DISABILITY CAN POUR L'AUTONOMIE

formerly MARCH OF DIMES CANADA anciennement LA MARCHE DES DIX SOUS DU CANADA

ACDP - Application

Aphasia and Communication Disabilities Program

a Program of March of Dimes Canada

13311 Yonge Street, Suite 202 Richmond Hill ON L4E 3L6
1-800-567-0315, (905)773-7758 Fax 1-844-990-4160
acdp@disabilitycan.ca
https://www.disabilitycan.ca/acdp

Unless otherwise noted within a section, the information in this form is required so that we may assess the applicants eligibility and appropriateness for the Aphasia and Communication Disabilities services. The information will be kept confidential and will only be provided to persons who require the information in order to consider the application or in order to provide service to the applicant.

Who is completing this application?

- ☐ I am the applicant
- ☐ I am a family member or close contact
- ☐ I am a Health Care or other Service Provider

There are 3 signature sections/pages at the end of this form. Please complete your applicable signature section/page.

After this application has been completed and received by ACDP staff, the applicant will be contacted for an ACDP Assessment / Interview and a site visit if eligible and interested.

Applicant Information

The Aphasia and Communication Disabilities program runs in person at 6 sites; please check the applicant's preferred location.

☐ Applicant prefers virtual programming.

- ☐ Parkview Village 12184 Ninth Line **Stouffville**
- ☐ Newmarket Health Centre 194 Eagle St. **Newmarket**
- ☐ Maple Health Centre 10424 Keele St. **Maple (no virtual option)**
- ☐ 9401 Jane Street, **Vaughan (no virtual option)**
- ☐ Westminster United Church 1850 Rossland Rd. **Whitby**
- ☐ Northminster United Church, 300 Sunset Blvd, **Peterborough**

How did you hear about our program? (colleagues, Doctor, SLP):

☐ She/her ☐ He/him ☐ Other: ☐ Prefer not to answer	☐ Female ☐ Male ☐ Other: ☐ Prefer not to answer	***First Name:** **Preferred Name:**	***Last Name:**

***Street Address (#, Street, Suite):**	***City/Town:**	***Postal Code:**
***Home Phone:**	**E-mail Address:**	
Birth Date (mm/dd/yy):	**Ontario Health Card #:**	**Expiration Date:**
English Spoken: ☐ Yes ☐ No	**Language preference:** Written:	Spoken:

Marital Status: ☐ Married ☐ Divorced ☐ Never Married ☐ Separated ☐ Widowed

Living Situation: ☐ Alone ☐ Spouse/Life Partner ☐ With Spouse & Family ☐ With Family
☐ Other Arrangement (Specify):

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Primary Caregiver / Support Person

Name:		**Relationship:**	
Phone:	Home:	Work:	Cell:
Address:		**Email:**	

Family Physician Information

Name:	
Phone:	**Fax:**

Disability / Medical History Information

Date of Stroke or Brain Injury *(mm/dd/yy)*:	**Site of Lesion:**

Nature /Type of Injury /Event

- ☐ Anoxia
- ☐ Assault
- ☐ Fall
- ☐ Motor Vehicle Collision
- ☐ Sports
- ☐ Stroke
- ☐ Tumor
- ☐ Viral Infection
- ☐ Work-Related Injury
- ☐ Other:

Circumstances Surrounding Injury:

Physical Changes *(e.g., right sided paresis/ paralysis/neglect, etc.)*:

Previous Medical / Rehabilitation Facilities

Facility Name	Length of Stay

Please indicate any other disabilities or medical conditions that may affect delivery of services:

- ☐ Swallowing
- ☐ Visual
- ☐ Hearing
- ☐ Allergies
- ☐ Special Diet
- ☐ Heart Disease
- ☐ Unstable Medical Condition
- ☐ Communicable Disease
- ☐ Cognitive
- ☐ Mental Health Issues
- ☐ Other (explain)

Other Information:

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Medical Information Prior to Acquired Brain Injury

Please list any illnesses, injuries or diagnosis prior to injury, and any related hospitalizations, treatments, etc. *(if additional space is required, please attach separate sheet)*:

Seizures

Does applicant experience seizures: ☐ Yes ☐ No **Date of last seizure:**_____

Important information about applicant's seizures:

Assistive Devices

Please indicate which, if any, of the following are used by the applicant:

- ☐ Cane
- ☐ Walker
- ☐ Wheelchair (electric / manual)
- ☐ Scooter
- ☐ G-Tube Feeding
- ☐ Ventilator / breathing assist
- ☐ Other, *please specify:* _____

Description of Applicant's Communication

Speech Language Disability:

☐ **Aphasia:**	☐ Mild	☐ Moderate	☐ Severe
☐ **Apraxia:**	☐ Mild	☐ Moderate	☐ Severe
☐ **Dysarthria:**	☐ Mild	☐ Moderate	☐ Severe
☐ **Cognitive Communication:**	☐ Mild	☐ Moderate	☐ Severe
☐ **Other:**	☐ Mild	☐ Moderate	☐ Severe

Details:

Understanding of spoken words:

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Speaking:

Reading:

Writing:

Memory, Attention:

Alternative or Augmentative/Communication Aids or Books:

Pragmatic Skills:

Useful Communication Strategies:

Other:

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Social Information

Living Conditions	Living Arrangements
☐ Home (Rented) ☐ Home (Owned) ☐ Home (Family or Friend) ☐ Convalescent Hospital ☐ Long Term Care Setting ☐ Hospital (Please name): ☐ Institution ☐ Other: *(please explain)*	☐ Live alone ☐ Live alone with dependent children ☐ Live with parents or step-parents ☐ Live with spouse or other adults ☐ Live with spouse or other adults and dependent children ☐ Live in Shared Housing with support staff ☐ Other: *(please explain)*

If the applicant is currently staying at hospital / rehabilitation unit, what is the anticipated discharge date:

What will applicant's living situation be after he/she is discharged from hospital / rehab unit?

Applicant Signature Section (if applicable)

For stroke survivors: I, the undersigned, am interested in talking to an After Stroke Coordinator about local community and/or MODC stroke resources that may be helpful. ☐ Yes ☐ No

Please note: MODC is required to provide some of your demographic and personal health information to Ontario Health at Home as the centralized database centre for Ontario Health funded Adult Day Programs.

Do you consent to share this information? ☐ Yes ☐ No

Please contact our office with any questions or concerns.

Applicant Signature

Name:	Signature:	Date:

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Family / Close Contact Signature Section (if applicable)

For stroke survivors: I, the undersigned, am interested in talking to an After Stroke Coordinator about local community and/or MODC stroke resources that may be helpful. ☐ Yes ☐ No

Family / Close Contact		
Name:	**Signature:**	**Date:**

Decision Making		
Applicant has an active Substitute Decision Maker ☐ Yes ☐ No	**Name:**	**Relationship to Applicant:**

Note: please provide documentation if the above applies to the applicant.

Health Care / Other Service Provider Signature Section (if applicable)

Applicant is aware this application has been submitted ☐ Yes ☐ No

Family / Close Contact is aware this application has been submitted ☐ Yes ☐ No

Name/Relationship: _____

NOTE: Please include speech-language and other relevant rehabilitation assessments and progress reports.

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Health Care / Service Provider Information

Agency Name:	
Contact Name:	**Contact Title:**
Address:	**Phone:**
Fax:	**Email:**

Name/Title:	**Signature:**	**Date:**