

Information for applicant - Please Read This First

The following will answer many of the common questions we receive about intake and our Centre.

GRAND RIVER COMMUNITY HEALTH CENTRE

We believe everyone matters. We provide primary health care services, nutrition services, social work and counselling, health & wellness programs, specialized programs such as Caring for My COPD and Memory Clinics, outreach programs such as International Seasonal Worker programs, and we participate in a variety of community partnerships and initiatives.

We are experiencing very high volumes of individuals applying for primary health care providers at Grand River CHC, and as such there is lengthy wait time (at a minimum of 8 to 10 months) before you will hear from us regarding your application.

CLIENT INTAKE PROCESS

To ensure we are the right fit for you, please carefully read this sheet, including the rights & responsibilities, before submitting an intake application.

Step 1: Fill in an intake application form

Intake application forms are available on our website and at the front desk. If you need help filling in the form, please contact our centre at 519.754.0777. It is important that you complete the form in as much detail as possible.

Step 2: Submit the application form

Your completed form can be dropped off with our front reception staff. Please do not send your completed form to us by email, to protect the privacy of your information.

Step 3: Application Process

As a first step in processing your application, our office will contact you to update your package as needed. Please be patient as this can take some time, depending on the number of applications. If you already have a health provider at a different centre, please do not leave your provider until it is determined that we are able to meet your needs. Making primary care services available to community members without existing primary care providers is a priority of our CHC.

Step 4: Your first appointment

Your first meeting with your provider at the Centre will be a “meet and greet” appointment. No prescriptions will be provided during this first visit. Your medications will be reviewed and it is possible they may be changed. You will need to bring all medications you currently take with you to this appointment.

Client Rights and Responsibilities

Client Rights:

Staff, students and volunteers will work as a team to ensure client needs are met. This will be accomplished by respecting the “client rights.”

A client of GRCHC has the right to:

- Feel welcome while at Grand River Community Health Centre
- Be treated in a considerate and respectful manner, where uniqueness is valued, and consideration is given to the client as a whole person
- Receive services and attend programs in a clean environment
- Have personal health information kept private and confidential
- Be informed about your care, have opportunities to ask questions and share your concerns to support you to make decisions about your care
- Accept or decline treatment and learn how doing so might impact your health
- Bring a support person to any appointment or request accommodation if needed
- Provide feedback

Client Responsibilities:

Staff, students and volunteers commit to working in partnership with clients. Clients are in turn expected to uphold certain responsibilities.

A client of GRCHC is responsible to:

- Act in a way that allows other clients and our staff to feel safe
- Treat others with respect including respecting the gender, sexual orientation, ethnic, cultural and religious values of all GRCHC clients, visitors, volunteers, students and staff
- Attend and be on time for appointments and programs
- Share with us information necessary for your care including any changes in your contact information
- Be accountable for your actions
- Keep appointments, or cancel appointments in a timely fashion
- Inform reception or your service provider if you have cough, fever and/or flu like symptoms
- Any behavior that is found to be abusive, threatening, and/or destructive may result in having the person leave and/or may be grounds for service restriction
- Use prescriptions and/or medical devices as prescribed.



363 Colborne Street Brantford ON. N3S 3N2
Telephone: (519) 754-0777

The information requested on this form will help us assign you a primary care provider (doctor or nurse practitioner).
We are collecting additional information from clients to find out what unique needs our clients have.
We will also use this information to understand client experiences and outcomes.

Primary Care Intake Form

General Information

Last Name: _____ First Name: _____ Preferred Name: _____

Pronouns (check **one**): ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Their
☐ Other (please specify): _____

Health Card #: _____ Version Code (letters): _____ Expiry: _____

Birth Date: _____ / _____ / _____
(dd) (mm) (yy)

Address: _____
(Apt. #) (No. And Street) (City) (Postal Code)

Preferred Contact #: _____ Message allowed? Yes ☐ or No ☐

Back- up Contact #: _____ Message allowed? Yes ☐ or No ☐

Your email Address: _____

****at GRCHC we are starting to use email as a way to share information with our clients****

Emergency Contact Name: _____ Phone/Cell #: _____

Relationship: _____ Message allowed? Yes ☐ or No ☐

Biological Sex (check **one**): ☐ Male ☐ Female ☐ Intersex

Gender (check **one**): ☐ Male ☐ Female ☐ Intersex ☐ Trans female to male ☐ Trans male to female
☐ Two Spirit ☐ Gender fluid ☐ Other (please specify) _____
☐ Do not know ☐ Prefer not to answer

