Square/Plaut Manor	2468 & 2480 Eglinton Avenue W.
	Access Independent Living Services - Aldebrain Tower	2155 Lawrence Avenue E.
	Access Independent Living Services - St. Mark's	7 The Donway E.
	Bellwoods Centres - Mimico Co-op	1 Summerhill Road
	Bellwoods Centres - Shaw Street	300 Shaw Street
	Bellwoods Centres - Dundas	1082 Dundas Street W.
	Canadian Red Cross - Elm Street	25 Elm Street
	Canadian Red Cross - Walton Place	835 Birchmount Road
	Nucleus Independent Living - Trimbee Court	30 Denarda Street
	Nucleus Independent Living - Humberview Co-op	2100 Weston Road
	March of Dimes Canada - McCaul	22 McCaul Street
	March of Dimes Canada - Bloor	341 Bloor Street West
	March of Dimes Canada - Cooperage Street	75 Cooperage Street (Pan Am Site)
	PACE Independent Living - Bathurst/Prince Charles	3270 Bathurst Street
	PACE Independent Living - Caboto Terrace	3050 Dufferin Street
	PACE Independent Living - Windward Project	34 Little Norway Crescent
	PACE Independent Living - Broadway	8, 10, 12 Broadway Avenue
	PACE Independent Living - Henry Lane	25, 49 Henry Lane Terrace; 140 The Esplanade
	PACE Independent Living - Palace Street	20 Palace Street (Pan Am Site)
	Tobias House Attendant Care - Carlton Ave	84 Carlton Street
	Tobias House Attendant Care - Jarvis Street	460 Jarvis Street
	Tobias House Attendant Care - Coxwell Ave	695 Coxwell Avenue
ENHANCED SUPPORT PROJECT (see ASAC Application Guide page 18)		
	PACE Independent Living - Bello Horizonte	1500 Keele Street
SPECIALIZED PROJECT (Attendant services are not provided) (see ASAC Application Guide page 18)		
	NABORS - Chord Co-op	43 & 53 Goldwin Avenue
	NABORS - Courtyards Co-op	10 Broadway Avenue
YORK UNIVERSITY / SENECA COLLEGE @ YORK – STUDENTS, STAFF & FACULTY ONLY (see ASAC Application Guide page 9)		
	March of Dimes Canada - York University/Seneca@York	4700 Keele Street; 70 The Pond Road

CHECK (✓)	SUPPORTIVE HOUSING - YORK REGION	ADDRESS
	March of Dimes Canada – Richmond Hill	25 Marshall Street, Richmond Hill
	March of Dimes Canada - Markham	65 Founders Way, Markham
	Participation House Markham - Cedarcrest Manor	20 Water Street, Markham
	Participation House Markham - Hagerman Corners	4460 14th Avenue, Markham
	Participation House Markham - St. Luke's Lodge	49 Green Lane, Thornhill

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V. ATTENDANT SERVICES PROJECTS *(Continue)*

CHECK (✓)	SHARED LIVNG - TORONTO	ADDRESS
	North Yorkers - Bayview & Sheppard	2880 Bayview Avenue
	March of Dimes Canada - Meynell House	30 St. Lawrence St. ** Requires 5.5 hours or more of care per day
	Participation House - Condo Project	11753 Sheppard Ave. E.
CHECK (✓)	SHARED LIVNG - YORK REGION	ADDRESS
	March of Dimes Canada Vaughan Congregate Care program	49 Lebovic Campus Drive, Vaughan ** For young adults 18-35 years of age
	Participation House Markham Tony Wong Place - Aging At Home Program	25 Deverill Court, Markham ** For adults 55 years of age and older

