Communication Assistance for Youth and Adults
Suite 700-655 West Kent Ave N, Vancouver, B.C., Canada V6P 6T7
Phone: 604 326-3500 Fax: 604 266-2463 www.cayabc.org

Request for Service (RFS)

(May, 2015)

CAYA USE ONLY : Date Received _____ Initials: _____

Applicant's Personal Information:	**Please check appropriate health authority:**
Surname: _____	☐ Northern Health Authority
Given Name(s): _____	☐ Interior Health Authority
Birth date (yy/mm/dd): _____	☐ Island Health
Gender: ☐ Male ☐ Female	☐ Vancouver Coastal Health Authority
Personal Health Number:_____	☐ Fraser Health Authority
Mailing Address for where Applicant resides:	**Funding Agency:**
Address: _____	☐ WCB ☐ ICBC ☐ CLBC ☐ Other _____
City: _____ Province: _____	If Applicable:
Postal Code: _____Tel: _____	Claim Number: _____
Fax: _____ Email: _____	Representative: _____

School Information - if Applicable

Name of School: _____ School District & Number: _____

Key School Contact: Name:_____ Tel: _____ Email: _____

Disability Diagnosis:	**What is the goal for this request?**

Describe the Applicant's current communication skills:

Speech/Language Services:	**Physical/Occupational Therapy:**	**Other >> Specify: _____**
Name: _____	Name: _____	Name: _____
Agency: _____	Agency: _____	Agency: _____
Phone: _____ Date: _____	Phone: _____ Date: _____	Phone: _____ Date: _____

KEY CONTACT (who we will contact regarding this request):	**Family/Guardian (if not already identified in this request):**
Surname: _____	Surname: _____
Given Name(s): _____	Given Name(s): _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City: _____ Prov: _____	City: _____ Prov: _____
Postal Code: _____ Tel (home): _____	Postal Code: _____ Tel (home): _____
Tel (work): _____ Email: _____	Tel (work): _____ Email: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize CAYA and/or its representatives to release to or obtain from such agencies, individuals, provincial resource programs, educational institutions, medical centres, or hospitals, any and all pertinent information which may be necessary to assist in providing me (the applicant) with communication assistance services.

I understand that all such information will be treated as confidential and privileged, and used only for the purpose of providing communication assistance.

I am nineteen years of age or older, or I am in my last semester of high school.

Signed: _____ Name (Please Print):_____
(signature)

Relationship: ☐ applicant, ☐ parent, ☐ guardian, ☐ representative, ☐ other _____

Signed on the ____ day of (month) _____ 20 ___.

Witness: _____ Name: _____
(signature) Address: _____
_____

If the applicant is unable to sign, a second witness is required.

Witness: _____ Name: _____
(signature) Address: _____
_____

PLEASE LIST ANY COMMUNICATION SYSTEMS THAT THE APPLICANT IS CURRENTLY USING:	
System:	Who provided it:
Please provide any other information which could be of assistance to CAYA staff in providing service. Attach additional pages and reports that are relevant to this request.	

Important: Please return this signed form to CAYA

(May, 2015)