

## Application form for Home Care Service for Persons with Severe Disabilities

Please fax the application form to the respective Home Care Service Team  
(Please tick in the appropriate box ☐)

<input type="checkbox"/>	Tung Wah Group of Hospitals	Hong Kong (Central, Western, Southern, Islands, Eastern and Wan Chai)	Tel. No.: 2803 2103 Fax No.: 2803 2145 Email: lkhcs@tungwah.org.hk
<input type="checkbox"/>	Yang Memorial Methodist Social Service	Kowloon (1) (Sham Shui Po, Kowloon City, Yau Tsim Mong and Tseung Kwan O)	Tel. No.: 2337 9966 Fax No.: 2337 9060 Email : khcs@yang.org.hk
<input type="checkbox"/>	Christian Family Service Centre	Kowloon (2) (Kwun Tong and Wong Tai Sin)	Tel. No.: 3996 8515 Fax No.: 3996 8514 Email : rhc@cfsc.org.hk
<input type="checkbox"/>	SAHK	New Territories (1) (Shatin, Sai Kung, Tai Po and North)	Tel. No.: 2602 8900 Fax No.: 2699 4070 Email: ntehss@sahk1963.org.hk
<input type="checkbox"/>	Po Leung Kuk	New Territories (2) (Tsuen Wan, Yuen Long, Tin Shui Wai)	Tel. No.: 2154 3818 Fax No.: 2154 3889 Email: homecare.nt@poleungkuk.org.hk
<input type="checkbox"/>	The Neighbourhood Advice-Action Council	New Territories (3) (Tuen Mun, Kwai Chung and Tsing Yi)	Tel. No.: 2618 0411 Fax No.: 2618 0198 Email : tohc@naac.org.hk

### I. Service Applied

<b>Type of Service</b>	<input type="checkbox"/> Personal Care	<input type="checkbox"/> Nursing Care	<input type="checkbox"/> Rehabilitation Training
	<input type="checkbox"/> Escort Service	<input type="checkbox"/> Home Respite Service	<input type="checkbox"/> Carer Support Service

### II. Personal Particulars

1. Name	(English)	(Chinese)
2. Sex/ Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female   (dd)   (mm)   (yyyy)	
3. HKID No.	or No. of Certificate of Exemption :	
4. Residential Address & Contact Tel. No./ Email:	Address: Email:	Tel. No.:
5. Residential District	<input type="checkbox"/> Central & Western <input type="checkbox"/> Southern <input type="checkbox"/> Islands <input type="checkbox"/> Eastern <input type="checkbox"/> Wan Chai <input type="checkbox"/> Sham Shui Po <input type="checkbox"/> Kowloon City <input type="checkbox"/> Yau Tsim Mong <input type="checkbox"/> Tseung Kwan O <input type="checkbox"/> Kwun Tong <input type="checkbox"/> Wong Tai Sin <input type="checkbox"/> Shatin <input type="checkbox"/> Tai Po & North <input type="checkbox"/> Sai Kung <input type="checkbox"/> Tsuen Wan <input type="checkbox"/> Yuen Long & Tin Shui Wai <input type="checkbox"/> Kwai Chung & Tsing Yi <input type="checkbox"/> Tuen Mun	

