APPLICATION FOR

PARTICIPATION HOUSE MARKHAM

COMMUNITY PROGRAMS

ASSISTED LIVING

- Mission/Philosophy
- Participation House Markham Assisted Living location information
- Information Sheet/Procedure
- Outline of Services Available/Not Available/What is required of Clients
- Release of Information
- Assisted Living Service Contract
- Applicant Information (to be fill out and returned)
- Functional Assessment (to be fill out and returned)
- Medical Forms (to be fill out and returned)

Our Mission

The mission of Participation House, Markham is to be a leader in enhancing the quality of life of individuals with disabilities through a continuum of services designed to reflect individualized approaches, community involvement and a respect for human dignity.

Our Values

Respect

We value and respect the uniqueness, choices and diversity of all people. We strive to foster respect between the individuals we serve, our employees and the community.

Quality

We believe that quality of life is determined by the individual, their family, and/or support network and we will work together to ensure that the services and supports for the individuals we serve are provided to the highest degree of quality possible.

Safety

We believe in a healthy and safe living and working environment.

Flexibility and compassion

We believe that our organization must be flexible, accountable, innovative and compassionate in responding to the needs of the individuals and their families supported by our organization. We recognize that growth and development of individuals is a dynamic process and that our services must reflect this reality.

Collaboration and Leadership

We will work collaboratively with other service providers and will take a leadership role within our community in promoting the quality of life of individuals with disabilities.

Revised July 2012

HEAD OFFICE

4261 Hwy 7 Suite 204, Markham, ON L3R 9W6 — Main Line: 905-513-2756
Website: www.participationhouse.net — Fax: 905-513-7963

RESIDENTIAL PROGRAMS FUNDED BY LOCAL HEALTH INTEGRATED NETWORK

CEDARCREST MANOR

20 Water Street, Markham, Ontario L3P 7P7 — Staff Line: 905-472-5860
Highway 48 and Water Street — Fax: 905-472-4978
Number of Units: 8 one-bedroom apartments

HAGERMAN CORNERS

4460 14th Ave, Markham, Ontario L3R 1H1 — Staff Line: 905-947-0537
Kennedy Road and 14th Avenue — Fax: 905-947-0536
Number of Units: 8 one-bedroom apartments

ST. LUKE'S LODGE

49 Green Lane, Thornhill, Ontario L3T 7M9 — Staff Line: 905-731-0792
John Street and Bayview Avenue — Fax: 905-731-2160
Number of units: 20 one-bedroom apartments

TONY WONG PLACE

25 Deverill Court, Markham, Ontario L3R 1H1 — Staff Line: 905-513-9660
Main intersection–Kennedy Road and 14th Avenue — Fax: 905-470-4122
4 Three Bedroom Apartments (Shared Units)

RESIDENTIAL PROGRAMS FUNDED BY MINISTRY OF COMMUNITY AND SOCIAL SERVICES

MAIN RESIDENCE

9 Butternut Lane Markham, Ontario L3P 3M1 — Telephone: 905-294-0944
Main Intersection–9th Line and Church Street — Fax: 905-294-7834
48 Continuing Care Beds

HENDERSON HOUSE GROUP HOME

113 Henderson Ave, Thornhill, Ontario L3T 2L — Staff Line: 905-881-5155
Main Intersection–John Street & Bayview Avenue — Fax: 905-881-5158
6 Continuing Care Beds

FARINTOSH HOUSE GROUP HOME

7811 Kennedy Road, Markham, Ontario L3R 2C8 — Staff Line: 905-477-9925
Main Intersection–Kennedy Road and 14th Avenue — Fax: 905-477-5350
10 Continuing Care Beds

CLIFFWOOD MANOR

4000 Don Mills Rd, Willowdale, Ontario M2H 3N2
Don Mills Road and Steeles Avenue
Outreach Attendant Services only.

APPLICATION PROCEDURE

1. Application forms, including medical/immunization records and physician's statement of medical and psychological stability, income verification and services available are enclosed. Please complete and return the last 8 pages of this package.

2. When the last 8 pages of this package are completed and returned to the Community Service Manager, a telephone interview/assessment will be conducted to determine placement on the waiting list. At the time of a vacancy, a formal interview will be scheduled.