CHECK (✓)	TRANSITIONAL & LIFE SKILLS PROGRAMS - TORONTO	(see ASAC Application Guide page 16-17)
	Gage Transition to Independent Living - 100 Merton Street <i>(With attendant services)</i>	
	Bellwoods Centres Community Connect - 300 Shaw Street <i>(With attendant services) Only individuals currently in acute care, rehab, Complex Continuing Care hospitals or LTCH are eligible. (Please complete Appendix A on page 11)</i>	
	Bellwoods Centres MILE Program - Home-based <i>(Without attendant services) (Please complete Appendix A)</i>	
CHECK (✓)	COMMUNITY CLUSTER PROGRAM	(see ASAC Application Guide page 19)
	Bellwoods Centres Sudbury - 180 Sudbury Street <i>24/7 services and support on an ad-hoc and prescheduled basis; community based transitional programs; skills development, independence training & safe living education</i>	

ATTENDANT OUTREACH SERVICE - TORONTO

() *I will accept services from any of the following attendant outreach service providers in Toronto*
OR Check (✓) which projects you wish to apply (please ensure that you reside in the service area)

CHECK (✓)	SERVICE PROVIDERS	SERVICE AREA (Base on resources and funding)
	Access Independent Living Services	West to East Toronto, north of Eglinton Avenue
	Bellwoods Centres	Entire city of Toronto
	Spinal Cord Injury Ontario	Entire city of Toronto
	PACE Independent Living	East of Weston Road, from south to north Toronto
	Canadian Red Cross	East York, North York, York, Scarborough, Etobicoke, Downtown Toronto between Yonge & Roncesvalles & St. Clair & the Lakefront

ATTENDANT OUTREACH SERVICE - YORK REGION AND SOUTH SIMCOE (ensure you reside in the service area)

CHECK (✓)	SERVICE PROVIDER	SERVICE AREA
	March of Dimes Canada	York Region (South to Steeles Avenue, North to Pefferlaw, East to Stouffville, West to Nobleton); South Simcoe and Central Local Health Integration Network (LHIN) boundary

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VI. ATTENDANT SERVICES LEVEL & SERVICE CHECKLIST

*** Applicants must have personal support needs; not just homemaking services or supervision.

SERVICES	CHECK (√)	SERVICES	CHECK (√)
1. TRANSFERS		4. GENERAL HYGIENE	
a. Pivot, towel, transfer board		a. Bath/shower	
b. Lift, mechanical transfer		b. Bed Bath	
c. Onto/off toilet/commode		c. Grooming	
2. BOWEL AND BLADDER		d. Peri-care	
a. Bladder - condom catheter		e. Menstruation (sanitary pads)	
b. Bladder -indwelling catheter		5. SKIN CARE	
c. Bladder -intermittent catheter		a. Turns at night	
d. Bowel		b. Skin Care	
e. Ileo-conduit care		6. MEALS AND DRINKS	
f. Bed pans/Urinal		a. Cooking	
g. Adult Diapers		b. Cutting up food	
3. DRESSING & UNDESSING		c. Assistance with eating (feeding)	
a. Lower body		d. Splints	
b. Upper body		e. Drinks	
c. Buttons/zippers hooks		f. G-tube feeding	
d. Brace prosthesis / Corset		7. BREATHING ASSISTANCE	
		a. Suctioning	
		b. Vent / Trachea Care	

Do You Require Nurturing Assistance? If Yes, please complete **Appendix B**. (Not offered by all service providers)

- *Nurturing Assistance is a consumer-directed service that provides physical assistance to parents who have physical disabilities with caring of their young children. It is NOT babysitting or day care services.*

CHECK (√) ONE	AVERAGE SERVICE HOURS PER DAY*	IF YOU HAVE CHECKED ATTENDANT OUTREACH SERVICES:
	Less than 1 ½ hours daily	How many days per month would you require Attendant outreach service? _____
	Between 1 ½ to 3 hours daily	
	Between 3 to 5 hours daily	
	Between 5 to 6 hours daily	
	More than 6 hours daily	

* **Note:** If you have checked both supportive housing and attendant outreach projects and your service hours for supportive housing and attendant outreach are different, please indicate the service hours you need for supportive housing.

