TECHNOLOGY FOR INDEPENDENT LIVING - APPLICATION FOR SERVICE

MEMBER INFORMATION

Name of Applicant (member): _____ Date of Birth (DD/MM/YYYY): _____

MEMBERS CURRENT RESIDENCE

Facility Name (if applicable): _____
Street Address: _____ City: _____ Postal Code: _____
Home Phone: _____ Cell Phone: _____ Email: _____

MEMBERS HOME ADDRESS (if different than above)

Street Address: _____ City: _____ Postal Code: _____

MEDICAL INFORMATION AND COVERAGE

Medical Diagnosis: _____ Onset/Reason: _____
Referring Therapist: _____ Facility/Organization: _____
Therapist Phone: _____ Therapist Email: _____
Street Address: _____ City: _____ Postal Code: _____

Does applicant have ICBC/WCB Coverage? ○ **ICBC** ○ **WCB** ◉ **NONE**
ICBC/WCB Claim #: _____ Case Manager Name: _____
Phone: _____ Fax: _____ Email: _____

APPLICANT ALTERNATE CONTACT

Name: _____ Relation to Applicant: _____
Phone: _____ Email: _____
Street Address: _____ City: _____ Postal Code: _____

ENVIRONMENTAL CONTROL AND HOME AUTOMATION REQUEST

Does applicant have any environmental controls at present? ○ **YES** ◉ **NO**
If yes, please describe: _____

Describe any smartphones, tablets, or smart home automation devices currently used by applicant:

What devices does applicant want to control from bed and/or wheelchair?

Describe barriers/challenges applicant faces when using these devices:

What technology, switches or switch placement will best assist the applicant (if unknown, leave blank)?

APPLICATION SUBMITTED BY:

☐ **Applicant** By entering my email address, and submitting this application using the same email address, I agree with all conditions outlined below.
EMAIL ADDRESS: _____

☐ **Alternate Contact**
By entering my email address, and submitting this application using the same email address, I confirm that I have discussed with the applicant all conditions outlined below, and the applicant has agreed with all conditions outlined below.
EMAIL ADDRESS: _____

☐ **Referring Therapist**
By entering my email address, and submitting this application using the same email address, I confirm that I have discussed with the applicant all conditions outlined below, and the applicant has agreed with all conditions outlined below.
EMAIL ADDRESS: _____

APPLICATION CONDITIONS

- I authorize the Technology for Independent Living program, 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 information which has been provided in order for the Technology for Independent Living program to determine my eligibility to receive services at no cost, or at 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.
- I understand that, upon my approval for assistance from Technology for Independent Living, I will automatically become a member of Technology for Living.

APPLICATION SUBMISSION AND NEXT STEPS

Upon completion of this application, please submit, email, fax, or mail to:

TECHNOLOGY FOR LIVING
#103 - 366 East Kent Ave South
Vancouver, BC V5X 4N6
Fax: 604-326-0176
Email: til@technologyforliving.org

PRINT APPLICATION

RESET APPLICATION

After submitting your application for TIL services, a TIL representative will be in contact with the applicant and their referring therapist to confirm applicants status, gather further information about the applicants needs and abilities (if required), and/or to setup an appointment to start TIL services.

If the applicant would also like to apply for a door opener, a "Door Opener Request - Addendum" form must be completed.

We look forward to being of service to you and your care team!