3. This formal interview will be carried out by the Admission/Discharge Committee of Participation House, Markham, and an appropriate Housing representative if applicable. An OT/PT assessment may be requested.

4. The committee will determine and notify the selected candidate and all other applicants will remain on the waiting list for a future appropriate vacancy.

TO BE ELIGIBLE FOR PARTICIPATION HOUSE COMMUNITY PROGRAMS ASSISTED LIVING THE APPLICANT MUST:

- Be 18 years of age and over
- Have a valid Ontario Health Card
- Have a permanent physically disabled and require physical assistance with activities of daily living in order to accomplish such tasks safely and within a reasonable time. You may also require homemaking assistance, but these activities must be in addition to the physical assistance needed and is considered depending on program resources.
- Be safe in their own home when left unattended
- Demonstrated that activities of daily living are difficult to do or cannot be done on a regular basis
- Express a desire to live independently
- Be capable, or "potentially capable" of:
  - Determining when and what assistance is required
  - Making the request for assistance
  - Participating in the development of their own assisted living service plan
  - Personal management (planning meals, assisting with care of premises and arranging financial matters).
- Be in general good health with medical conditions relatively stable.
- Have medical needs met by existing community health network (e.g.: family physicians, out-patient clinics, visiting nurses).
- Be aware that the extent of disability must be within the range of care available within existing program resources.
- Meet the eligibility requirements of the housing provider.

ASSISTED LIVING

Participation House client must provide or obtain the following information prior to commencement of personal support care service and to maintain ongoing personal support care service:

- Proof of income as requested by Participation House and Building Management
- Ontario Health Insurance
- Apartment insurance
- Land line telephone
- Medical information as requested by Participation House
- Power of Attorney for Personal Care
- access to apartment as requested by Participation House (request to see schedule 1)
- Proper supplies to ensure the safety and cleanliness in each client apartment (request to see schedule 2)
- A lock box for money, jewelry, health card etc., and
- Information as requested for Apartment Property Management

Participation House, Markham Assisted Living
Does not provide or include:

- Any medical care at any level
- Support care outside of client apartment unless organized through Life Skills staff or Supervisor
- Any supplies or necessities for client daily living needs

Participation House, Markham Assisted Living
Will Provide:

- On site 24-hour personal support care with all aspects of daily living within your apartment from Unregulated Personal Support Care Workers. The number of staff at each location is based on the client needs
- Individual training for staff on procedures under the guidelines for working with Unregulated Care Providers
- Life Skills Coach available to assist with budgeting, banking, meal planning, home management skills, accessing community services and providing resource
- Access to Participation House, Markham Adult Education Day Program
- Communication system that allows client to contact staff 24 hours a day 7 days a week.
- Complaint process (request to see schedule 3)
- Service contract to be reviewed and updated yearly
- An unfurnished self contained one bedroom apartment
- Interview with Property Manager and information on building
- Sub-lease
- Part III Bill of Rights of Bill 173, an Act respecting Long Term Care
- Assessment for transfers to be reviewed and updated yearly
- Five days for client to review all information before accepting and signing the Service Contract

PARTICIPATION HOUSE, MARKHAM
ASSISTED LIVING AGREEMENT

Between:

Client Name: Address:	-and-	Participation House, Markham 9 Butternut Lane Markham, ON L3P 3M1

ASSISTED LIVING AGREEMENT

Participation House, Markham (hereafter known as Participation House), operates as an approved agency as outlined in the Long-Term Care Act, 1994 (Ontario) (hereafter known as the LTC Act) and pursuant to directives of the Ministry of Health and Long-Term Care.

This Attendant Services Agreement addresses the requirements of providing Attendant Services, as defined in section A below, under the LTC Act and is subject to the provisions of the LTC Act. In this Agreement, a reference made to "you" includes or means your substitute decision-maker (as defined in the LTC Act), as applicable.