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VII. ACCOMMODATION INFORMATION (Supportive housing & Transitional housing applicants must complete this page)

HOUSING INFORMATION: (Supportive housing applicants must complete.)

Do you need subsidized housing? Yes No Not sure

I will be living alone

I will not be living alone

I will live with a person who requires attendant services.

He/She must apply separately to ASAC. To link applicants so services are introduced for both at the same time, please provide co-applicant's name and phone number here:

Name: _____ Phone: _____

ACCOMMODATION PREFERENCES: (Supportive housing applicants must complete.)

Please **check (√)** which types of accommodation you would accept. If you have preference, among those choices, please rank them in order of preference 1, 2, 3, 4, 5, etc.

CHECK (√)	RANK	TYPES OF ACCOMMODATION
		Bachelor apartment
		One bedroom
		Two bedroom
		Three bedroom
		Four bedroom
		Shared accommodation
		Any

IS YOUR CURRENT LIVING SITUATION SUITABLE? (Supportive housing applicants must complete)

Yes

No Please explain:

Living arrangements (i.e. living alone, elderly parents, personal difficulties etc.)

Architectural barriers (i.e. stairs, access to washroom, kitchen etc.)

Inadequate/lack of services

Geographic location (i.e. employment or educational opportunity, proximity to family)

Change in family size (i.e. children or other arrive or leave)

Other: Please specify:

TRANSITIONAL HOUSING APPLICANTS MUST COMPLETE:

Do you have accommodation to move to when the transitional program is completed?

Yes Where: _____

No Will you require assistance in seeking accommodation? Yes No

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VIII. DECLARATION, CONSENT TO DISCLOSURE OF APPLICANT INFORMATION AND RELEASE FROM LIABILITY

I _____ (Applicant's name)

declare that the information contained in this application is complete and correct, to the best of my knowledge.

I hereby authorize the Centre for Independent Living in Toronto (C.I.L.T.) Inc. - Attendant Service Application Centre (ASAC) to forward the information contained in the application and supporting documents to the attendant service providers listed in the ASAC application and/or to the following agencies/individuals (e.g. spouse, parents, social worker, etc.) specifically for the purpose of discussing this application for attendant services and/or of receiving attendant services.

NAME	PHONE NUMBER	RELATIONSHIP	ORGANIZATION (if applicable)

I understand that any Attendant Service Provider listed in the ASAC application is hereby authorized and directed to inform the Attendant Service Application Centre of assessment results or significant information that affects the provision of attendant services including the commencement or termination of my attendant services with that Attendant Service Provider.

I understand that all Attendant Service Providers will discuss the contents of this application with ASAC and/or amongst (between) themselves for the purpose of making attendant services available to me more quickly.

I understand that any Attendant Service Provider listed in the ASAC application may contact me for assessment.

I understand that by virtue of being deemed eligible for acceptance into the ASAC database I agree to inform ASAC of any changes affecting that eligibility, including providing ASAC with information about:

- Any change of my address
- Any change in my family or other status that affects my housing requirements
- Any change in my disability and resulting change in attendant service requirements
- The commencement or termination of my attendant services by my selected attendant service providers
- My continued interest or need to remain "active" on the ASAC database.

I ACKNOWLEDGE AND AGREE THAT THE *CENTRE FOR INDEPENDENT LIVING IN TORONTO (C.I.L.T.) INC.* - ATTENDANT SERVICE APPLICATION CENTRE (ASAC) NEITHER WARRANTS THE SERVICES PROVIDED BY ANY ATTENDANT SERVICE PROVIDER NOR ACCEPTS ANY LIABILITY OR RESPONSIBILITY FOR ANY HARM THAT I MAY SUFFER ARISING OUT OF OR CONNECTED IN WAY TO MY RECEIVING ATTENDANT SERVICES FROM AN ATTENDANT SERVICE PROVIDER.

