BELLWOODS
INNOVATING INDEPENDENCE

TRANSITION PROGRAMS

COMMUNITY CONNECT
INDEPENDENT LIVING FACILITATION
HOUSING WITH LAYERED SUPPORTS

SEPTEMBER 2022

INFORMATION SHEETS

ABOUT US

Established in 1957, Bellwoods Centres for Community Living Inc. is a charitable, not-for-profit organization that provides community-based support services for the physically disabled who want to remain living independently in the community. In recent years, our client caseload has expanded to serve a growing number of seniors, individuals at risk of homelessness, and supporting patients transitioning from hospital after a catastrophic illness or injury. Services are provided to people 16 years of age or older with physical support needs. Services are delivered to clients who reside at one of our many housing sites or through attendant outreach in the broader community. We also operate a short-term transition program to support individual being discharged from hospital following an illness or a debilitating injury.

Transition Programs are time-limited, goal-oriented programs that support the transition of individuals who are returning to the community from hospital. In keeping with the philosophy of Independent Living (IL), clients direct their own services with staff onsite for pre-scheduled services.

As an organization providing direct services to persons with disabilities we are committed to improving and enhancing future transition program to support those who want to remain living in the community.

WHAT WE BELIEVE IN

Our Vision:
We envision a future where barriers do not exist.

Our Mission:
Fostering independent living through excellence and innovation.

Our Values:
- Client & family centred services
- Delivering high quality programs
- Building collaborations and partnerships
- Performance excellence
- Ensuring staff are valued, engaged and supported

COMMUNITY CONNECT (CC) PROGRAM

300 Shaw Street

The **Community Connect (CC) Program** is one of the reintegration care units (RCUs) that is currently being funded by the Ministry of Health and Ontario Health (Toronto Region) as part of a pilot project to test the value of Short-Term Transitional Care Models (STTCMs) and support discharge from hospital. The program facilitates timely discharge of clients who have experienced a significant change in their physical function and require help setting goals and learning new skills to help them learn to live independently in the community with supports. Most clients are recovering from a life-altering traumatic injury or health event that has resulted in significant change to their pre-hospital level of physical functioning.

Client Profile in our Hospital to Community Transitional Program

All clients discharged from hospital (majority Alternate Level of Care)

- Recovering from catastrophic illness (e.g., stroke) or event (e.g., automobile accident, gunshot) resulting in significant change to their baseline level of function (most often necessitating use of a power or manual wheelchair)
- Require an affordable, accessible community environment in which to learn new independent living skills to prepare them for living in their own environment post-transition
- Most clients require a high degree of care coordination and support from our Independent Living Facilitation (ILFs) to ensure they have equipment, independent living skills, connection to an income source and completion of applications to use accessible transit

COMMUNITY CONNECT (CC) PROGRAM

GOAL(s)

The program supports patients who are in hospital designated Alternate Level of Care (ALC) or at risk of becoming ALC. This time- limited, client-centred, goal-oriented program provides clients with an independent apartment and personal support services that focus on meeting their community transition goals. A dedicated team collaborates with clients in the development of skills, and provides education and support to ensure they have the adaptive equipment and knowledge needed to help support their independence in the community.

SCOPE & DURATION OF SERVICES

Clients accepted to the program require a barrier-free environment due to mobility, strength and/or endurance challenges. Most clients are dependent on personal support services (e.g., hygiene, toileting, bathing, assistance with meal preparation). Participants in the program reside in one of 15 barrier-free apartments units with access to on-site, prescheduled professional and support services.

The program supports clients in setting goals for independence. CC clients are assigned an Independent Living Facilitator (ILF) and/or a Community Integration Worker (CIW), who work with the Support Service Supervisor to establish goals for their time in CC program. Clients in the CC Program receive education and training in independent living skills, adaptive coping skills and the responsibilities of directing services, and work with staff to support their transition to a more permanent residence in the community.

The ILF/CIW team often liaises with outpatient rehabilitation partners, home and community care and housing providers as needed.

The length of stay in the CC program is a maximum of four months during which time the focus is on preparing the client to transition to a more permanent location in the community. Most clients are discharged as soon as they have met their goals. Discharge planning begins the first week of admission.

COSTS

Currently, all program costs are covered by funds provided by the MOH and OH. Participants are responsible for all costs related to purchasing their groceries, equipment, medication, medical supplies, cleaning supplies and personal hygiene items.

