B.I.A.P.R.
Brain Injury Association
Peterborough Region

APPLICATION FOR SERVICE

The Brain Injury Association of Peterborough Region (BIAPR) aims to enrich the lives of people affected by Acquired Brain Injury (ABI) in Peterborough, Kawartha Lakes, Haliburton, and Northumberland communities. Through our ABI Personal Support and Independence Training, ABI Day Services, Case Management and Coordinated Care Café, community health promotion, education, development, engagement, and System Navigation, we support people living with brain injuries, their care partners & community.
Contact information:

Tel: 705-741-1172 Toll Free: 800-854-9738 Fax: 705-741-5129 Email: intake@biapr.ca

Eligibility Criteria -

We may be able to help you if you meet the following criteria:

- Have a primary diagnosis of an Acquired Brain Injury (ABI) (if undiagnosed please fill out HELPS Screener attached)
- Be 18 – 65 years of age
- Reside in Peterborough, Kawartha Lakes, Haliburton or Northumberland communities
- Be ready and able to participate in the programs and services

Please note that the intake process will be delayed if the application for service is incomplete.

1 APPLICANT'S PERSONAL INFORMATION - *be sure to fully complete this section*

Last name	*First name*		*Date of birth* (dd-mm-yyyy)	
Pronouns	*Gender* ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer not to say			
Health card number	*Version Code*		*Expiry date* (dd-mm-yyyy)	
Address	*Apt. #*	*City*	*Province*	*Postal Code*
Home telephone	*Cell phone*		*E-mail address*	

Marital status ☐ Single ☐ Married/Common Law ☐ Separated/Divorced ☐ Other, please describe _____	*Current living situation* ☐ Alone ☐ With Relative(s) ☐ With Non-Relative(s) ☐ Other, please describe _____	*Accommodation* ☐ House ☐ Residential Care ☐ Apartment Building ☐ Supported Housing ☐ Long Term Care ☐ Hospital ☐ Room/Board ☐ Other, please describe _____
Is your rent geared to income? If Yes please enter Subsidy Provider or Housing Corporation ☐ Yes ☐ No		*Which region are you a resident of?* ☐ Peterborough ☐ Haliburton ☐ Kawartha ☐ Northumberland
Citizenship ☐ Canadian ☐ Other	*Language spoken* *Interpreter required* ☐ Yes ☐ No	*Are you Indigenous?* ☐ Yes ☐ No

2 BRAIN INJURY INFORMATION

Date of Injury (dd-mm-yyyy)

Cause of Injury

☐ Aneurysm ☐ Anoxia ☐ Assault ☐ Fall ☐ Infection

☐ Motor Vehicle Accident ☐ Stroke ☐ Tumor ☐ Other, please describe:

Concerns Identified

☐ Orientation ☐ Motivation/ Initiation ☐ Impulsive ☐ Organization/ Planning ☐ Verbal Aggression

☐ Memory ☐ Pain ☐ Irritability ☐ Anxiety ☐ Other

☐ Fatigue ☐ Depression ☐ Concentration ☐ Insight

☐ Physical Aggression ☐ Self-harm ☐ Perseveration ☐ Communication

Additional ABI details / comments

3 SERVICES REQUESTED (descriptions can be found on www.biapr.ca)

☐ Day Service ☐ Case Management ☐ Outreach (Community Support) ☐ Coordinated Care Cafe

☐ Peer Support ☐Other, please specify:

4 PERSONAL SUPPORT NETWORK AND EMERGENCY CONTACTS

Emergency contact last name	*Emergency contact first name*		*Relationship*	
Address	*Apt. #*	*City*	*Province*	*Postal Code*
Home telephone	*Work telephone*		*E-mail address*	

Other contact last name	*Other contact first name*		*Relationship*	
Address	*Apt. #*	*City*	*Province*	*Postal Code*
Home telephone	*Work telephone*		*E-mail address*	

5 REFERRING AGENT (Person making the request)

Who is making the referral?

☐ Myself *(if self-referral, please move on to next section)* ☐ Family/Friend ☐ Community Service Provider ☐ Professional ☐ Hospital

Name	*Name of Agency*	*Position/Relationship*
Phone number	*E-mail address*	*Is the applicant aware of the referral?* ☐ Yes ☐ No *Will you remain involved with supports?* ☐ Yes ☐ No

6 MEDICAL INFORMATION (BIAPR does not provide Clinical or Crisis Intervention Services)

Seizures - If yes, describe

☐ Yes ☐ No

Administering Medication(s)	*Wheelchair*
☐ Self ☐ With help from others ☐ No medication prescribed	☐ Does not use a wheelchair ☐ Manual ☐ Electric

Assisted Transfers - If yes, describe

☐ Yes ☐ No

Assistive Devices/Medical Equipment - If yes state what is needed

☐ Yes ☐ No

Attendant Care - If yes, describe

☐ Yes ☐ No

Supervision or assistance with walking

☐ Yes ☐ No If yes, does it apply to ☐ Level surfaces ☐ Stairs ☐ Both

Communication Issues - If yes, describe

☐ Yes ☐ No

Other Medical Conditions (allergies, heart conditions, Diabetes, hypertension, etc.) - If yes, describe

☐ Yes ☐ No

Pre-Injury History of Substance Use	*Current Substance Use*	
☐ Yes ☐ No ☐ History not available	☐ Yes ☐ No ☐ Not known	

Previous Mental Health History - If yes, describe

☐ Yes ☐ No

Current Mental Health Diagnosis

Primary Healthcare Provider	*Telephone*	*Fax*	
Address	*City*	*Province*	*Postal Code*

7 SOCIAL INFORMATION

Highest Education Achievement

☐ Grade School ☐ High School ☐ College ☐ University ☐ Trade

Name of Current or Previous Employer	*Position*	*How long were you in this position?*

Previous or Current Involvement with the Criminal Justice System?

