

# Service Application Form

Complete all sections. Page 1 and 3 are mandatory.



For more information about our services, please visit wesn.ca

First name:		Last name:	
Address:			Buzzer:
City:	Province:	Postal code:	
Date of birth (MMM/DD/YYYY):	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-Binary <input type="checkbox"/> Transgender <input type="checkbox"/> Other: _____ <input type="checkbox"/> Prefer not to answer		
Phone number:			<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Alternate phone number:			<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Email:			<input type="checkbox"/> Do not send E-newsletter
<u>Emergency contact:</u>			
First name:		Last name:	
Emergency contact relationship:			
Phone number:			<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Email:			

<b>Referral date (MMM/DD/YYYY):</b>	
<b>Referral source (choose one):</b> <input type="checkbox"/> Self-referred <input type="checkbox"/> Family / Friend <input type="checkbox"/> Primary Care <input type="checkbox"/> Home Health <input type="checkbox"/> Mental Health <input type="checkbox"/> Acute Care <input type="checkbox"/> Other: _____	
<u>Referral contact name:</u>	
First name:	Last name:
Job title: <input type="checkbox"/> Allied health professional <input type="checkbox"/> Nurse <input type="checkbox"/> Physician <input type="checkbox"/> Other: _____	
Health Authority: <input type="checkbox"/> VCH <input type="checkbox"/> PHC <input type="checkbox"/> Other: _____	
Phone number:	Email:

## Demographics

### Primary language (choose one):

- English    Cantonese    Farsi    French    German    Indigenous Language  
 Japanese    Korean    Mandarin    Portuguese    Punjabi    Spanish  
 Other: \_\_\_\_\_

**Interpreter needed:**  Yes  No

### Ethnic origin (choose one):

- African    East / South East Asian (e.g. Chinese, Vietnamese, Japanese)  
 European    North American Indigenous (e.g. First Nations, Indigenous, Metis)  
 Latin, Central, South American    West Asian / Middle Eastern (Persian)  
 Oceania (e.g. Australia)    Other: \_\_\_\_\_  
 South Asian (e.g. Indian, Pakistani)    Prefer not to answer

**Were you born in Canada?**  Yes   No:  I came to Canada **less than** 5 years ago  
 I came to Canada **more than** 5 years ago

**I identify as:**  Gay    Lesbian    Heterosexual    Bisexual / Pansexual  
 Other: \_\_\_\_\_    Prefer not to answer

## Home and Health

**Household information:**  Lives alone    Lives with other: \_\_\_\_\_  
 Independent living    Assisted living    Care home

**Mobility:**  Cane    Wheelchair    Walker  
Able to get in and out of vehicle without assistance:  Yes  No

### Describe factors necessitating request for service(s)

**Physical health:**  Yes  No

Details:

**Mental health:**  Yes  No

Details:

**Cognition:**  Yes  No

Details:

\*\* Is this service request temporary?  Yes  No  
If yes, how long is the service required (months)? \_\_\_\_\_

**Do you receive other publicly funded home supports?**  Yes  No  Unknown

If yes:  Veterans Affairs Canada    Health Authority / home support services  
 Other \_\_\_\_\_

Services requested	Additional information required	✓
<input type="checkbox"/> Better at Home Light Housekeeping <b>Note:</b> Does NOT include personal care tasks	Total Income from the Canada Revenue Agency income tax Notice of Assessment <b>Line 15000 \$</b> _____ <b>Tax year</b> _____	<input type="checkbox"/>
<input type="checkbox"/> Check-In Calls and Emails	<b>FOR OFFICE USE ONLY</b>	<input type="checkbox"/>
<input type="checkbox"/> Choose to Move	Service request(s) confirmed <input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Friendly Visiting		<input type="checkbox"/>
<input type="checkbox"/> Grocery Shopping and Delivery		<input type="checkbox"/>
<input type="checkbox"/> Housing Navigation		<input type="checkbox"/>
<input type="checkbox"/> LinkAGE Social Prescribing	Data entry completed <input type="checkbox"/> by (initials): ____	<input type="checkbox"/>
<input type="checkbox"/> Minor Home Repairs <b>Note:</b> Tasks that are non-trades only (e.g. no electrical, plumbing)		<input type="checkbox"/>
<input type="checkbox"/> Peer Support		<input type="checkbox"/>
<input type="checkbox"/> Transportation to / from Medical Appointments		<input type="checkbox"/>

**Consent for Collection and Release of Information:**

I \_\_\_\_\_ (applicant full name) hereby consent to the collection and release of my information to West End Seniors' Network staff, volunteers, contracted and/or other service providers. I understand that this information will only be used to provide me with appropriate services, and I reserve the right to cancel at any time (request to cancel must be received in writing). Having provided emergency contact information, I am aware that WESN staff may contact this person if deemed necessary for service delivery.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date (MMM/DD/YYYY)

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
Date (MMM/DD/YYYY)

**Please submit the completed form to:**

- **Email:** info@wesn.ca
- **Fax:** 1-877-885-6561
- **Mail:** West End Seniors' Network  
1447 Barclay Street  
Vancouver, BC  
V6G 1J6

VERBAL CONSENT obtained by:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (MMM/DD/YYYY)