



## **TECHNOLOGY FOR INDEPENDENT LIVING**

**#103 - 366 East Kent Avenue South**

**Vancouver, BC V5X 4N6**

**Phone: 604-326-0175**

**Fax: 604-326-0176**

**Email: [til@bcits.org](mailto:til@bcits.org)**

**Website: [www.bcits.org](http://www.bcits.org)**



## CLIENT INFORMATION UNDERTAKING

I, \_\_\_\_\_, hereby authorize the Technology for Independent Living Program (TIL) a program of The BC Association for Individualized Technology and Support for People with Disabilities (BCITS), and/or its representatives to release to or obtain from such agencies, individuals, medical centres or hospitals as are concerned with my medical rehabilitation, any and all pertinent information which may be necessary to assist in providing me with medical rehabilitation services.

I declare that any financial and other information which I have provided in order for the Technology for Independent Living Program to determine my eligibility to receive service at no cost or at a reduced cost is true to the best of my knowledge and belief.

I understand that all such information will be treated as confidential and privileged, and used only for the purpose of assisting my medical rehabilitation.

I am nineteen years of age or older.

DATED THIS \_\_\_\_\_ DAY OF \_\_\_\_\_ 20 \_\_\_\_\_

SIGNED BY: \_\_\_\_\_ WITNESS: \_\_\_\_\_  
CLIENT/REPRESENTATIVE SIGNATURE

\_\_\_\_\_  
STATE RELATIONSHIP TO CLIENT NAME

\_\_\_\_\_  
STREET

\_\_\_\_\_  
CITY / PROVINCE / POSTAL CODE

**"IF CLIENT IS UNABLE TO SIGN,  
A SECOND WITNESS IS REQUIRED"**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
NAME

\_\_\_\_\_  
STREET

\_\_\_\_\_  
CITY / PROVINCE / POSTAL CODE

**PERSONAL INFORMATION**

Name of Applicant: \_\_\_\_\_  
(First) (Last)

Date of Birth: \_\_\_\_\_ Sex: M:  F:  Date of Application: \_\_\_\_\_  
M/D/Y M/D/Y

Name of Current Care Residence (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ (ext) \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Home Address if different from above:

\_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ (ext) \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**MEDICAL INFORMATION AND COVERAGE**

Medical Diagnosis: \_\_\_\_\_

Onset/Reason (e.g., MVA, Accident): \_\_\_\_\_

Referring Therapist/Doctor \_\_\_\_\_ Phone: \_\_\_\_\_ (ext) \_\_\_\_\_ Fax: \_\_\_\_\_

Facility/Organization: \_\_\_\_\_ Phone: \_\_\_\_\_ (ext) \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Postal Code: \_\_\_\_\_

Do you have ICBC coverage?  Yes  No Do you have WCB coverage?  Yes  No

Claim # \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ (ext) \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ Postal Code: \_\_\_\_\_

**CONTACT PERSONS:**

(i.e., A person who will assume responsibility for completion of forms, arranging appointments, etc. if client is unable to do this.)

**Primary Contact**

Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ (ext) \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**Alternate Contact**

Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ (ext) \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**Person Prescribing Equipment**

Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ (ext) \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**Form Completed by:**

Client: Yes  No       Primary Contact: Yes  No       Alternate Contact: Yes  No

If none of the above:

Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ (ext) \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

## ENVIRONMENTAL CONTROL SYSTEM REQUESTS

An Environmental Control System (ECS) allows a person who is unable to control his/her environment in a usual manner to do so electronically. Devices which are typically operated via an ECS include: lights, radio, television, and telephone. A person who can directly access a standard remote control or push button telephone may not qualify for our services.

**TIL's Environmental Control Systems are not intended to provide emergency call or home security functions, or to control kitchen appliances or heating facilities.**

In many cases, complicated electronic controls may not be needed to enable the user to operate equipment. Our technical staff can advise as to whether the your own equipment can be adapted, and will adapt it, if appropriate.

A potential candidate for an ECS is any individual who has the desire to maximize independence via personal control over their immediate environment.

An Occupational Therapist or others assisting in this process should be prepared to act as a resource person, who will inform the TIL of any change in status and to be available to assist with the installation and/or follow-up. All system users are asked to be part of an ongoing evaluation and education process.

Our program includes assessment, installation, repairs and follow-up throughout the entire Province. Because of this there may be some delay before we can provide the service you need. If any changes occur after the completion of this form, please let us know. We look forward to being of service to you.

Do you have any environmental control devices at present?      Yes       No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What things do you wish to do or operate from your wheelchair/sitting position? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What is stopping you from doing these things? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What switch or equipment do you think will help you to meet your wishes? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What things do you wish to do or operate from your bed/reclined position? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What is stopping you from doing these things? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What switch or equipment do you think will help you to meet your wishes? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have access to person(s) with technical expertise to assist you with equipment? Y  N

If you are working with a therapist, please include contact information: \_\_\_\_\_

Facility/Firm: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ (ext) \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Please attach most recent report/assessment. Date last seen/projected date: \_\_\_\_\_

Please add any other relevant information: \_\_\_\_\_

\_\_\_\_\_

If you have any questions please call us at 604-326-0175

Please submit this form to us by mail, fax or email:

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We look forward to being of service to you.

# The Importance of Membership

by Christine Gordon, BCITS Board Member



**Even if you're not a "joiner", we urge BCITS clients to become members. Here's why.**

- BCITS was developed as a consumer-driven organization because consumers told us they wanted PROP and TIL to be person-centered in all of our supports and services. We need PROP and TIL clients to be members, so we don't lose that vision.
- When we apply for grants to finance the programs and services that support you, potential funders look at the number of members as one important piece of evidence that BCITS is a member-driven, democratic organization.
- As a non-profit charitable society, BCITS is governed by its members. If you are not a member, you cannot participate at Annual General Meetings, be nominated for the Board of Directors or elect the members of the Board. This is equivalent to not voting in a general election!

**You do not need to be a BCITS member to be our client. However, your membership is very important, so please become a member today.**

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## **Yes, I accept your invitation to join BCITS!**

Home of Provincial Respiratory Outreach Program and Technology for Independent Living

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

### **Please check one:**

Membership for registered BCITS Clients

Please mail completed form to BCITS. (The cost of postage constitutes your membership fee)

Non-Client Membership Fee

Please mail completed form along with \$20 annual membership fee payable to BCITS.

### **Please mail to:**

BCITS, #103-366 East Kent Avenue South Vancouver, BC V5X 4N6.

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**Thank you for your support!**