Serving East / West Parry Sound and Muskoka

27 Forest Street, Parry Sound, ON P2A 2R2 Phone: (705) 746.5102 Fax: (705)746.8139 Website: www.thefriends.on.ca

CLIENT APPLICATION FORM

Please consider my application for:

□ Forest Hill Apartments, Parry Sound

□ Oakwood Heights, Bracebridge

NAME: _____

ADDRESS: _____

_____ POSTAL CODE: _____

TELEPHONE: (Home): _____ WORK: _____

DATE OF BIRTH: _____

COPY OF ONTARIO HEALTH CARD ATTACHED: □ YES □ NO

PRIMARY DIAGNOSIS: _____

OTHER DIAGNOSIS (if any): _____

Do you feel your medical condition is: (Please check one)

□ Stable □ Deteriorating □ Fluctuating □ Improving

REFERRED BY:

□ Self

□ Physician

□ Family Member

□ Health Care Worker

□ OTHER _____

REASON FOR APPLYING:

_____

_____

SELF ASSESSMENT FOR ATTENDANT CARE SERVICES

DESCRIPTION OF ACTIVITIES

This section asks questions about how you do certain activities

How do you get around from room to room in your place of residence?

☐ walk ☐ walker ☐ other kinds of assistance

☐ use electric wheelchair ☐ use manual wheelchair

☐ use power scooter ☐ walk with canes/crutches

Specify: _____

List other Home Care devices you have (i.e. communication devices, hoyer, bath lift, electric bed, oxygen):

_____

_____

What are the biggest problems/barriers you are experiencing in your current residence?

_____

_____

What type of outdoor transportation do you use?

☐ own car/van ☐ taxi/wheelchair taxi

☐ family/friends ☐ volunteer transportation

1. COMMUNICATION

1.1 Spoken language: ☐ English ☐ French ☐ Other

1.2 Special form of Communication:

☐ Braille ☐ Computer ☐ Writing

☐ Communication board ☐ Sign language

1.3

Do you require a special telephone system?

☐ Yes ☐ No

If yes, what type? _____

1.4 Are you able to read? ☐ Yes ☐ No

1.5 Are you able to write? ☐ Yes ☐ No

2. VISION

☐ Normal ☐ Impaired ☐ Corrected with glasses or other aids

3. HEARING

☐ Normal ☐ Impaired ☐ Corrected with aid

4. MEMORY

Do you have problems with ☐ short-term memory ☐ long-term memory?

5. PERSONAL CARE

Do you have any special needs or procedures in the bathroom?

_____

_____

Explain your usual toilet routine, if assistance is required.

_____

_____

What are the biggest problems you now have when using the bathroom in your house?

_____

_____

Are you working with other Agencies that might assist you (e.g. Home Care, Voc. Rehab, and Community Mental Health)? Please list them.

_____

_____

What services do you expect from *The Friends*?

_____

_____

Are there any additional comments that you would like to make? Please use the space below as well as the reverse side of this page if you need to.

_____

_____

Please complete the following charts to indicate your personal care and activities of daily living:

6. DRESSING

	MANAGES ALONE	MANAGES WITH EQUIPMENT	MANAGES WITH ASSISTANCE	REQUIRES TOTAL ASSISTANCE
Indoor Garments				
Outdoor Garments				
Shoes				
Buttons/Ties/Snaps				
Applying slings, braces				

7. FEEDING

Do you have difficulty chewing and/or swallowing? ☐ Yes ☐ No

	MANAGES ALONE	MANAGES WITH EQUIPMENT	MANAGES WITH ASSISTANCE	REQUIRES TOTAL ASSISTANCE
Feeding				

8. TRANSFERS

	MANAGES ALONE	MANAGES WITH EQUIPMENT	MANAGES WITH ASSISTANCE	REQUIRES TOTAL ASSISTANCE
Turn while in bed				
Transfer in/out of bed				
Get on/off toilet				
Get in/out of bath/shower				
Transfer to/from chair				
Transport various items				

9. MEAL PREPARATION

	MANAGES ALONE	MANAGES WITH EQUIPMENT	MANAGES WITH ASSISTANCE	REQUIRES TOTAL ASSISTANCE
Meal Preparation				
Shopping				
Cooking Meal				
Snacks				
Clean-Up After Meal				

10. TRANSFER TO VEHICLE

□ No assistance required □ Assistance required

Please Comment:

_____

_____

_____

11. HOUSEKEEPING AND LAUNDRY

	MANAGES ALONE	MANAGES WITH EQUIPMENT	MANAGES WITH ASSISTANCE	REQUIRES TOTAL ASSISTANCE
Light housekeeping (i.e. dusting, sweeping)				
Heavy housekeeping (i.e. wash floors, vacuum, windows, oven)				
Pick up dropped items from floor				
Use laundry facilities				

Do you have any special interests or hobbies? (Indoors and/or outdoors)

_____

Do you have any special needs, other than those outlined on the checklist?

_____

What are your biggest challenges as a person with a physical disability?

_____

_____ _____

Signature of Applicant **Date**

The Friends Tenant Selection and Review committee is comprised of community members and health professionals. I understand and agree to these individuals discussing my application.

