



Main Office:
Unit A - 249 Caroline St. S.
Hamilton, ON L8P 3L6

Tel: 905-529-0454
Toll Free: 866-529-0454
Fax: 905-529-0355

Hamilton Intake Application Form

Dear Prospective Client:

Thank you for your interest in the ministry of Homestead Christian Care. Please take the time to thoroughly complete this Intake Application, as the information will allow us to consider how we could most effectively support you.

This Intake Application must be filled out completely in order for us to schedule an admission date. Please pay particular attention to the items related to your specific medical conditions, including listing any clinical/medical and community-based supports you are connected with.

For applications to our Residential Care programs, municipal regulations require that we receive a discharge summary and assessment reports before we can accept clients into our programs. Thank you for providing these as requested.

Should you have any questions, please contact me at 905-529-0454 x 221. Thank you again for taking the time to complete this Intake Application.

Sincerely,

Daphne Prinzen, B.Sc., RRP
Program Director



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INTAKE APPLICATION FORM
(Revised: February 2009)

GENERAL INFORMATION

Applicant's name: _____ Gender: male female
Current address: _____

(If currently hospitalized, please give previous address) Telephone number: _____

If currently hospitalized: Hospital name: _____
Admission Date: _____ Contact Number: _____

Date of Birth: _____ Ethnicity: _____ Language spoken: _____
Health Card Number: _____ version code: _____ Social Insurance Number: _____
Marital Status (please circle): never married / married / separated / divorced / widowed
Any dependents (with ages): _____ Education history: _____
Religious affiliation or spiritual background (if applicable): _____

Emergency Contact Information

Next of Kin (indicate relationship to you): _____
Address: _____ Telephone: _____

SUPPORT SERVICES AND HOUSING PROGRAM REQUEST

Why are you seeking our services: _____

Which type of supportive housing are you seeking (please circle):

- Hamilton Program: Residential Care supported housing / Supported Independent Living apartments
- Oxford Program: Residential Care supported housing / Supported Independent Living apartments

Who referred you to our programs: _____

When would you like to enter our supported housing program: _____

Please attach all relevant documents related to your need for supported housing (most recent discharge summary, case management reviews, and reports from previous treatment or support programs)

Attached documents included (please list): _____

PERSONAL HISTORY

Please describe social supports that you have (family, friends, etc.): _____

What is your current (or most recent) living situation:

- living independently in own house or apartment
- living in parental home
- living in a group home-type setting
- living in another type of supported housing - describe: _____
- staying with friends
- staying in emergency housing or hostels
- homeless

How long have you been in your current living situation: _____

Are you currently on a Court Order: yes no

If so, please provide details: _____

FINANCIAL SITUATION

What is your current source of income:

- Employed (please circle: full-time, part-time, seasonally, occasionally)
- Employment Insurance (E.I.)
- Workplace Safety and Insurance Board (W.S.I.B)
- Ontario Disability Support Program (O.D.S.P)
- Ontario Works (O.W.)
- Other: _____

If you currently have no source of income, have you applied for any social assistance: _____

Do you have assets which would disqualify you from receiving social assistance: _____

If not employed, when were you last able to work: _____

Do you manage your own finances: yes no

If not, do you have a trustee: yes no

If so, please provide their name and contact details: _____

BRIEF MEDICAL OVERVIEW and CURRENT PHYSICAL HEALTH STATUS

- Do you have problems with:
- | | | |
|-----------|-----------------------------|---|
| Vision | <input type="checkbox"/> no | <input type="checkbox"/> yes, specifically: _____ |
| Hearing | <input type="checkbox"/> no | <input type="checkbox"/> yes, specifically: _____ |
| Diet | <input type="checkbox"/> no | <input type="checkbox"/> yes, specifically: _____ |
| Allergies | <input type="checkbox"/> no | <input type="checkbox"/> yes, specifically: _____ |
| Mobility | <input type="checkbox"/> no | <input type="checkbox"/> yes, specifically: _____ |
| Diabetes | <input type="checkbox"/> no | <input type="checkbox"/> yes, specifically: _____ |
| Epilepsy | <input type="checkbox"/> no | <input type="checkbox"/> yes, specifically: _____ |

Other health issues, including cognitive concerns: _____

Do you currently take any medications: no yes, specifically: _____

(please attach a full listing of medications)

Are all medications being taken as prescribed: yes no

Psychiatric Status

Primary Diagnosis: _____

Secondary Diagnoses: _____

(Please attach any relevant documents related to psychiatric admissions)

Physical Status

Primary Diagnosis: _____

Secondary Diagnoses: _____

Family Physician: _____

Address and Telephone: _____

Psychiatrist: _____

Psychiatric Nurse: _____

Address and Telephone: _____

Social Worker: _____

Address and Telephone: _____

Case Manager: _____

Address and Telephone: _____

Other Supports: _____

Address and Telephone: _____

Please fill the out the Consent for Release of Health Information form attached for each person listed above
(photocopy as many forms as are needed).

