



249 Caroline St S. Unit A
Hamilton, ON, L8P 3L6
www.homesteadchristiancare.ca

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

Oxford County Application Form

We would like to take this opportunity to thank you for your interest in our ministry and the services we offer. We realize that this intake application requires a lot of information. We feel that the more information we have the better we will be able to determine if our service will be able to support the individual applying. The information will help us determine where within Homestead Christian Care continuum of service one might fit in best at the time of admission.

If it imperative that this intake application is filled out in its entirety prior to an admission date being set. The individual being considered for service must also come with Clinical Follow Up addressing their psychiatric disability, and medication monitoring by a psychiatrist. The request for discharge summary and/or assessment reports and documentation is so that the information filled out on the application can be reduced. We also require that a second party review and sign off on this application if it is being completed by the person requesting service, to ensure accuracy of information is being provided.

If you have any questions, please do not hesitate to contact us at 905-529-0454 ex. 221. When the application is completed, please fax directly to our Oxford program: 519-539-3564. If you have any questions regarding the Oxford program, please call 519-539-2917 and speak to the Oxford Program Manager.

Thank you for taking the time in assisting us in providing the best service by completing this intake application.

Daphne Prinzen, B.Sc. RRP
Program Director



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Intake Application form (Revised March 2009)

General Information

Applicant's Name: _____ male _____ female _____

Current Address: _____

Telephone: _____ (If currently in hospital, please give former address)

Date of Birth: _____ Social Insurance Number: _____

Health Card #: _____ Version Code: _____

Marital Status: never been married

Separated

Number of dependents _____

Divorced

Ages: _____

Widowed

Married

Next of Kin (relationship to you): _____

Address: _____

Telephone: _____ Cell: _____

Diagnosis

Primary: _____ Secondary: _____

Other: _____

Reason for Referral: Please attach all relevant documents (most recent discharge summary, case management reviews etc.) Also please include any or all reports from previous treatment programs or facilities.

Current Professionals involved with applicant

Family Physician: _____

Address: _____ Telephone: _____

Psychiatrist: _____

Psychiatric Nurse: _____

Address: _____ Telephone: _____

Social Worker: _____

Address: _____ Telephone: _____

Outpatient/Community Professional Follow-up

Psychiatrist: _____ Psychiatric Nurse: _____

Address: _____ Telephone: _____

Social Worker: _____ Occupation: _____

Address: _____ Telephone: _____

Others: _____

Please fill out a consent form for all professionals listed. A form is attached, photocopy where necessary.

Personal Background History

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

Most recent living situation (Prior to hospital admission):

Parental home Group home or 2nd level Lodging home Apartment Own Home

Other _____

Financial Circumstances

Current Source of income: Ontario Works Employment Insurance (UI/EI) W.S.I.B.
ODSP Employed Other

If you currently have no source of income, what has been applied for: _____

Do you (applicant) have a Public Trustee or other person involved in assisting in your financial affairs?

Yes NO If yes, please provide name, address and phone number: _____

Health Status

Are there any problems with: Vision: Yes No

Hearing: Yes No

Diet: Yes No If yes, specify: _____

Physical Challenges eg mobility: Yes No If yes, specify: _____

Physical Disorders (diabetes, epilepsy) _____

Cognitive Concerns (acquired brain injury, learning disability) _____

Are medications currently being taken: Yes No (Please attach list of medications)

Is the applicant compliant with taking medications at this time? Yes No

Psychiatric History (please attach any relevant documents of psychiatric admissions).

Personal Areas of Concern (please circle)

History of Violence	yes	no	Non Compliance with Meds	yes	no
Verbal Abuse	yes	no	Conflict with the Law	yes	no
Physical Abuse	yes	no	Verbal/Physical Threats	yes	no
Substance Abuse	yes	no	Fire Setting	yes	no
Stalking	yes	no	Careless Smoking	yes	no
Suicide Ideations	yes	no	Suicide Attempts	yes	no
Self Harm	yes	no	Aggression	yes	no

(If yes has been circled in any of the above, please provide additional information below.)

Strengths & Areas for Skill Development

- 1 independent
- 2 assistance needed
- 3 unable to complete at this time

	1	2	3
Knowledge of Disability: Adherence to prescribed medication Knowledge of impact of illness Knowledge of negative impact of alcohol and drug use Self administration of medications			
Skills for Living: Self-adherence to a reasonable schedule Awareness of time Able to arrive on time for appointments/work			
Personal Care: Personal Hygiene (showering/bathing every other day) Laundry (weekly) Able to dress appropriate for weather or occasions			
Maintenance of Self in home: Meal planning Meal Preparation Able to construct a shopping list Budgeting funds for one month periods Able to pay monthly expenses (on time) Safely operates equipment at home Able to maintain adequate cleanliness of apartment			
Maintenance of Self in Community: Is able to self identify safety issues and respond appropriately Awareness of how to locate resources Able to manage or negotiate with income source(s)			
Social Skills: Able to make needs clearly known Is able to be considerate of others (noise, personal space, property, time of day) Willing to accept support where needed			

DATE THAT APPLICANT WOULD LIKE TO BEGIN IN SERVICE: _____

The above information is correct and current to the best of the applicant's and/or the referring individual's knowledge.

Applicant's Signature

Referring/Reviewing Person's Signature

Date: _____

Referring/Reviewing Person's Name

Relation to the occupant

Contact Phone Number:



MEDICAL ASSESSMENT FORM

Residential Care Facility: _____

Address: _____

Telephone Number : _____

Name of Tenant: _____ Gender: _____

Surname

First Name

Date of Birth: _____ **Admission Date:** _____

Allergies: _____ Language Spoken: _____

Personal Physician: _____ Telephone: _____

Brief Medical History:

Diagnoses:

Medications Currently Prescribed:

Tenant: ___ is able ___ is not able to self-medicate.

Ambulation: (check all that apply)

1. Fully Ambulatory ___ on the level ___ on the stairs ___ wanders
2. Independent with aids ___ cane ___ walker ___ wheelchair
3. Requires assistance ___ on the level ___ on the stairs

Bladder: ___ responsible for self (not incontinent)
___ rare incontinence (use of briefs)
___ frequent incontinence

Bowels: ___ responsible for self(not incontinent)
___ rare incontinence(use of briefs)
___ frequent incontinence

Nutrition:

able to eat: ___ independently ___ with supervision ___ assistance

Special diet? ___ No ___ Yes, specify _____

Hygiene: ___ independent ___ supervision ___ assistance

Dressing: ___ independent ___ supervision ___ assistance

Mental Health:

Oriented to: Person, place and time ___ Yes ___ No, (specify): _____

Confusion: ___ never ___ occasionally ___ frequently

Cognitive Impairment: Impedes functional ability ___ never ___ occasionally ___ frequently

Agitation: ___ never ___ occasionally ___ frequently _____

Aggression: ___ never ___ occasionally ___ frequently _____

Significant recent mental or physical changes/incidents/hospitalizations:

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

Date: 1st _____ 2nd _____ Results: 1st _____ 2nd _____

If TB test positive, result of chest x-ray and doctor's assessment: _____

Date of Chest x-ray: _____

Additional Care: ___ Yes ___ No

Describe: _____

Please Give Opinion: The Individual requires a level of care services that the operator

___ is able ___ is not able to provide in the facility.

Date Completed: _____

Physician's/Health Professional's Name (print): _____

Physician's/Health Professional's Signature _____