TARGET POPULATION, ELIGIBILITY & APPLICATION REQUIREMENTS

Applications for the CC program are submitted by hospital partners to the Centralized Referral Management (CRM) Team managed by Bellwoods. Applicants must meet the following minimum criteria:

- Be in hospital and be designated Alternate Level of Care (ALC) or at risk of becoming ALC
- Have a valid OHIP number Be medically stable
- Have a confirmed transition location and discharge plan that can be met within the maximum length of stay of the program
- Have personal support needs

COMMUNITY CONNECT (CC) PROGRAM

Additional considerations for acceptance into Bellwoods CC' program include:

- Clients must be able to direct their own care
- Clients must be able to be left alone in an independent apartment
- Clients require time, opportunity, and support in learning to adapt to changes in function in a community-based setting
- Clients (and their support network) must agree with identified discharge location
- Clients must participate in goal-oriented transition planning with the CC team.

LOCATIONS

The CC program is located at Bellwoods' 300 Shaw Street site. The program has 15 apartment units (bachelor and one bedroom), providing barrier-free units and personal care supports for participants until their goals are achieved up to a maximum of four months.

For more information contact us at:

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INDEPENDENT LIVING FACILITATION PROGRAM

The **Independent Living Facilitation Program** provides goal-oriented assessment, and consultation to support clients. Client's may be existing Bellwoods community members or individuals across a variety of hospital or community-based settings. The team of IL Facilitators offer a community-based education program for adults (16+) with a physical support need.

Services offered do not replace or duplicate available Home and Community Care resources. Services are goal-oriented and aimed at improving safety and independence (e.g., home safety assessment, assessment and provision of mobility and seating aide). The program provides support services, equipment and other resource needs that impact the clients' activities of daily living.

INDEPENDENT LIVING FACILITATOR PROGRAM

Independent Living Facilitators (ILFs) and Community Integration Workers (CIWs) make up the ILFP Team. They collaborate with clients to identify their support and equipment needs and provide skills training to support their independence, safety and wellbeing in the community. Examples of areas of support provided by the ILFP Team include:

- Improved home safety
- Community orientation
- Mobility and seating
- Improved self-care skills
- Household management skills
- Improved health and wellness
- Housing, income security and linkages to community resources
- Transition from hospital or a long-term care facility back to the community

SCOPE OF SERVICES

The ILFP Team provide a range of services to help clients achieve their independent living goals. Clients are supported in identifying their goals through completion of a comprehensive assessment and review undertaken by the Team. The Team works with clients to facilitate access to resources providing coordination and navigation, direct teaching, coaching, and recommendations on service and equipment needs to achieve client-specific goals.

DURATION OF SERVICES

The program is goal-oriented. Therefore, the duration of service (s) is dependenton achievement of the individual objectives established at the outset of the partnership.

COSTS

There is no cost for core services offered by the ILFP Team; however, clients must have a valid OHIP number to participate. Costs associated with the purchase of equipment or payment for private services that the client may decide to use is their responsibility.

TARGET POPULATION & ELIGIBILITY

All clients who reside in a Bellwoods supported apartment unit or any client receiving attendant outreach services from Bellwoods staff are eligible for ILFP Services. They may self-refer directly to the ILFP Team or they may connect with their Support Service Supervisor to refer on their behalf.

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HOUSING WITH LAYERED SUPPORTS (HLS)

Bellwoods is partnering with the City of Toronto in the Housing with Layered Supports (HLS) project. The focus of the project is to reduce or prevent homelessness, assist the chronically and episodically homeless, and support those at-risk of homelessness in the City of Toronto.

Bellwoods participation in HLS focuses on supporting clients who are homeless in hospital or residing in a transitional unit. HLS provides flexible and individualized case management for one-year from date of eligibility to support clients with moving, establishing landlord relationships and set up in their new home.

HLS

GOAL(s) OF HLS

- Help eligible applicants achieve and maintain longer-term safe housing
- Support eligible applicants in improving physical and mental health outcomes, social connectedness, individual resiliency and community connections through resource navigation, coaching, direct teaching and linking to other community partners.

TARGET POPULATION & ELIGIBILITY CRITERIA

Applicants need to have a physical disability impacting their ability to move to housing from hospital or a transitional unit to be eligible for this program. Other eligibility criteria include:

- Adults in the City of Toronto who have been without housing for six (6) months or more and are being discharged from hospital or a transitional/reintegration program.
- Willingness of the applicant to work with a case manager to set and achieve independent living goals.
- An income source with the ability to share in the cost of accommodation based on a rent-geared-to-income approach.
- Have not applied or have plans to claim refugee status. [Note: Refugee claimants may have access to similar services through the Resettlement Assistance Program (RAP)].

REFERRAL & ASSESSMENT PROCESS

Referrals can be made by a candidate directly or by a staff member at the applicant's current site/program. Referrals are assessed by the Bellwoods HLS Team and will include an initial telephone pre-screening interview with the referral source. Eligible applicants will be required to complete an income verification form and participate in an assessment.

COSTS

There is no cost for Case Management supports. All furnishings, household supplies and expenses related to living in an independent apartment (e.g., food, cell phone, TTC, etc.) will be the responsibility of the applicant. HLS staff will work with the client to explore funding and potential cost saving options.

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