A. Assisted Living

1. Participation House provides personal support services, homemaking services in concert with personal support service and in some cases independence training, all as defined in the Planning, Funding and Accountability Manual under the LTC Act to persons over 18 years of age with physical disabilities who require assistance with the activities of daily living and to carry out tasks that they cannot physically do for themselves (hereinafter collectively referred to as "Attendant Services"). The majority of adults with physical disabilities direct their own services. Participation House assists the recipient of Attendant Services in carrying out the activities of daily living in accordance with the needs and preferences of the recipient. Independence Training may be provided where persons are in a transition, from being dependent upon others, to making their own decisions and independent living, or when persons are not yet able to fully self direct their own services. The amount and type of service will depend upon the person's needs. The Attendant Services and related supports that Participation House will provide to a recipient are determined by agreement of the parties, through the development and regular updating of an Individual Service Plan. The independence training service will only be offered where it will be useful to support the person's goal of independent living.

B. Agency's Responsibilities

Participation House agrees:

1. To deliver Attendant Services in compliance with the requirements of the LTC Act.

2. To ensure that the Bill of Rights contained in the LTC Act, and set out in Schedule "A" to this Agreement, is fully respected and promoted as required under the LTC Act.

3. To implement the plan adopted by Participation House pursuant to the LTC Act regarding the prevention of abuse and neglect in accordance with our Policies and Procedures.

4. To develop an Individual Service Plan with you, a copy of which will be attached as Schedule "B" to this Agreement, in accordance with the LTC Act. To provide you with the Attendant Services outlined in your Individual Service Plan, within the human and financial resources of Participation House

5. To review and revise the Individual Service Plan with you to reflect your changing needs and preferences. This review will be undertaken annually or at any time upon a reasonable request by you or Participation House.

6. To ask for your input on a regular basis, be responsive to and understanding of your suggestions and concerns on how service can be improved.

7. To hire, train, supervise, evaluate and schedule staff in accordance with the requirements of your Individual Service Plan, the Bill of Rights, and Participation House related policies and procedures.

8. To provide staff at mutually agreed-upon scheduled times indicated in the Individual Service Plan. Where possible and subject to compliance with human rights legislation, we will provide you with a staff of the gender requested. However, services may be offered by a staff of the other gender under the following circumstances:
    a. In case of an emergency.
    b. For non-personal services (services that do not involve dressing, toileting, bowel routines, and bathing).
    c. For services to numerous individuals where there is not a consensus with respect to preference of gender.

9. To provide support in accessing and coordinating medical, dental, and other health and social services in accordance with your expressed needs and wishes.

10. If you wish, help to establish and maintain an environment that enables you to be connected with natural supports such as family, friends, and community activities in accordance with your Individual Service Plan as developed with Participation House.

11. At your request Participation House will:
    a. Provide you with a copy and an explanation of your Individual Service Plan.
    b. Review with you your personal record or file and make adjustments as required.
    c. Let you review, at the address mentioned in section G of this Agreement, any agreement between Participation House and the Ontario Ministry of Health and Long Term Care relating to your Attendant Services or their funding.

C. You agree:

1. To participate in the development, direction, review, and revision of your Individual Service Plan.
2. To allow Participation House to enter your apartment/living space to provide services in accordance with the Individual Service Plan and in all emergency situations.
3. To make every effort to look after your health, social, recreational, and emotional needs.
4. To provide at your own expense equipment and supplies reasonably necessary for your care.
5. To promptly inform Participation House if there are any changes in your health or other circumstances affecting, or anticipated to affect, the type, nature or frequency of services required under this Agreement. You also agree to professional assessments when requested by Participation House.
6. To notify Participation House if insurance payments or benefits for Attendant Services have been received as a result of a settlement (i.e., past and future service costs) for a physical injury. These funds must be used to offset the costs of providing services in compliance with the Insurance Act (Ontario) and any other applicable health and insurance legislation.
7. To provide as much notice as possible if planning to be absent for one or more sessions of service or for an extended period of time.
8. To provide as much notice as possible when returning from vacation, a hospital stay, etc. to ensure that Participation House has time to reactivate services.
9. To abide by all applicable laws and not to ask, assist or encourage any other person to violate any such laws.
10. To maintain a safe environment for you and the staff or volunteers providing the services.

D. Confidentiality

1. All personal and medical information provided by you will be kept confidential except as permitted or required to be disclosed according to applicable law.