AREAS OF PERSONAL CONCERN

History of violence no yes

Verbal abuse no yes

Physical abuse no yes

Substance abuse no yes

Suicide attempts no yes

Suicide ideations no yes

Self-harm no yes

Non-compliance with meds no yes

Conflict with the Law no yes

Verbal or physical threats no yes

Fire setting no yes

Careless smoking no yes

Stalking, or being stalked no yes

Aggression no yes

(If you have checked "yes" for any of the above concerns, please provide additional information)

PERSONAL STRENGTHS, CAPABILITIES, and AREAS NEEDING DEVELOPMENT

Please mark each category according to the following scale:

- 1 –independently capable**
- 2 –assistance is needed**
- 3 –unable to complete at this time**

	<i>1</i>	<i>2</i>	<i>3</i>
Knowledge of Disability:			
Knowledge of impact of illness			
Knowledge of negative impact of alcohol and drug use			
Adherence to prescribed medication			
Self-administration of medications			
Skills for Living:			
Self-adherence to a healthy personal schedule			
Awareness of time			
Able to arrive on time for appointments/work			
Personal Care:			
Able to maintain personal hygiene (bathing and grooming regularly)			
Laundry (weekly)			
Able to dress appropriately for weather conditions or occasions			
Maintenance of Self in Home:			
Meal planning			
Create a shopping list and purchase groceries			
Meal preparation			
Budget funds for one-month periods			
Manage and pay monthly expenses on time			
Safely operate household equipment (kitchen appliances, vacuum, etc.)			
Maintain an adequate cleanliness of apartment			
Maintenance of Self in Community:			
Able to identify safety issues and respond appropriately			
Awareness of responsibilities and rights as a tenant			
Act conscientiously towards other people			
Able to locate and access community resources			
Able to manage on available income			

	<i>1</i>	<i>2</i>	<i>3</i>
Social Skills:			
Able to make needs clearly known			
Show consideration for others: personal space, property, finances			
Willing to accept support where and when needed			

If a formalized assessment of personal functioning has been prepared, please attach documentation.

SIGNATURES

By signing this application, you confirm that the information provided above, and in any attachments, is correct and can be used by Homestead Christian Care in making appropriate decisions regarding our housing and support services.

Applicant's Signature

Date

Referring or Reviewing Person's Signature

Date

Referring Person's Relationship to Applicant

Contact Number

Medical Assessment Cover Sheet

Prior to admitting an individual as a tenant of our programs, we are required to obtain an up-to-date assessment from a physician or other member of a regulated health profession employed by a referring agency designated under Municipal guidelines, which provides an opinion as to whether or not the individual requires a level of care services which the operator is authorized, or able, to provide in the facility.

The Medical Assessment may be completed by an authorized professional as outlined below.

- A “regulated health professional” means a discipline under the Regulated Health Professions Act, 1991.
- The up-to-date assessment, which provides an opinion, shall be performed and obtained from one of the following disciplines regulated under the Regulated Health Professions Act, 1991: medicine, nursing, physiotherapy, or occupational therapy. In the alternative, the up-to-date assessment may be obtained from a social worker provided that it has been completed by a regulated health professional.
- In the case of the individual being referred on an emergency basis by an emergency service, for example a hospital or COAST, the up-to-date assessment, which provides an opinion, shall be obtained within one week of placement.
- A “referring agency” includes a hospital, a community agency, or a private clinic.
- The regulated health professional employed by a referring agency or the physician completing the assessment, shall have specific knowledge of the individual’s care needs.
- An assessment shall be done not more than 30 days before the tenant is accepted into the facility. It shall include information on the mental and physical function of the individual in regards to activities of daily living, such as maintaining sufficient personal nutrition, hygiene, warmth, rest, and safety.
- The written assessment which is obtained by the operator shall include an opinion as to whether or not the individual requires a level of care services that the operator is able to provide in the facility. The operator shall not admit an individual if the opinion is that the individual requires a level of care services that the operator is not able to provide.

Homestead Christian Care will use the opinion provided in this assessment to help determine whether we can provide the level of care services required by the applicant. We will not admit any tenant who we are unable to adequately serve.



