

Confidential When Complete

APPLICATION FORM FOR RESPITE UNIT WITHOUT SUPPORT CARE

NAME _____
(Last Name) (First Name)

ADDRESS _____
(Street Name and Number) (Apt)

(City) (Province) (Postal Code)

TELEPHONE _____
(Home) (Office)

BIRTHDATE _____ AGE _____ FEMALE _____ MALE _____
(dd/mmm/yy)

ONTARIO HEALTH CARD # _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Relationship _____

Address _____

Phone (Day) _____ (Evening) _____

1. RESPITE SERVICES REQUESTED:

From: _____ to _____
(dd/mmm/yy) (dd/mmm/yy)

Approximate Arrival Time: _____

Approximate Departure Time: _____

2. REASON RESPITE UNIT IS BEING REQUESTED:

DECLARATION

I certify that the information provided in this application is accurate and complete. I agree that I do not require attendant services during my respite stay.

DATE

APPLICANT

WITNESS

Please return this completed application form to:

The In Community
1150 Morrison Drive, Suite 110 Ottawa, ON K2H 8S9
Phone: 613-724-5886 Fax: 613-724-5889
www.theincommunity.ca