ADMISSION APPLICATION

KOTITALO SUPPORTIVE HOUSING FACILITY

725 North Street, Sault Ste. Marie, ON P6B 5Z3 Phone: (705) 945-9987

Dear Prospective Resident:

Thank you for your interest in admission to Kotitalo, the Supportive Housing Facility of the Ontario Finnish Resthome Association.

Please find attached a general information page about the facility and several forms requiring completion. These forms include the following:

- ✓ Kotitalo—General Application Form
- ✓ Kotitalo—Medical Assessment Form

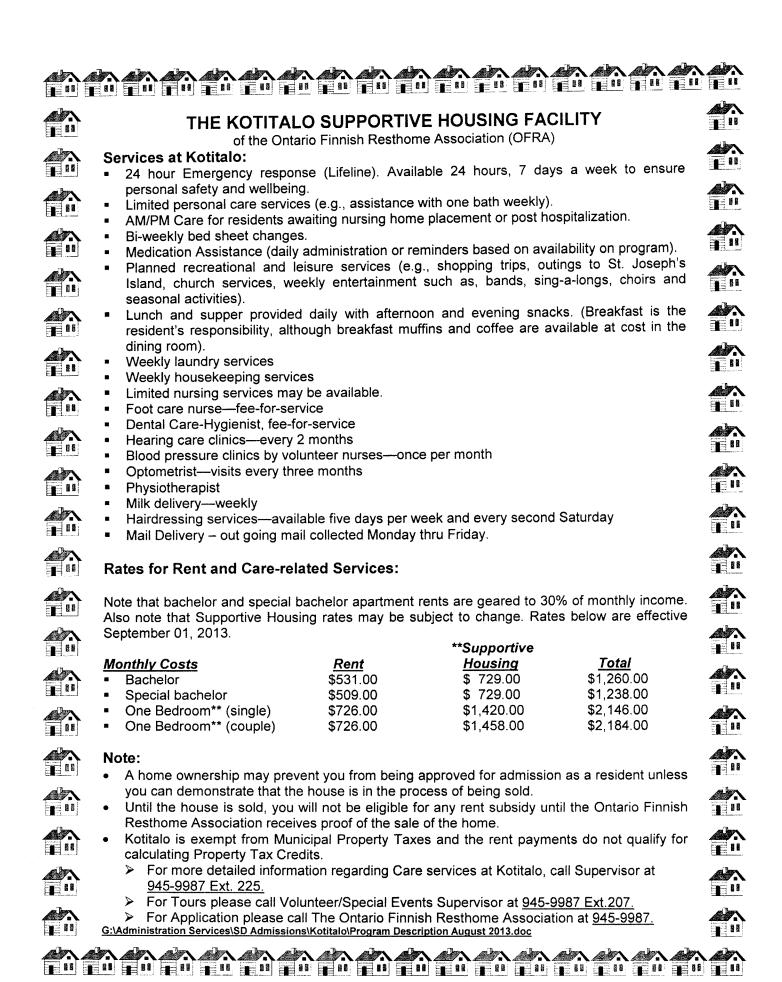
Note that the Supervisor at the Ontario Finnish Resthome Association determines your eligibility for admission. You can find a description of the eligibility criteria on the facility information page.

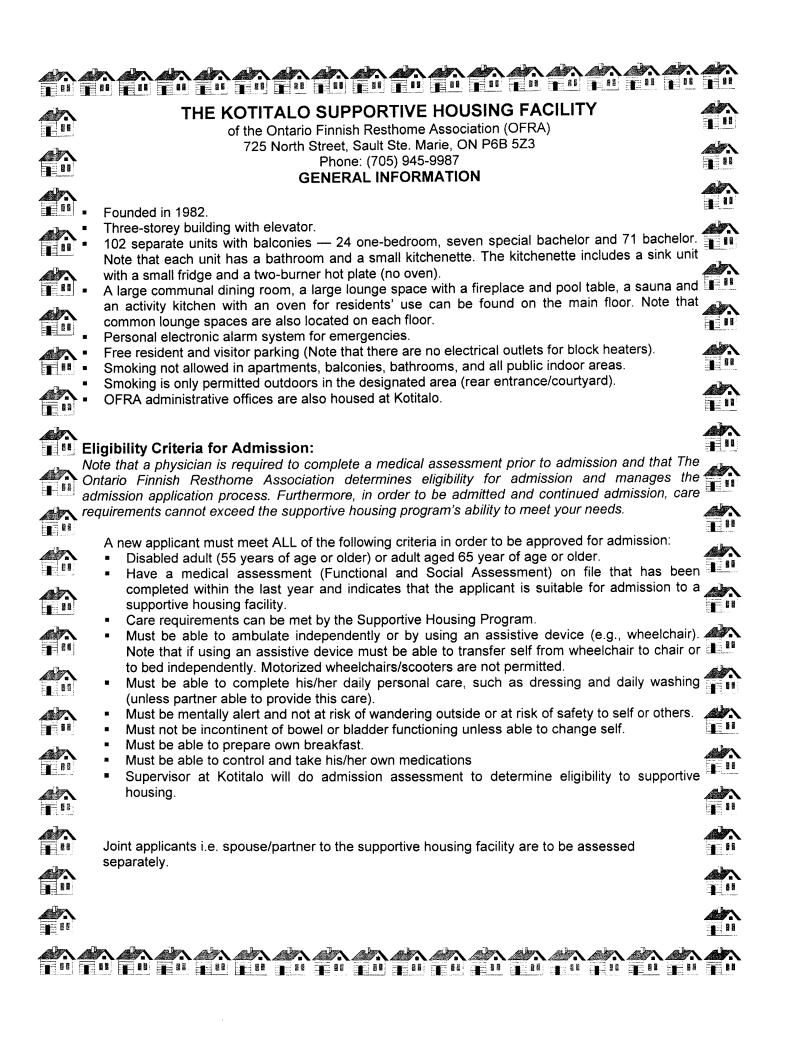
Also note that the cost of the medical assessment is at your expense and that additional medical assessments may be required before you are admitted. These are also at your expense.