Medical Assessment Form

Required by City of Hamilton, to be completed by a Regulated Health Professional

Service Provider:

Homestead Christian Care, A-249 Caroline Street South, Hamilton Telephone: 905-529-0454 Fax: 905-529-0355

Applicant's name: _____ Gender: Male Female
Surname First name

Date of birth: _____ Language spoken: _____

Proposed date of admission: _____

Allergies: _____

Personal physician: _____ Contact number: _____

Brief medical history:

Diagnoses:

Significant recent mental or physical changes, incidents, or hospitalizations:

Medications currently prescribed:

Applicant is able to self-medicate: yes no

TB skin test (must be completed within 14 days of admission)

Date: 1st _____ 2nd _____ if positive, date of chest x-ray: _____

Results: 1st _____ 2nd _____

Doctor's assessment of positive test results:

Additional care required: yes no (please describe): _____

Physical health status indicators:

Wanders:	<input type="checkbox"/> yes* <input type="checkbox"/> no	Can maintain hygiene independently:	<input type="checkbox"/> yes <input type="checkbox"/> no
Fully ambulatory:	<input type="checkbox"/> yes <input type="checkbox"/> no*	Able to dress independently:	<input type="checkbox"/> yes <input type="checkbox"/> no
Ambulatory with aids:	<input type="checkbox"/> yes <input type="checkbox"/> no*	Oriented to person, place, time:	<input type="checkbox"/> yes <input type="checkbox"/> no*
Frequent bladder incontinence:	<input type="checkbox"/> yes* <input type="checkbox"/> no	Experiences confusion:	<input type="checkbox"/> yes* <input type="checkbox"/> no
Frequent bowel incontinence:	<input type="checkbox"/> yes* <input type="checkbox"/> no	Experiences agitation:	<input type="checkbox"/> yes <input type="checkbox"/> no
Able to eat independently:	<input type="checkbox"/> yes <input type="checkbox"/> no	Experiences aggression:	<input type="checkbox"/> yes <input type="checkbox"/> no

City of Hamilton Schedule 20 regulations state that, if the healthcare professional selected any of the asterisk-marked boxes above (), this individual shall not be admitted as a tenant due to their requiring more care than can be provided in a residential care facility regulated by the City of Hamilton.

Regulated Health Professional's Name (printed): _____

Regulated Health Professional's Signature: _____

Date Medical Assessment Completed: _____

Appendix B

OPINION FORM TO DETERMINE INDIVIDUAL’S/TENANT’S LEVEL OF CARE

To be completed prior to admission to service or with a change in tenant’s condition.

Name: Homestead Christian Care Phone Number: 866 529 0454

Name of Individual/Tenant: _____
Date of Birth: _____
Date of Admission: _____

Dear Dr./Regulated Health Profession Member _____:

According to Section 40(1) of Schedule 20 of the City of Hamilton, Licensing Code, 2001, (Residential Care Facilities) please note that “prior to admitting an individual as a tenant of a facility, the operator shall obtain an up-to-date assessment from a physician or other member of a regulated health profession employed by a referring agency designated in the Guidelines, which provides an opinion as to whether or not the individual requires a level of care services which the operator is authorized to provide in the facility.”

Based on the following information provided by the operator, please give your opinion:
Qualifications of and number of care staff on duty to meet the special needs:

All staff of Homestead Christian Care have either or all of the following: education in the social service field, experience in the social service field, or training in the area of social services. All staff will receive training within the facility prior to being on shift alone. Staff is expected to continue with education and additional training once hired. There are a House Manager, and a Director of Client Services supervising the staff on regular bases. There is a 24-hour on call system. There will be no less than 1 staff available at all times, generally during wake hours. All staff will have First Aid and CPR training. The Residential Coordinator and the Director of Client Services have a university degree in the area of social services, and combined have many years experience in the area.

Services provided: Homestead Christian Care goal is to provide the best custodial care in our 2nd Level Lodging Home. Although tenants are encouraged to participate and be as independent as possible the staff are there to provide as much or little support as necessary in the areas of: personal hygiene, life skills (budgeting, scheduling), laundry, medication management, social and recreational pursuits, a/vocational interests, accessing the community, and providing support in the community. All meals are provided and if interested tenants are encouraged to participate in the preparation, serving, and cleaning associated around mealtime. Staff at any given time may provide advice, information or a referral as requested by the tenants. As suggested by the name we are a Christian Agency and do provide spiritual support where and when requested. In the Supported Independent Living and Advanced Independent Living support is provided based on a needs assessment to be completed within first week of move in, or prior if applicable. There is a 24 hour on-call system available, and staff make regularly scheduled visits, and drop ins.

It is my opinion that this individual/tenant requires a level of care services which the operator _____ is able _____ is not able to provide in the facility.

Physician/Regulated Health Profession Member’s comments:

Physician/Regulated Health Profession Member’s Signature: _____

Date: _____ - Implemented November 2002 -