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I ALSO AGREE THAT I WILL RELEASE AND HOLD HARMLESS THE *CENTRE FOR INDEPENDENT LIVING IN TORONTO (C.I.L.T.) INC. - ATTENDANT SERVICE APPLICATION CENTRE (ASAC)*, TOGETHER WITH ITS EMPLOYEES, DIRECTORS AND OFFICERS, AS WELL AS THE ATTENDANT SERVICE PROVIDERS LISTED IN THE ASAC APPLICATION, FROM ALL LIABILITY FOR ANY HARM OR ANY DAMAGES THAT I MAY SUFFER AS A RESULT OF THE RELEASE OR DISCLOSURE, IN ACCORDANCE WITH THE TERMS OF THIS CONSENT, BY THE *CENTRE FOR INDEPENDENT LIVING IN TORONTO (C.I.L.T.) INC. - ATTENDANT SERVICE APPLICATION CENTRE (ASAC)* OR BY THE ATTENDANT SERVICE PROVIDERS LISTED IN THE ASAC APPLICATION OF PERSONAL INFORMATION ABOUT ME.

I hereby declare that I fully understand the terms of this agreement and that I have been afforded the opportunity to get legal advice prior to the signing of this document.

Signature / Mark of Applicant

Signature of Witness

Name of Applicant

Name of Witness

Date of Signature

Date of Signature

PLEASE NOTE: This information is collected, and personal privacy protected, under the Province of Ontario's <u>Personal Health Information Protection Act, 2004</u> , the <u>Freedom of Information and Protection of Privacy Act</u> , and the Federal <u>Access to Information Act</u> .

Please mail or deliver the form to:	Contact information:
Attendant Service Application Centre c/o Centre for Independent Living in Toronto (CILT) Inc. 365 Bloor Street East, Suite 902 Toronto, Ontario, M4W 3L4	Tel: 416-599-2458 ext. 225 Fax: 416-599-3555 Email: asac.info@cilt.ca Website: www.cilt.ca

Note: You can mail, fax or email your application. If your application is not clear or if some pages are missing, we will return it to you without putting you on the waiting list.

Please keep a copy of your application for your information and for updating your application in the future.

It is **your responsibility** to keep your application up to date. If your contact information changes, inform us right away. **Your application will become inactive if ASAC or service providers cannot contact you.**

This is **your application**. Physical assistance may be used to record your responses, but family members, professionals or others may not make submissions on your behalf.

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APPENDIX A: BELLWOODS CENTRES' COMMUNITY CONNECT AND MILE APPLICANTS

*** Complete this page only if you have selected Bellwoods Centres' Community Connect and/or MILE Program on page 6

COMMUNITY CONNECT PROGRAM: Supportive Housing at 300 Shaw Street (Attendant Services are provided)

- The Community Connect Program is an up to 6-month residential independence training program, with program coordination, designed to facilitate the individual's successful transition from institution to community through safe living education and 24/7 access to personal support services.

Please indicate (✓) which of the following safety areas you need to work on:

Living Situation/Housing <i>Eg. seek accessible housing, change in living conditions</i>	Medication <i>Eg. prescribed/non-prescribed drugs</i>
Communication and Scheduling <i>Eg. telephone use/emergency number, learn to direct your services, ability to schedule, seek and training in use of AAC equipment</i>	Kitchen <i>Eg. microwave, stove, food supply/storage</i>
Mobility <i>Eg. seek equipment and/or training with walking/devices, wheelchair/ scooter/transfers, venturing outdoors</i>	Household <i>Eg. meal preparation, shopping, money management</i>
Personal Care <i>Eg. seek equipment and/or training in use of personal equipment, dress/undress, hair care</i>	Environmental Hazards <i>Eg. manage clutter</i>
Bathroom and Toilet <i>Eg. seek bathroom/toilet equipment, training in bath/shower method, non-slip aids, toileting transfer</i>	Finances <i>Eg. budgeting, accessing ODSP and funding sources for equipment</i>
Eating <i>Eg. feeding, nutrition</i>	Medical and Other Professional Assistance <i>Eg. accessing family physician, social work support, other</i>
Community Services <i>Eg. accessing personal care/attendant services, shopping, mental health or addiction support</i>	

