Project ASAP Program Referral Form

Name:

Date:

Age: ☐ **D.O.B.** ____ / _____ / _____

Gender: ☐ **Male** ☐ **Female**

Do you have working smoke alarms in your house now?

☐ **Yes** ☐ **No**

If Yes, how many do you have?

☐ 1 ☐ 2 ☐ 3 ☐ 4

Do you have working CO alarms in your house now?

☐ **Yes** ☐ **No**

If Yes, how many do you have?

☐ 1 ☐ 2 ☐ 3

Telephone Number:

(705) _____ - _____

City:

Sault Ste. Marie, ON

Address:

Postal Code:

Reason for Referral:

In-Home Care:

☐ **Yes** ☐ **No**

Home Care Provider:

Referral Agency:

☐ **Family** ☐ **Physician**

☐ **LHINS** ☐ **Other:**

_____

Type of Dwelling:

☐ **Single Storey** ☐ **Condo**

☐ **Bungalow** ☐ **Apartment**

☐ **High Rise** ☐ **Other**

Suggested Approval:

☐ **Approved** ☐ **Decline**

Referral Agent:

Approval Signature: _____ **Date:** _____

Fax: (705) 949-2341
Email: a.gravelle@cityssm.on.ca

Project ASAP
Assisting Seniors Awareness Program