

## 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
<input type="checkbox"/>	Yang Memorial Methodist Social Service	<b>Hong Kong Island and Kowloon</b> (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  Units 501-502, On Hing House, Hing Wah (II) Estate, Chai Wan, Hong Kong
<input type="checkbox"/>	Po Leung Kuk	<b>New Territories</b> (Sha Tin, Tai Po, North, Sai Kung, Tsuen Wan, Kwai Tsing, Tuen Mun, Yuen Long and Tin Shui Wai)	3547 1171	3547 1170	LG2/F, Ching Lung House, Ching Fu Court, 18 Tsing Yi Road, Tsing Yi, New Territories  LG/F, Social Service Building, Fu Tip Estate, 11 Chung Nga Road, Tai Po, New Territories

### I. 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/ Tel. No./ Email	Address:  Email:      Tel. No.:	
5. School Attending	<input type="checkbox"/> Nil <input type="checkbox"/> Special School <input type="checkbox"/> Boarding Section of Special School <input type="checkbox"/> Others, please specify: _____ Name of School: _____ Category of School: <input type="checkbox"/> Special School for Severely Intellectually Disabled Children <input type="checkbox"/> Special School for Physically Disabled Children <input type="checkbox"/> Others, please specify: _____	
6. Service Receiving (May choose more than one item)	<input type="checkbox"/> Nil Community support <small>Note:</small> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 30%;"> <input type="checkbox"/> District Support Centre for Persons with Disabilities  <input type="checkbox"/> Home Care Service for Persons with Severe Disabilities  <input type="checkbox"/> Community Rehabilitation Day Centre  <input type="checkbox"/> Day Care Service for Persons with Severe Disabilities  <input type="checkbox"/> Transitional Care and Support Centre for Tetraplegic Patients  <input type="checkbox"/> Integrated Home Care Services (Frail Cases)  <input type="checkbox"/> Home Support Services  <input type="checkbox"/> Enhanced Home and Community Care Services  <input type="checkbox"/> Community Care Service Voucher for the Elderly  <input type="checkbox"/> Day Care Centre/Unit for the Elderly  <input type="checkbox"/> Respite Services  <input type="checkbox"/> Special Child Care Centre  <input type="checkbox"/> Others, please specify: _____           </div> <div style="width: 30%;"> <input type="checkbox"/> Integrated Vocational Rehabilitation Services Centre  <input type="checkbox"/> Integrated Vocational Training Centre Day  <input type="checkbox"/> Supported Employment Training for Persons with Disabilities  <input type="checkbox"/> Sheltered Workshop  <input type="checkbox"/> Day Activity Centre  <input type="checkbox"/> Others, please specify: _____           </div> </div> Vocational Rehabilitation Services / Day Training:	

	Residential service : <input type="checkbox"/> Private Residential Care Home/Hostel <input type="checkbox"/> Self-financing Home <input type="checkbox"/> Supported Hostel <input type="checkbox"/> Hostel for Moderately Mentally Handicapped Person <input type="checkbox"/> Hostel for Severely Mentally Handicapped persons <input type="checkbox"/> Hostel for Severely Physically Handicapped Persons <input type="checkbox"/> Care and Attention Home for Severely Disabled Persons <input type="checkbox"/> Others, please specify: _____
	Medical treatment: <input type="checkbox"/> Psychiatric In-patient <input type="checkbox"/> Day Hospital <input type="checkbox"/> Non-Psychiatric In-patient <input type="checkbox"/> Out-patient clinic, please specify: _____
7. Waitlisting for Subvented Residential Care Services	<input type="checkbox"/> Yes, please specify the category of residential care service: _____ <input type="checkbox"/> No

<sup>Note</sup> 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	<input type="checkbox"/> Tetraplegia/Quadriplegia <input type="checkbox"/> Paraplegia <input type="checkbox"/> Hemiplegia <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Loss of hand/foot or finger/toe <input type="checkbox"/> Loss of upper or lower limbs <input type="checkbox"/> Others, please specify: _____ <input type="checkbox"/> Medical report attached
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 <input type="checkbox"/> Not Known 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"/> Down's Syndrome <input type="checkbox"/> Visual impairment ( <input type="checkbox"/> Blind / <input type="checkbox"/> Partially impaired) <input type="checkbox"/> Autism <input type="checkbox"/> Mental illness, please specify: _____ <input type="checkbox"/> Others, please specify: _____
4. Illness/ Health Problem	Please specify if any: _____
5. Need for Respiratory Support Medical Equipment (RSME)	<input type="checkbox"/> Yes, please specify the category of RSME: _____ <input type="checkbox"/> No
6. Mobility	<input type="checkbox"/> Walk unaided <input type="checkbox"/> Walk with escort <input type="checkbox"/> Walk with aid <input type="checkbox"/> Wheelchair bound <input type="checkbox"/> Bed ridden
7. 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

### III. Care System

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 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)	<input type="checkbox"/> The use of Respiratory Support Medical Equipment (RSME) and medical consumables	<input type="checkbox"/> Nursing care service	<input type="checkbox"/> Nutrition/ Use of drugs
	<input type="checkbox"/> Cash subsidy for renting RSME and purchasing medical consumables (For persons with severe physical disabilities depending on respiratory support medical equipment)	<input type="checkbox"/> Rehabilitation training	<input type="checkbox"/> Home modification
	<input type="checkbox"/> Personal care service	<input type="checkbox"/> Home respite service	<input type="checkbox"/> Community activities
	<input type="checkbox"/> Others, please specify: _____	<input type="checkbox"/> Social work service	<input type="checkbox"/> Carer support service
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	<input type="checkbox"/> Tetraplegia (To be completed by Medical Officer) <input type="checkbox"/> Tetraplegia with medical report attached <input type="checkbox"/> Others, please specify: _____		
2. Discharge Date			
3. Post-discharge Arrangement by Hospital/Clinic	<input type="checkbox"/> Occupational therapy <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Speech therapy <input type="checkbox"/> Nursing care service <input type="checkbox"/> Day rehabilitation centre <input type="checkbox"/> Day hospital <input type="checkbox"/> Others, please specify: _____ <input type="checkbox"/> 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)	<input type="checkbox"/> The use of Respiratory Support Medical Equipment (RSME) and medical consumables <input type="checkbox"/> Nursing care service <input type="checkbox"/> Nutrition/ Use of drugs <input type="checkbox"/> Cash subsidy for renting RSME and purchasing medical consumables (For persons with severe physical disabilities depending on respiratory support medical equipment) <input type="checkbox"/> Rehabilitation training <input type="checkbox"/> Home modification <input type="checkbox"/> Home respite service <input type="checkbox"/> Community activities <input type="checkbox"/> Personal care service <input type="checkbox"/> Social work service <input type="checkbox"/> Carer support service <input type="checkbox"/> 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)	<input type="checkbox"/> The use of Respiratory Support Medical Equipment (RSME) and medical consumables	<input type="checkbox"/> Nursing care service	<input type="checkbox"/> Nutrition/ Use of drugs
	<input type="checkbox"/> Cash subsidy for renting RSME and purchasing medical consumables (For persons with severe physical disabilities depending on respiratory support medical equipment)	<input type="checkbox"/> Rehabilitation training	<input type="checkbox"/> Home modification
	<input type="checkbox"/> Personal care service	<input type="checkbox"/> Home respite service	<input type="checkbox"/> Community activities
	<input type="checkbox"/> Others, please specify: _____ <input type="checkbox"/> Social work service <input type="checkbox"/> Carer support service		
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: _____	