MILE PROGRAM: (Home-based) (Attendant Services are not provided)

The MILE Program provides ongoing independence training including

- Program coordination including accessing resources such as community services, accessible housing, personal care/mobility, equipment and maintenance, medical and other professional assistance and financial resources
- Skills development in home and community activities

Please indicate (✓) which of the following safety areas you need to work on:

Living Situation/Housing <i>Eg. seek accessible housing, change in living conditions</i>	Medication <i>Eg. prescribed/non-prescribed drugs</i>
Communication and Scheduling <i>Eg. telephone use/emergency number, learn to direct your services, ability to schedule, seek and training in use of AAC equipment</i>	Kitchen <i>Eg. microwave, stove, food supply/storage</i>
Mobility <i>Eg. seek equipment and/or training with walking/devices, wheelchair/ scooter/transfers, venturing outdoors</i>	Household <i>Eg. meal preparation, shopping, money management</i>
Personal Care <i>Eg. seek equipment and/or training in use of personal equipment, dress/undress, hair care</i>	Environmental Hazards <i>Eg. manage clutter</i>
Bathroom and Toilet <i>Eg. seek bathroom/toilet equipment, training in bath/shower method, non-slip aids, toileting transfer</i>	Finances <i>Eg. budgeting, accessing ODSP and funding sources for equipment</i>
Eating <i>Eg. feeding, nutrition</i>	Medical and Other Professional Assistance <i>Eg. accessing family physician, social work support, other</i>
Community Services <i>Eg. accessing personal care/attendant services, heavy housekeeping, shopping, home maintenance, grass cutting, snow shovelling, or mental health or addiction support</i>	Leisure/Employment/ School/Volunteering <i>Eg. hobby/employment/school/volunteering/ safety, accessing resources</i>

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APPENDIX B: NURTURING ASSISTANCE

*** Please complete this page only if you indicate you need **nurturing assistance** on page 7

Nurturing Assistance is a consumer-directed service that provides physical assistance to parents who have physical disabilities with caring of their young children. It is not babysitting or day care services.

Do you require nurturing assistance? () Yes () No

If **YES**, please indicate number of children: _____ and specify their genders and age:

	GENDER	AGE	NOTES (HEALTH CONDITION, ETC)
1			
2			
3			
4			
5			

Indicate (✓) if and when services are needed.

NURTURING ASSISTANCE ACTIVITIES	YES	NO	SOMETIMES
a. Bathing			
b. Grooming			
c. Dressing and undressing			
d. Holding			
e. Cuddling			
f. Changing diapers			
g. Lifting and carrying the child to the parent			
h. If mother is breastfeeding, assist with positioning			
i. If formula is used, prepare formula and bottles according to the parent's direction			
j. Feeding and assisting with feeding			
k. Assist with parent hand washing, position receiving blanket(s)			
l. Assist parent with burping child			
m. Washing/drying family dishes			
n. Baby's laundry			
o. Keeping baby's furniture (crib, change table, etc.) clean			
p. Dusting and cleaning baby's belongings			
q. Caring for baby's belongings			
r. Assistance in tidying other rooms as needed			
s. Organize child's play area to facilitate parent-child interaction			
t. Position baby with parent for play; assist in activity involving music, songs, dancing, clapping			
u. Accompany the parent and child to go for walks, pushing stroller			
v. Accompany the parent and child to go shopping, e.g., helping in and out of car seat			
w. Others, please specify:			
x. Others, please specify:			