E. Termination

1. This Agreement may be terminated at any time by written notice of termination to you for any of the following reasons:
   - You withdraw your consent to receive the Attendant Services or refuse to consent to the use or limited disclosure of information necessary to provide such Attendant Services in accordance with this Agreement and applicable laws.
   - You have not received the Attendant Services for an extended period of time and have not reached a mutually satisfactory agreement with Participation House for the continuance of the services beyond such extended period. The term “extended period of time” means a period of at least 90 days unless Participation House determines that a shorter period constitutes an extended period of time due to your failure to reasonably collaborate with Participation House during such period of time in which you have not received Attendant Services.
   - You are no longer eligible for the Attendant Services provided.

- Your service needs exceed the Attendant Services that can be provided through the Attendant Services guidelines of Participation House. In such cases, your Attendant Services will not be terminated until alternate service possibilities are developed with you, your family physician or other appropriate persons or organizations unless you fail to collaborate with Participation House in arranging alternate services.

- You have deliberately attempted to cause injury or abuse in any way, or have repeatedly shown disrespect, to another client, staff or volunteer, have repeatedly failed to collaborate with Participation House, staff or volunteers or have failed to follow generally accepted safety procedures. In such cases, to the extent possible and as appropriate, you will be informed of specific instances described through incident reports and Participation House will make efforts to resolve the situation with you.

- You deliberately make misrepresentations or provide false information to Participation House, staff or volunteers regarding your personal situation or health, which will adversely affect the service being provided to you.

2. Upon receiving a termination notice, you may appeal the decision according to the LTC Act.

F. Obligations of Participation House and Limitation of Liability

1. Participation House will comply with its obligations under the LTC Act and will use its reasonable best efforts to provide you with the Attendant Services and otherwise to fulfill its obligations pursuant to this Agreement. You acknowledge and agree that none of Participation House**,** its employees, agents, representatives, volunteers, officers and directors have any liability for any failure to provide such Attendant Services except as required by the LTC Act and this Agreement, as set out in this paragraph, and all such liability is hereby excluded. Participation House makes no warranty, representation, condition or guarantee respecting the Attendant Services except as set out in this paragraph.

G. General

1. Any requests, complaints or suggestions that you may have pursuant to this Agreement must be made to:
   Participation House, Markham ON L3P 3M1
   Contact Person: Chuck Johnston, Director, Community Services
   Tel: 905-294-0944 Fax: 905-294-7834 Email: chuck.johnston@participationhouse.net

You acknowledge receipt of a copy of this Agreement including the schedules and Individual Service Plan.

We hereby accept and agree to the terms of this Agreement.

Client Signature	Date
Witness (as to signature of Client) signature	Witness Name
Participation House, Markham Representative signature	Date

____/____/_____ placed on client file

Schedule A

THE BILL OF RIGHTS

1. **Courtesy, Respect, and Freedom from Abuse**
   You have the right to be treated in a courteous and respectful manner and to be free from mental, physical, and financial abuse.

2. **Privacy and Freedom to Make Your Own Decisions**
   You have the right to be dealt with in a manner that respects your dignity and privacy and promotes your autonomy.

3. **Being an Individual**
   You have the right to be dealt with in a manner that recognizes your individuality and that responds to your needs and preferences. This includes preferences based on ethnic, spiritual, linguistic, familial and cultural factors.

4. **Information and Answers**
   You have the right to have information about community services provided to you and to be told who will be providing the services.

5. **Participation**
   You have the right to participate in the assessment of your requirements, development of your service plan, review of your requirements, evaluation, and revision of your service plan.

6. **Control and Consent**
   You have the right to give or refuse consent to the provision of any community service.

7. **Freedom to Speak Out**
   You have the right to raise concerns or recommend changes in connection with the community services provided to you and in connection with policies and decisions that affect your interests, to your service provider, government officials, or any other person, without fear of interference, coercion, discrimination, or reprisal.

8. **Knowing the Rules**
   You have the right to be informed of the laws, rules, and policies affecting the operation of the service provider and the right to be informed in writing of the procedures for initiating complaints about the service provider.

9. **Confidentiality**
   You have the right to have your records kept confidential in accordance with the law.

Schedule B

INDIVIDUAL SERVICE PLAN

(Master Booking Sheet)

Client				Update Date			
Booking & Time	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Time							
Booking							
Length							
Time							
Booking							
Length							
Time							
Booking							
Length							
Time							
Booking							
Length							

Housekeeping	Laundry	Life Skills	Total Hours of Personal Support Care Service	Total Hours of Support Care Service

- Staff will strive to be at clients' bookings on time. Clients are expected to be ready for their bookings. Should a staff need to come early they must first obtain the client's approval. Should staff be more than 10 minutes late without notifying the client, please call for assistance.
- Changes can be requested at any time by notifying Senior Staff.