6. School attending (if applicable)	<div> <input type="checkbox"/> Special School           <input type="checkbox"/> Boarding Section of Special School         </div> <div> <input type="checkbox"/> Other, please specify: _____         </div> <div>           Name of School: _____         </div> <div>           Category of School:             <input type="checkbox"/> Special School for Physically Disabled Children             <input type="checkbox"/> Special School for Severely Intellectually Disabled Children             <input type="checkbox"/> Others, please specify: _____         </div>
7. Service Receiving (may choose more than one item)	<div> <input type="checkbox"/> Nil         </div> <div>           Community support:           <div> <input type="checkbox"/> District Support Centre for Persons with Disabilities             <input type="checkbox"/> Respite Services           </div> <div> <input type="checkbox"/> Integrated Support Service for Persons with Severely Physical Disabilities (Cash Subsidy)             <input type="checkbox"/> Integrated Support Service for Persons with Severely Physical Disabilities (Integrated Home-based Support Service)           </div> <div> <input type="checkbox"/> Community Rehabilitation Day Centre             <input type="checkbox"/> Day Care Service for Persons with Severe Disabilities             <input type="checkbox"/> Integrated Home Care Services (Frail Cases)             <input type="checkbox"/> Home Support Services             <input type="checkbox"/> Enhanced Home Care and Community Care Service             <input type="checkbox"/> Day Care Centre/Unit for the Elderly             <input type="checkbox"/> Community Care Service Voucher for the Elderly             <input type="checkbox"/> Special Child Care Centre             <input type="checkbox"/> Others, please specify: _____           </div> </div> <div>           Vocational Rehabilitation Services/Day Training:           <div> <input type="checkbox"/> Integrated Vocational Rehabilitation Services             <input type="checkbox"/> Integrated Vocational Training Centre Day           </div> <div> <input type="checkbox"/> Supported Employment Training for Persons with Disabilities             <input type="checkbox"/> Sheltered Workshop           </div> <div> <input type="checkbox"/> Day Activity Centre             <input type="checkbox"/> Others, please specify: _____           </div> </div> <div>           Residential service:           <div> <input type="checkbox"/> Private Hostel             <input type="checkbox"/> Self-financed Home           </div> <div> <input type="checkbox"/> Supported Hostel             <input type="checkbox"/> Hostel for Severely Physically Handicapped Persons           </div> <div> <input type="checkbox"/> Hostel for Moderately Mentally Handicapped Persons             <input type="checkbox"/> Care and Attention Home for Severely Disabled Persons           </div> <div> <input type="checkbox"/> Hostel for Severely Mentally Handicapped Persons             <input type="checkbox"/> Others, please specify: _____           </div> </div> <div>           Medical treatment:           <div> <input type="checkbox"/> Psychiatric In-patient             <input type="checkbox"/> Non-Psychiatric In-patient           </div> <div> <input type="checkbox"/> Day Hospital           </div> <div> <input type="checkbox"/> Out-patient clinic, please specify: _____           _____         </div> </div>
8. Waitlisting for subvented residential care services	<div> <input type="checkbox"/> Yes, please specify the category of residential care service : _____         </div> <div> <input type="checkbox"/> No         </div>

### III. Information on Disabilities and Health Issues

1. Physical Disability	<input type="checkbox"/> Not physically disabled <input type="checkbox"/> Hemiplegia <input type="checkbox"/> Loss of hand/foot or finger/toe <input type="checkbox"/> Medical report attached	<input type="checkbox"/> Quadriplegia <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Others, please specify: _____	<input type="checkbox"/> Paraplegia <input type="checkbox"/> Loss of upper or lower limbs
2. Intellectual Disability	<input type="checkbox"/> Not intellectually disabled <input type="checkbox"/> Profound <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild Date of psychological assessment:    (dd)    (mm)    (yyyy) <input type="checkbox"/> Psychological report attached		
3. Other Disability (may choose more than one item)	<input type="checkbox"/> Speech impairment <input type="checkbox"/> Deaf / Hearing impairment <input type="checkbox"/> Autism <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Visual impairment <input type="checkbox"/> Mental illness, please specify: ( <input type="checkbox"/> Blind/ <input type="checkbox"/> Partially impaired) _____ <input type="checkbox"/> Others, please specify: _____ _____		
4. Illness/Health Problem	Please specify if any: _____ _____		
5. Mobility	<input type="checkbox"/> Walk unaided <input type="checkbox"/> Walk with escort <input type="checkbox"/> Walk with aid <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bed ridden bound		
6. Treatment Receiving	<input type="checkbox"/> Occupational therapy <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Speech therapy <input type="checkbox"/> Nursing care service <input type="checkbox"/> Others: _____ <input type="checkbox"/> Not applicable		

### IV. Information of Carer(s)

#### Particulars of Carer(s)

- “Primary 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 neighbors, 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.
(a) Primary carer						
(b) Other carer(s)						

### V. Referrer Information

Case Ref. No.:

Name of Referrer: (Chi) \_\_\_\_\_  
(Eng) \_\_\_\_\_

Service Unit: \_\_\_\_\_

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

Tel./Fax No.: \_\_\_\_\_

Date: \_\_\_\_\_

**Remarks**

Persons with severe 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 service. The applicant cannot receive both kinds of services at the same time. For the applicant with severe 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 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.