(Rev.08/2020)

Application Form for Integrated Support Service for Persons with Severe Physical Disabilities

(Please put a "✓" in the appropriate box in accordance with the residential address of the applicant)

	Service Operator	Regional Cluster	Telephone Number	Fax Number	Address
☐	Yang Memorial Methodist Social Service	**Hong Kong Island and Kowloon** (Central, Western, Southern, Islands, Eastern, Wan Chai, Kowloon City, Yau Tsim Mong, Sham Shui Po, Wong Tai Sin, Kwun Tong and Tseung Kwan O)	3959 1700	3425 4994	Units 6-10, G/F, Lai Tak House, Lai On Estate, Sham Shui Po
☐	Po Leung Kuk	**New Territories** (Sha Tin, Tai Po, North, Sai Kung, Tsuen Wan, Kwai Tsing, Tuen Mun, Yuen Long and Tin Shui Wai)	3708 8690	3708 8693	Shop No. RB2, Commercial Centre, Cheung Shan Estate, New Territories

I. Personal Particulars

1. Name	(English) (Chinese)
2. Sex/ Date of Birth	☐ Male ☐ Female *(dd) (mm) (yyyy)*
3. HKID No.	or No. of Certificate of Exemption:
4. Residential Address/ Tel. No./ Email	Address: Email: Tel. No.:
5. School Attending	☐ Nil ☐ Special School ☐ Boarding Section of Special School ☐ Others, please specify: _____ Name of School: _____ Category of School: ☐ Special School for Severely Intellectually Disabled Children ☐ Special School for Physically Disabled Children ☐ Others, please specify:
6. Service Receiving (May choose more than one item)	☐ Nil Community support [Note]: ☐ District Support Centre for Persons with Disabilities ☐ Home Care Service for Persons with Severe Disabilities ☐ Community Rehabilitation Day Centre ☐ Day Care Service for Persons with Severe Disabilities ☐ Transitional Care and Support Centre for Tetraplegic Patients ☐ Integrated Home Care Services (Frail Cases) ☐ Integrated Home Care Services (Ordinary Cases) ☐ Enhanced Home and Community Care Services ☐ Community Care Service Voucher for the Elderly ☐ Day Care Centre/Unit for the Elderly ☐ Respite Services ☐ Others, please specify: _____ Day training: ☐ Integrated Vocational Rehabilitation Services Centre ☐ Special Child Care Centre ☐ On the Job Training for People with Disabilities ☐ Supported Employment ☐ Day Activity Centre ☐ Sheltered Workshop ☐ Others, please specify: _____ Residential service : ☐ Private Residential Care Home/Hostel ☐ Self-financing Home ☐ Supported Hostel ☐ Hostel for Moderately Mentally Handicapped Persons ☐ Hostel for Severely Mentally Handicapped Persons ☐ Hostel for Severely Physically Handicapped Persons ☐ Care and Attention Home for Severely Disabled Persons Medical treatment: ☐ Psychiatric In-patient ☐ Non-Psychiatric In-patient ☐ Day Hospital ☐ Out-patient clinic, please specify:
7. Waitlisting for Subvented Residential Care Services	☐ Yes, please specify the category of residential care service: _____ ☐ No

Note Persons with severe physical disabilities over the age of 60 can opt for (1) Home Care Service for Persons with Severe Disabilities/ Integrated Support Service for Persons with Severe Physical Disabilities or (2) services for the elderly including Integrated Home Care Services/ Enhanced Home and Community Care Services/ Day Care Centre/Unit for the Elderly/ Community Care Service Voucher for the Elderly if the applicant is assessed to be eligible for the service. The applicant cannot receive both kinds of services at the same time. For the applicant with severe physical disabilities under the age of 60, he/ she can only choose Home Care Service for Persons with Severe Disabilities or Integrated Support Service for Persons with Severe Physical Disabilities depending on their eligibility for the respective service. To avoid service duplication, Applicant/ Guardian/ Appointee is required to make a declaration for the service operator of not using similar services of other subvented non-government organisations during service application, and gives consent for the service operator to confirm information with relevant agencies.