I agree with the above Individual Service Plan developed with my input.

Client Signature	Date
Supervisor Signature Date	Life Skills Staff Signature Date

____/____/_____ placed on client file

CONSENT TO RELEASE INFORMATION		
Client Name	Date of Birth	Address
I authorize the agencies, professionals and individuals listed below to release to Participation House, Markham any information in their files that may be relevant to my care, guidance, and other needs, and I authorize Participation House, Markham to retain and use that information.		
Name of agency/professional/individual		Contact Number
Client Signature		Date
Participation House, Markham Representative		Contact Number
Participation House, Markham Representative Signature		Date

____/____/_____ placed on client file

PARTICIPATION HOUSE, MARKHAM COMMUNITY PROGRAMS
ASSISTED LIVING

APPLICANT CONTACT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms.

Name: _____
(last) *(first)* *(middle)*

Date of Birth: _____ Gender: ☐ Male ☐ Female

Health Card #: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced

Address: _____ Phone: _____

_____

P.O.A (personal care): _____ Phone: _____

Please note this application will be shared with a centralized waiting list for Supportive Living in the Central, Local Health Integrated Network (LHIN) area.

Please indicate the Community Program of interest:

☐ CEDARCREST, 20 Water Street, Markham, Ontario L3P 7P7

☐ HAGERMAN CORNERS, 4460 14th Avenue, Markham, Ontario L3R 0J2

☐ ST. LUKE'S LODGE, 49 Green Lane, Thornhill, Ontario L3T 7M9

OTHER SERVICES

What other services do you currently receive? (*List all services in the chart below)*

Service	Current Provider	Hours/Week

Is there any expectation that these services will be increased, discontinued or reduced?

☐ YES ☐ NO

If yes, on what **date** is the change anticipated? _____

What is the anticipated change? _____

Please complete and return

PARTICIPATION HOUSE – COMMUNITY PROGRAMS

Requested Schedule of Service (Please indicate the time slots when you would require assistance. Include all snacks, extra service, total number of hours, number of persons)

Time Period	Minutes	Type of Assistance	Daily	Number of Persons
Midnight – 1 A.M.				
1 A.M. – 2 A.M.				
2 A.M. – 3 A.M.				
3 A.M. – 4 A.M.				
4 A.M. - 5 A.M.				
5 A.M. – 6 A.M.				
6 A.M. – 7 A.M.				
7 A.M. – 8 A.M.				
8 A.M. – 9 A.M.				
9 A.M. – 10 A.M.				
10 A.M. – 11 A.M.				
11 A.M. – Noon				
Noon – 1 P.M.				
1 P.M. – 2 P.M.				
2 P.M. – 3 P.M.				
3 P.M. – 4 P.M.				
4 P.M. – 5 P.M.				
5 P.M. – 6 P.M.				
6 P.M. – 7 P.M.				
7 P.M. - 8 P.M.				
8 P.M. – 9 P.M.				
9 P.M. – 10 P.M.				
10 P.M. – 11 P.M.				
11 P.M. – Midnight				

SIGNATURE _____ DAILY TOTAL HOURS _____

Please complete and return

PARTICIPATION HOUSE, FUNCTIONAL ASSESSMENT

Please check appropriate need	Independently	Set up help	Supervision Only	Limited Assistance	Extensive Assistance	Total Dependence
Medication						
Mobility						
Walk short distances						
Rise, sitting to standing						
Manual wheelchair						
Electric wheelchair/Scooter						
Transfer to/from toilet						
Transfer to/from shower						
Phone use						
Eating And Meal Preparation						
Drink						
Feed Self						
Prepare sandwiches/snack						
Cooking						
Clean up table						
Take dishes to sink						
Wash/dry dishes						
Rising, Dressing, Sleeping						
Reach above head						
Dress self						
Undress						
Get in/out of bed						
Turn in bed						
Transfer to bed						
Transfer out of bead						
Grooming						
Toileting						
Self						
Catheterization						
Urinal						
Ileo/Colostomy						
Bowel Care						
Commode						

