BCITS technology for living

Provincial Respiratory Outreach Program • PROP
Technology for Independent Living Program • TIL

Automatic Door Request

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
Website: www.bcits.org

Automatic Door Opener Requests

TIL's automatic door opener program assists individuals with high level disabilities with electromechanical access to their home door when they cannot open or close it on their own.

People requesting these services must be a registered TIL client or must meet the eligibility requirements for TIL services. The applicant must be able to demonstrate that they cannot open the door in question without assistance.

The candidate must be prepared to stay at the residence where the door opener is being installed for up to five years or pay the move fee.

TIL can only provide door openers if the funds are available. In some cases, individual applicants may be asked to provide some partial funding and/or be placed on a waiting list.

TIL will not provide door openers designed to access main building doors, such as in apartments or condominiums owned or operated by others. Only those requiring access to suite doors or single family homes are eligible to apply.

Applicants for this service that rent or lease their home must obtain permission from the owners of the building before any installation relating to doors can take place.

A potential candidate for an automatic door opener is any individual who has the desire to maximize independence via personal control over their immediate environment. The program is not designed to provide access for applicants who are able to physically open doors independently. Nor is the program designed to solely facilitate entry for visitors and personal attendants.

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

_____

_____

_____

_____

_____

How do you open the door in question at present? _____

_____

_____

_____

Where in your dwelling is the door in question? _____

_____

_____

Can you or your family contribute towards the cost of the door opener? Yes ☐ No ☐

What is your living situation (e.g. alone, with family, in an apartment, in a house, in a facility, etc.)?

_____

Number of people in family: _____ **Age:** _____

Number of dependants: _____ **Age:** _____

Financial Information: (Mandatory Fields)

Gross Family Income (as recorded on your last tax return): _____

Property (e.g. house, land, etc.) Yes ☐ No ☐ Value (as per last assessment): _____

Mortgage: Yes ☐ No ☐ Value of Mortgage: _____

Cash savings in Bank: _____ **RRSP:**_____ **Investments:** _____

Medical related expenses during last calendar year as per income tax return: _____

Do you have ICBC or WCB coverage: Yes ☐ No ☐ Claim #: _____

Pension: Yes ☐ No ☐ Monthly Amount: _____

What alternatives to an automatic door opener have you considered (e.g. automatic door lock, modified door handle, etc.)? _____

_____

_____

Have you applied for funding through Home Adaptations for Independence (HAFI)? If not, please apply by visiting http://www.bchousing.org/Options/Home_Renovations and filling out their application form.

Yes ☐ (Please provide a rejection letter) No ☐ (Please apply to HAFI first)

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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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 or a settlement? ☐ 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:_____

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:_____