Only answer next question if this intake form is for yourself

Sexual Orientation (check **one**): ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Queer ☐ Two Spirit
☐ Do not know ☐ Prefer not to answer

Please list all children under the age of 16 who need care at GRCHC (complete intake for each)

Name	Date of Birth	Relationship

Social/Cultural Information

1. What language do you feel most comfortable speaking in with your health care provider? (check **one** only):

- ☐ English ☐ French ☐ Arabic ☐ Bengali ☐ Chinese (Cantonese) ☐ Chinese (Mandarin)
☐ Czech ☐ Dari ☐ Farsi ☐ Greek ☐ Hindi ☐ Hungarian
☐ Italian ☐ Korean ☐ Nepali ☐ Polish ☐ Portuguese ☐ Punjabi
☐ Russian ☐ Serbian ☐ Slovak ☐ Somali ☐ Spanish ☐ Tamil
☐ Turkish ☐ Ukrainian ☐ Urdu ☐ Vietnamese ☐ ASL ☐ Mohawk
☐ Cayuga ☐ Ojibway ☐ Cree ☐ Other Indigenous (please specify) _____
☐ Other (please specify) _____ ☐ Do not know ☐ Prefer not to answer

2. What is your current Household composition? (check **one** only):

- ☐ Couple with children ☐ Couple without children ☐ Single parent (mother) ☐ Single parent (father)
☐ Sole Member ☐ Extended family ☐ Siblings ☐ Unrelated housemate
☐ Grandparents with grandchildren

3. Place of residence (check **one** only):

- ☐ House/Apartment Condo ☐ Shelter ☐ Homeless

Ethnic/Cultural Information

1. Were you born in Canada? ☐ Yes ☐ No

a. If NO, when did you arrive in Canada? _____ If NO, country of birth? _____

☐ Canadian citizen ☐ Permanent resident ☐ Refugee Other: _____

Please circle your answer:

What is your sense of belonging in our community?	Very Strong	Somewhat Strong	Somewhat Weak	Very Weak	Do not know	Prefer not to answer	
What is your assessment of your own physical health?	Excellent	Very Good	Good	Fair	Poor	Do not know	Prefer not to answer
What is your assessment of your own mental health?	Excellent	Very Good	Good	Fair	Poor	Do not know	Prefer not to answer

2. Which of the following best describes your racial or ethnic group?

- ☐ Asian-East (e.g. Chinese, Japanese, Korean)
- ☐ Asian-South (e.g. Indian, Pakistani, Bangladeshi)
- ☐ Asian South-East (e.g. Malaysian, Filipino, Vietnamese)
- ☐ Black-African (e.g. Ghanaian, Kenyan, Somali)
- ☐ Black-Caribbean (e.g. Barbadian, Jamaican)
- ☐ Black-North American (e.g. Canadian, American)
- ☐ First Nations
- ☐ Indian-Caribbean (e.g. Guyanese with origins in India)
- ☐ Indigenous/Aboriginal
- ☐ Inuit
- ☐ Latin American (e.g. Argentinian, Chilean, Salvadoran)
- ☐ Métis
- ☐ Middle Eastern (e.g. Egyptian, Iranian, Lebanese)
- ☐ White-European (e.g. English, Italian)
- ☐ White-North American (e.g. Canadian, American)
- ☐ Mixed Heritage (e.g. Black-African & White-North American)
- ☐ Do not know
- ☐ Prefer not to answer

Education and Income

1. Highest level of education completed? (check **one** only):

- ☐ Primary (grades 1-8) ☐ Secondary (grades 9-13) ☐ College
- ☐ University-Bachelors ☐ University-Post Graduate ☐ No formal schooling
- ☐ Do not know ☐ Prefer not to answer
- ☐ other (please specify): _____