PARTICIPATION HOUSE, FUNCTIONAL ASSESSMENT

Please check appropriate need	Independently	Set up help	Supervision Only	Limited Assistance	Extensive Assistance	Total Dependence
HOUSEKEEPING, LAUNDRY, SHOPPING						
Handle light housework (dusting, sweeping, etc..)						
Handle heavy housework						
Wash/dry clothing						
FINANCIAL						
Daily shopping						
Budgeting						
Bill payment						
Outstanding debts						

POWER OF ATTORNEY

MEDICAL CARE	FINANCIAL CARE
Name:	**Name:**
Address:	**Address:**
Telephone #:	**Telephone #:**

Please complete and return

PARTICIPATION HOUSE, Markham

COMMUNITY PROGRAMS

GENERAL MEDICAL INFORMATION

This report will remain confidential.

Note To Physician:

Your patient has applied for Assisted Living. The information you provide will assist us in appropriately assessing the application. To be considered for this program the applicant must meet the following minimum criteria:

1. Be able to direct own care
2. Have all medical and clinical needs met in the community
3. Require personal care

Please give completed form to your patient or mail to:

Director, Community Services
Participation House, Markham
9 Butternut Lane, Markham, Ontario L3P 3M1

Thank you for your co-operation.

THIS SECTION TO BE COMPLETED BY A QUALIFIED MEDICAL PRACTITIONER: (please print or type)

GENERAL MEDICAL INFORMATION

Patient Name _____

Date of Birth _____ Health Card # _____

Primary Diagnosis and/or Secondary Diagnosis _____

_____

Are these conditions: ☐ Stable ☐ Improving ☐ Deteriorating

Please complete and return

CURRENT MEDICATIONS AND DATE REVIEWED BY FAMILY DOCTOR

1. _____ PRN _____

2. _____ _____

3. _____ _____

4. _____ _____

5. _____ _____

IMMUNIZATION HISTORY (dates)

_____ _____

*T.B. Test: Positive/Negative
(If positive, Chest X-ray required)

Measles

_____ _____

D.P.T.P.

Smallpox

_____ _____

*Tetanus

*Hepatitis B Vaccine

_____

Flu Vaccination

*Mandatory before Admission

PHYSICAL EXAMINATIONS AND FUNCTIONAL INQUIRY

Head & Neck: _____

Ears: _____

Eyes: _____

Respiratory System: _____

CVS: _____

G.I. _____

G.U. _____

CNS: _____

Back & Extremities: _____

Allergies: _____

Please complete and return

PAST HISTORY: MEDICAL – SURGICAL – PSYCHIATRIC:

_____

_____

_____

_____

CURRENT AND/OR RECURRING MEDICAL/PSYCHIATRIC CONDITIONS:

_____

_____

_____

_____

Does this individual require Personal Support Care Services? ☐ Yes ☐ No

Do you feel this individual with benefit from living in an Independent Supportive Housing Living environment? ☐ Yes ☐ No

Does your patient have any clinical needs? ☐ Yes ☐ No
If yes, are the clinical needs being met in the community?

_____

Does your patient have a history of mental illness and/or addictions? ☐ Yes ☐ No
If yes, is your patient receiving the necessary treatment?

_____

Do you feel your patient is capable of administering his or her own medication? ☐ Yes ☐ No

Is your patient currently receiving therapy or treatments? ☐ Yes ☐ No
Please specify (nursing, occupational therapy, physical therapy)

_____

_____

Please complete and return

Does your patient have any medical problems that we should be made aware of?

_____

General Health of Patient (check where applicable):

☐ Good ☐ Fair ☐ Poor

How often has the patient been admitted to hospital in the last 12 months?

_____

Do you feel that with non-medical support service available for activities of daily living (washing, grooming, toileting, and light housekeeping) that your patient is physically able to live in the community? ☐ Yes ☐ No

How well adjusted do you feel your patient is to their disability?

_____

IMPORTANT NOTE TO PHYSICIAN:

Please ensure that your patient has had a medical examination within the past 12 months. Date of examination: _____

PHYSICIAN: (please print)

Name: _____

Address: _____

Telephone: _____

Signature: _____ Date: _____

Please feel free to attach any additional information that you feel would assist us in processing this individual application.

Revised July 2012

Please complete and return