In order to provide the best possible service to clients, an extensive interview will be conducted within a short period of time of starting the Supportive Housing Program. We believe that the more knowledgeable we are about a client, the better we are able to provide a quality program.

Information is gathered via discussions, observations and program involvement and is documented. From time to time, we participate in government surveys, studies and research. This info is collected to study and make policy revisions.

A file is kept of each client and is the property of *The Friends*. The appropriate caregiver or client may view their file at an appointed time arranged with the Program Supervisor. The file viewing is supervised and photocopying is not permitted. Please contact the program supervisor for more information.

Please return this form along with completed:

Physician's Report
Therapist's Report (if applicable)
To:

The Friends
27 Forest Street
Parry Sound, Ontario P2A 2R2

1.888.746.5102 • Fax (705) 746.8139 • info@thefriends.on.ca

Note: If mail sent to the applicant's address is returned, or phone numbers provided are not in service, this application form will no longer be considered valid. Please be sure to notify *The Friends* if your information changes, or if you no longer wish to be considered for housing.

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MEDICAL INFORMATION FORM

INSTRUCTIONS:

1) To be completed by the family physician
2) The information provided is used to assist in determining your eligibility to *The Friends* and developing appropriate care services for the applicant.
3) Any charge for completion of this form is the responsibility of the applicant.

RELEASE:

I, _____, consent to release of my medical information to *The Friends.*

_____ _____

Signature **Date**

DEMOGRAPHICS:

1) Patient Name:_____
2) Date of Birth: _____

DISABILITY:

1) Diagnosis of main disabling condition

   _____

2) Current treatments for this condition

   _____

3) Prognosis

   _____

4) Comments

   _____

Other Medical Problems:

E.g. Active/medical/surgical

_____

Date of Diagnosis: _____

Treatments: _____

RELEVANT PAST MEDICAL/SURGICAL PROBLEMS:

_____

MEDICATIONS:

Please attach a list of current medications.

ALLERGIES:

_____

SERVICES REQUIRED:

Which community services does this patient currently require?

(E.g. physio, homecare, speech therapy, oxygen, etc.)

_____

_____

FUNCTIONAL ASSESSMENT:

Please help us determine the applicant's level of functioning and aid needs

	Yes	No
Visual impairments	□	□
Speech impairments	□	□
Hearing impairments	□	□
Mobility impairments	□	□
Cognitive impairments	□	□

Other: _____

PHYSICAL EXAM:

Last date of complete physical exam: _____

OTHER COMMENTS:

_____

Thank you!

_____ _____ _____

Date **Physician's Name** **Physician's Signature**

Physician's Address: _____

_____

Phone #: _____

ELIGIBILITY CRITERIA

FOR

SUPPORTIVE HOUSING UNITS

Eligible applicants and tenants receiving Attendant Services will meet the following criteria:

1. Over 18 years of age.
2. Physically disabled due to congenital or acquired conditions. Disability is defined as physical impairment which prevents the individual from carrying out activities of daily living unaided, without endangering themselves, or within a conventional period of time. The disability is likely to be permanent.
3. Require assistance with personal care and activities of daily living. This would include assistance with mobility, transferring and positioning, meal preparation and eating, rising and retiring, dressing and undressing, bathing and grooming, toileting, essential communication and physical body control (e.g. Spasms).
4. Assistance with light housekeeping and laundry may be provided, depending on staff availability. Tenants are encouraged to seek assistance from family and friends for shopping, banking, and outside appointments.
5. Directs their own care.
6. Have a desire to live independently.
7. Decisions regarding acceptance into the Attendant Services programs are made by The Friends Tenant Selections and Review Committees. There are separate Committees for Forest Hill Apartments and Oakwood Heights Apartments. Decisions made by this Committee may be appealed to the Board of Directors.
8. Priority is influenced by the applicant's level of need as well as availability of alternative housing and service options. Applications will be accepted from any resident of Ontario but priority may be given to residents from Muskoka/Parry Sound District and/or Northern Ontario assuming equal need as determined by the Tenant Selection and Review Committees.
9. Successful applicants are required to sign a Service Contract and provide a copy of their POA for personal care. At Forest Hill Apartments, tenants must also sign a Lease Agreement. These Agreements will be terminated if the tenant contravenes any part of the Agreements and/or the tenant no longer meets the criteria of the Attendant Services program by reasons that:
    a. Attendant services offered are no longer required.
    b. Tenant's service needs have developed beyond the time or expertise available at The Friends.
    c. The tenant has been in hospital or admitted to another institution for a prolonged period.
    d. Other circumstances indicate that the tenant is no longer suitable for this program.

    I have read and understand the Eligibility Criteria.

_____ _____

Signature Date

RELEASE FORM

I, _____give my permission to *The Friends'*

Management Team to contact the following with regards to my medical and personal care needs.

CONTACT	PROFESSION	ADDRESS (Include postal code)	PHONE
1.		_____ _____ _____	
2.		_____ _____ _____	
3.		_____ _____ _____	
4.		_____ _____ _____	

The Friends tenant Selection and Review committee is comprised of community members and health care professionals.

I understand and agree to these individuals discussing my application.

_____ _____ _____

Signature of Applicant **Date** **Witness**