2. What is your total household income before taxes last year? (check **one** only)

- ☐ \$0 - \$14,999 (\$1,249/month or less; \$7.69/hour or less)
- ☐ \$15,000 - \$19,999 (\$1,249 - 1,667/month; \$7.69 - \$10.26/hr)
- ☐ \$20,000 - \$24,999 (\$1,667 - \$2,083/month; \$10.26 - \$12.82/hr)
- ☐ \$25,000 - \$29,999 (\$2,083 - \$2,500/month; \$12.85 - \$15.38/hr)
- ☐ \$30,000 - \$34,999 (\$2,500 - \$2,916/month; \$15.38 - \$17.95/hr)
- ☐ \$35,000 - \$39,999 (\$2,916 - \$3,333/month; \$17.95 - \$20.51/hr)
- ☐ \$40,000 - \$59,999 (\$3,333 - \$4,999/month; \$20.51 - \$30.77/hr)
- ☐ \$60,000 - \$89,999 (\$5,000 - \$6,923/month; \$30.77 - \$46.15/hr)
- ☐ \$90,000 - \$119,999 (\$6,923 - \$9,230/month; \$46.15 - \$61.54/hr)
- ☐ \$120,000 - \$149,999 (\$9,230 - \$11,538/month; \$61.54 - \$76.93/hr)
- ☐ \$150,000 or more (\$11,538/month or more; \$76.93/hr or more)
- ☐ Do not know
- ☐ Prefer not to answer

3. How many people does this income support in your household?

Including: dependent parents, children, support payments etc.: _____

☐ Do not know ☐ Prefer not to answer

Health Care Providers

Do you have a current primary care doctor or nurse practitioner? Yes ☐ or No ☐

If YES, full name of doctor/nurse practitioner and the city where located: _____

If NO, by signing here you confirm you do not have a current doctor/nurse practitioner: _____

When was the last time that you saw a primary care doctor/nurse practitioner? _____

Do you see any specialists for your care? Yes ☐ or No ☐

If yes, please complete following table:

Specialist Name	Reason for Visit	Date of Last Visit

Medical History

Have you been diagnosed with any medical conditions? Yes ☐ or No ☐

If yes, please complete following table:

Medical Condition (e.g. diabetes, high blood pressure)	Year Diagnosed

Are you, or could you be pregnant? Yes ☐ or No ☐

Have you ever seen a therapist or counsellor for mental health support? Yes ☐ Year: _____ No ☐

Hospital Visits

Have you been to the hospital (Emergency Department or admitted) in the past year? Yes ☐ or No ☐

If yes, reason for visit/admission: _____

Have you had any surgeries? Yes ☐ or No ☐

If yes, please complete following table:

Surgery	Year

Current Medication

Are you currently taking any medications? Yes ☐ or No ☐ *If yes, please complete below table*

Prescribed Medications (name and dosage)	Prescribed by
Over the Counter Medications	

Name of Pharmacy: _____

Thank you for completing this package. Please read the following and initial each statement:

- ☐ The above information is accurate to the best of my knowledge. I understand that if I knowingly give false or misleading information, GRCHC may not be able to offer services.
- ☐ I understand that my information will be stored in a secure electronic medical record, and will be kept confidential in accordance with the Personal Health Information Protection Act (PHIPA)
- ☐ Grand River CHC staff work as a team to provide care / services and I understand that I may work with more than one health care professional.
- ☐ I agree to provide my email address and I agree that GRCHC may contact me using my email for the purpose of providing information regarding specialist appointments, diagnostic testing or information related to our upcoming programs, clinics, and events at GRCHC. I understand that GRCHC cannot guarantee the security of email messages. I understand that email messages may pose a risk to my privacy. I understand at this time, messages from GRCHC will not allow for any email response from me.
- ☐ I understand that some of the information I have provided is required by the Ministry of Health and Long Term Care. It will help Grand River CHC and our funders plan for, and deliver programs. Grand River CHC will release this information without names or other personal details.
- ☐ Grand River CHC may need to share personal and medical information with GRCHC staff, and referred specialists, about you to provide the best care/services possible.

Client/Parent/Guardian Signature _____

Date: _____

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I have read and understood my rights and responsibilities as a client of the Grand River Community Health Centre.

Client/Parent/Guardian Name: _____ Client signature: _____

Date: _____