☐ Yes ☐ No

Applicant will be travelling

☐ Independently ☐ With Assistance

Transportation Support

☐ Public Transit ☐ DRT Specialized Service ☐ Community Care ☐ Family

☐ Self ☐ Other

8 FINANCIAL INFORMATION

Please Specify Source(s) of Income

☐ Ontario Disability Support Program (ODSP)	☐ Old Age Security (OAS)	☐ Insurance Settlement
☐ Workplace Safety Insurance Board (W.S.I.B.)	☐ Veterans affairs Canada	☐ Long Term Disability (private)
☐ Ontario Works (OW)	☐ Canada Pension Plan (C.P.P./C.P.P.D.)	☐ Insurance Settlement
☐ Employment Insurance (E.I.)	☐ Employment	☐ Other

Do you make your own personal decisions? ☐ Yes ☐ No (If No, complete below)

Name:	*Phone:*	☐ Decision Maker ☐ Public Trustee ☐ Power of Attorney ☐ Other

9 ONGOING LITIGATION OR ONGOING CLAIM INFORMATION (Yes No)

Representative's Name	*Company*	*Phone*

10 AUTHORIZATION, CONSENT AND SIGNATURE – *you must complete this section*

I, _____ have or have had this application for service completed for me. I confirm that the above information is correct, to the best of my knowledge. I consent to receive services from BIAPR. I consent for BIAPR to collect, use, and disclose personal information related to me for the purposes of assessing eligibility, and provision of services and support with my care team, including family members, care providers, contracted services providers, community social service agencies, criminal justice agencies, other involved professionals, and physicians, etc.

Signature of Applicant X	Please print name	*Date (dd-mm-yyyy)*
Referring Agent (if applicable) X	Please print name	*Date (dd-mm-yyyy)*

RESPECTING YOUR PRIVACY

Respecting your privacy is a priority for Brain Injury Association of Peterborough (BIAPR)
BIAPR complies with the Personal Health Information Act (PHIPA), 2004 - *The information is confidential and no unauthorized person will have access to the information without the consent of the patient/client or substitute decision maker.*

SUBMISSION INSTRUCTIONS

Applications accepted via mail or fax only:
Fax: 705-741-5129

Brain Injury Association of Peterborough Region
Attn: Intake Coordinator
158 Charlotte Street
Peterborough, Ontario K9J 2T8

HELPS BRAIN INJURY SCREENING TOOL

Consumer Information: _____

_____

_____

Agency/Screener's Information: _____

_____

H Have you ever **H**it your **H**ead or been **H**it on the **H**ead? ☐ Yes ☐ No

Note: Prompt client to think about all incidents that may have occurred at any age, even those that did not seem serious: vehicle accidents, falls, assault, abuse, sports, etc. Screen for domestic violence and child abuse, and also for service related injuries. A TBI can also occur from violent shaking of the head, such as being shaken as a baby or child.

E Were you ever seen in the **E**mergency room, hospital, or by a doctor because of an injury to your head? ☐ Yes ☐ No

Note: Many people are seen for treatment. However, there are those who cannot afford treatment, or who do not think they require medical attention.

L Did you ever **L**ose consciousness or experience a period of being dazed and confused because of an injury to your head? ☐ Yes ☐ No

Note: People with TBI may not lose consciousness but experience an "alteration of consciousness." This may include feeling dazed, confused, or disoriented at the time of the injury, or being unable to remember the events surrounding the injury.

P Do you experience any of these **P**roblems in your daily life since you hit your head? ☐ Yes ☐ No

Note: Ask your client if s/he experiences any of the following problems, and ask when the problem presented. You are looking for a combination of two or more problems that were not present prior to the injury.

- ☐ headaches
- ☐ dizziness
- ☐ anxiety
- ☐ depression
- ☐ difficulty concentrating
- ☐ difficulty remembering
- ☐ difficulty reading, writing, calculating
- ☐ poor problem solving
- ☐ difficulty performing your job/school work
- ☐ change in relationships with others
- ☐ poor judgment (being fired from job, arrests, fights)

S Any significant **S**icknesses? ☐ Yes ☐ No

Note: Traumatic brain injury implies a physical blow to the head, but acquired brain injury may also be caused by medical conditions, such as: brain tumor, meningitis, West Nile virus, stroke, seizures. Also screen for instances of oxygen deprivation such as following a heart attack, carbon monoxide poisoning, near drowning, or near suffocation.

Scoring the HELPS Screening Tool

A HELPS screening is considered positive for a *possible* TBI when the following 3 items are identified:

1. **1.)** An event that could have caused a brain injury (yes to H, E **or** S), **and**
2. **2.)** A period of loss of consciousness or altered consciousness after the injury or another indication that the injury was severe (yes to L or E), **and**
3. **3.)** The presence of two or more chronic problems listed under P that were not present before the injury.

Note:

- A positive screening is **not sufficient to diagnose TBI** as the reason for current symptoms and difficulties - other possible causes may need to be ruled out
- **Some individuals could present exceptions** to the screening results, such as people who do have TBI-related problems but answered "no" to some questions
- Consider positive responses within the context of the person's self-report and documentation of altered behavioral and/or cognitive functioning

The original HELPS TBI screening tool was developed by M. Picard, D. Scarisbrick, R. Paluck, 9/91, International Center for the Disabled, TBI-NET, U.S. Department of Education, Rehabilitation Services Administration, Grant #H128A00022. The Helps Tool was updated by project personnel to reflect recent recommendations by the CDC on the diagnosis of TBI. See http://www.cdc.gov/ncipc/pub-res/tbi_toolkit/physicians/mtbi/diagnosis.htm.

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