II. Disability

1. Physical Disability	☐ Tetraplegia/Quadriplegia ☐ Paraplegia ☐ Hemiplegia ☐ Cerebral palsy ☐ Loss of hand/foot or finger/toe ☐ Loss of upper or lower limbs ☐ Others, please specify: _____ ☐ Medical report attached
2. Intellectual Disability	☐ Not intellectually disabled ☐ Profound ☐ Severe ☐ Moderate ☐ Mild ☐ Not Known Date of psychological assessment: *(dd)* *(mm)* *(yyyy)* ☐ Psychological report attached
3. Other Disability (May choose more than one item)	☐ Speech impairment ☐ Deaf/Hearing impairment ☐ Down's Syndrome ☐ Visual impairment (☐ Blind / ☐ Partially impaired) ☐ Autism ☐ Mental illness, please specify: _____ ☐ Others, please specify: _____
4. Illness/ Health Problem	Please specify if any:_____
5. Need for Respiratory Support Medical Equipment (RSME)	☐ Yes, please specify the category of RSME: _____ _____ ☐ No
6. Mobility	☐ Walk unaided ☐ Walk with escort ☐ Walk with aid ☐ Wheelchair bound ☐ Bed ridden
7. Treatment Receiving	☐ Occupational therapy ☐ Physiotherapy ☐Speech therapy ☐ Nursing care service ☐ Others:_____ ☐ Not applicable

III. Care System

Particulars of Carer(s)

- "Carer" refers to a family member that offers or would offer care or assistance to the applicant, including parents, relatives and kins.
- "Other carer(s)" refers to the neighbours, friends or employed domestic helpers who provide care to the applicant, but not staff of institutions or hospitals.

Types of Carer	Name	Sex/Age	Relationship	Whether living together	Occupation	Contact Tel. No.
Primary carer						
Other carer(s)						

IV. Signature of Applicant/Guardian/Appointee (Applicable to self-approach for service)

Type of Service Applied (May choose more than one item)	☐ The use of Respiratory Support Medical Equipment (RSME) and medical consumables ☐ Nursing care service ☐ Nutrition/ Use of drugs ☐ Cash subsidy for renting RSME and purchasing medical consumables (For persons with severe physical disabilities depending on respiratory support medical equipment) ☐ Rehabilitation training ☐ Home modification ☐ Home respite service ☐ Community activities ☐ Personal care service ☐ Social work service ☐ Carer support service ☐ Others, please specify: _____
Applicant/Guardian/Appointee: _____ Tel. No.: _____	

(Please delete as appropriate)

(Signature)

Date:

(Name)

V. Medical Information (To be completed by Medical Officer, Nursing or Allied Health Staff for patients planning for discharge from hospital or receiving outpatient treatment)

1. Medical Diagnosis	☐ Tetraplegia (To be completed by Medical Officer) ☐ Tetraplegia with medical report attached ☐ Others, Please specify:
2. Discharge Date	
3. Post-discharge Arrangement by Hospital/ Clinic	☐ Occupational therapy ☐ Physiotherapy ☐ Speech therapy ☐ Nursing care service ☐ Day rehabilitation centre ☐ Day hospital ☐ Others, please specify: ☐ Outpatient treatment, please specify clinic:
4. Areas Recommended to be Followed up by "Integrated Support Service for Persons with Severe Physical Disabilities" (May choose more than one item)	☐ The use of Respiratory Support Medical Equipment (RSME) and medical consumables ☐ Nursing care service ☐ Nutrition/ Use of drugs ☐ Cash subsidy for renting RSME and purchasing medical consumables (For persons with severe physical disabilities depending on respiratory support medical equipment) ☐ Rehabilitation training ☐ Home modification ☐ Home respite service ☐ Personal care service ☐ Social work service ☐ Community activities ☐ Carer support service ☐ Others, please specify:
5. Medical Information Completed by	(Signature) (Name) (Post Title) Hospital/Clinic: Tel. No.: Ref. No.: Date:

VI. Referrer's Information (To be completed by Referrer where applicable)

Suggested Follow up Areas (May choose more than one item)	☐ The use of Respiratory Support Medical Equipment (RSME) and medical consumables ☐ Nursing care service ☐ Nutrition/ Use of drugs ☐ Cash subsidy for renting RSME and purchasing medical consumables (For persons with severe physical disabilities depending on respiratory support medical equipment) ☐ Rehabilitation training ☐ Home modification ☐ Home respite service ☐ Personal care service ☐ Social work service ☐ Community activities ☐ Carer support service ☐ Others, please specify:

Case Ref. No.:		Service Unit:	
Name of Referrer:	(Eng)	Agency Name:	
	(Chi)	Post Title of Referrer:	
Email Address:		Tel./ Fax No.:	
Referrer's Signature:		Date:	