

CLIENT ANNUAL REVIEW		Today's date: (DD/MM/YY) _____	
CLIENT INFORMATION			
Last name:		First:	Middle:
			Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth(DD/MM/YY) / /	Day Time Phone Number	Evening Phone Number	
Street No:	Street Name:	City:	
Province:	Postal Code:	Email Address:	
Date of Injury/Loss (DD/MM/YY): / /	Cause of Injury/Loss:		
Primary Caregiver Last Name: Name:	First	Primary Caregiver Phone Number:	

1. HAS THERE BEEN A CHANGE IN THE NUMBER OF HOUSEHOLD MEMBERS OR INCOME FROM THE INITIAL APPLICATION FORM?

NO YES

If Yes please update the following information:

The client's annual income \$ _____.

The household income if client is less than 18 years of age \$ _____.

2. HAS THE CONDITION OF THE CLIENT CHANGED OVER THE PAST YEAR?

NO YES

If Yes, Please explain any symptoms, diseases or additional information:

3. WHAT TYPE OF SERVICE DOES THE CLIENT UTILIZE FROM THE RESPITE PROGRAM?

Please check off the appropriate box

Attendant Care

Nursing

Community/Social Support

Indoor/Outdoor Homemaking Services

Other (Please Explain) _____

4. PLEASE DESCRIBE HOW THE RESPITE PROGRAM IS CURRENTLY BEING USED BY THE CLIENT.

5. HAS THE RESPITE PROGRAM ENHANCED YOUR FAMILY'S QUALITY OF LIFE?

NO YES

Please Explain:

6. HAS THE RESPITE PROGRAM LED TO PROGRESS/POSITIVE CHANGES IN THE LAST YEAR?

NO YES

Please Explain:

7. HAS THE RESPITE PROGRAM MET YOUR EXPECTATIONS?

NO YES

Please Explain:

CURRENT SERVICE PROVIDER

Name of Current Service Provider: _____

Service Provider Phone Number: _____

APPLICANT AUTHORIZATION

I hereby certify that the information I have provided above is true and correct to the best of my knowledge.

Applicant signature

Date(DD/MM/YY)

Do you authorize the Yuri Mutiger Memorial Respite Care Fund to utilize your information to promote our program? NO YES

A picture is worth a thousand words. A picture of your loved one with the Respite Caregiver would add meaning to this review. If you are able to, please forward one to our office. Thank you very much.

CONFIDENTIALITY: In signing this document you understand that BIAPH will be sharing relevant information about this file with designated Service Providers. This information may be shared via e-mail.

PRIVACY: By signing this document, you give us permission to use your Personal Information to contact, correspond with and, when necessary, collect further Personal Information from you or your Service Provider, relevant to the BIAPH Respite Care Program.

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