Application Date: _____ Completed By: _____ Referral Source: _____

CAPCC ELIGIBILITY REQUIREMENTS

Review the following eligibility criteria to ensure the applicant meets **all** requirements:

- Living with an acquired brain injury
- Age 18 to 65
- Resides in facility-based continuing care
- Is a Canadian citizen or permanent resident
- Eligible for the Alberta Health Care Insurance Plan (AHCIP)
- A Canadian citizen or permanent resident
- Able to clearly communicate (verbally or non-verbally) their preferences and actively participate in establishing and working toward their goals

APPLICANT INFORMATION

Have you previously enrolled, or are you currently enrolled in a CAPCC program? ☐ Yes ☐ No

If yes, when were you enrolled and for how long? _____

At what organization(s) did you receive CAPCC services? _____

Are you currently receiving any funding? (check all that apply)

☐ AISH ☐ CPP ☐ WCB ☐ OAS ☐ Insurance ☐ Other: _____

CONTACT INFORMATION

Name of Applicant: _____ Date of Birth: _____

Home Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Alberta Health Care #: _____ Calgary Transit Access #: _____

Emergency Contact Name: _____ Relation: _____

Emergency Contact Phone #: _____ Alternate Phone #: _____

GUARDIANSHIP/TRUSTEESHIP

☐ Self

☐ Private Trustee Name: _____ Phone: _____

☐ Public Guardian & Trustee Name: _____ Phone: _____

ALTERNATE CONTACT

If you would prefer we communicate with an alternate contact, please provide the following:

Name: _____ Relationship to Applicant: _____

Email Address: _____ Phone Number: _____

MEDICAL INFORMATION

How did you acquire your brain injury? What area of your brain was affected?

Date of Injury: _____ What hospital were you admitted to? _____

Are you currently receiving any rehabilitation services? ☐ Yes ☐ No

What rehabilitation services have you received? (e.g., Ponoka, physiotherapy, home care)

Are you currently taking any medications? ☐ Yes ☐ No If yes, what for?

Do you have any allergies? ☐ Yes ☐ No If yes, what are they?

Do you use any mobility aides? ☐ Yes ☐ No If yes, what are they?

Do you have any health concerns regarding the following?

☐ Eyesight ☐ Hearing ☐ Fatigue ☐ Anger management ☐ Smell/taste ☐ Memory

Have you fallen within the last 12 months? ☐ Yes ☐ No If yes, please elaborate:

Other comments about health or mobility:

Do you have any present concerns or history of (the following)?

☐ Depression
☐ Drug misuse
☐ Psychological diagnosis
☐ Suicide ideation
☐ Alcohol misuse
☐ Physical aggression toward self or others

ADDITIONAL INFORMATION

What does your weekly schedule look like (e.g., regularly scheduled appointments and meetings)?

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Sunday: _____

Are you currently involved in the community? If so, how/where?

Do you currently require a support person to access the community? ☐ Yes ☐ No
If yes, for what activities and for what reasons?

What does your current support network look like? (e.g., family, friends)

What are your **current** leisure activities/interests?

What were your **previous** leisure activities/interests prior to your brain injury?

Are there any pets in your residence? ☐ Yes ☐ No If yes, what kind: _____

Any special instructions to get to your residence/facility?

Any parking instructions?

Other comments:

Please submit the completed application to: ***Intake@arbi.ca***