Please return ALL completed forms to the Ontario Finnish Resthome Association, 725 North Street, Sault Ste. Marie, ON P6B 5Z3. All information is confidential when completed.

Thank you.

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KOTITALO—General Application Form The Ontario Finnish Resthome Association

0207-05

The Ontario Finnish Resthome Association 725 North Street Sault Ste. Marie, ON P6B 5Z3

Phone: (705) 945-9987

1. PERSONAL INFOR	RMATION:		
Name	Applicant	Co-Applicant	
Address			
City & Postal Code			
Telephone			
Date of Birth Ontario Health Card #			
Ontano Health Card #			
	Name: Do you wish your mail sent to		
Do you wish us to conta Name:	act this person when an apartment bec		
Address:	City	Relationship: Postal Code:	
Telephone: Home:	City: Work:		
·		Cell:	
	Name: Do you wish your mail sent to		
Name:	act this person when an apartment beca	ome available: YES Relationship:	
Address:	City:	Postal Code:	
Telephone: Home:	Work:	Cell:	
Other Information:			
Ethnicity: Do you qualify for admission based on Finnish or Estonian ancestry? YES NO			
Apartment: What type of apartment are you interested in?			
	cial Bachelor 1-Bedroom		
Vehicle: Will you require DECLARATION:	e a parking spot for a vehicle?	ES 🗆 NO 🗆	
1. I (we) declare that the information submitted on this form is correct and authorize the Ontario Finnish Resthome Association to verify any or all of the information herein.			
2. I (we) understand that home ownership will prevent me (us) from being eligible for any rent subsidy			
unless I (we) can demonstrate that the house is in the process of being sold and when sold The Ontario Finnish Resthome Association has received proof of the sale of the home.			
3. I (we) also understand that Kotitalo, 725 North Street, Sault Ste. Marie, is exempt from Property Taxes			
and that rent payment 4. I (we) consent for this	nts do not qualify for calculating Prope is information to be made available to t	rty Tax Credits. Community Care Access Centre (CCAC)	
I (we) consent for this information to be made available to Community Care Access Centre (CCAC) Applicant's Signature: Date:			
Co-Applicant's Signature: Date:			



Ontario Finnish Resthome Association KOTITALO – PHASE 2 SUPORTIVE HOUSING/ASSISTED LIVING MEDICAL ASSESSMENT

Dear Doctor: Your patient is bringing this form to you for completion as part of the application process to the Kotitalo Supportive Housing Facility of the Ontario Finnish Resthome Association (OFRA). An information sheet about Kotitalo is attached to help you determine the suitability of your patient for admission. Please fax the completed form to <u>945-1285</u> or have the individual bring the form to the Ontario Finnish Resthome Association. Also note that your patient has been informed that he/she is responsible for any costs related to the completion of this form.

PATIENT'S PERSONAL INFORMATION:			
Name: Date of Birth:			
DIAGNOSIS & DATE OF ONSET:	-		
le nationt aware of diagnosis? Ves Cl. No. 1	······································		
Is patient aware of diagnosis? Yes No BRIEF HEALTH HISTORY:			
DIVIDITION ON THE PROPERTY OF			
History of VRE? Yes □ Date: No □	Date of Latest Flu Vaccine:		
History of MRSA? Yes □ Date:	Date of Pneumococcal Vaccine:		
Date of Last Chest X-ray:	Date of last TB skin test:		
Results:	Results:		
PRESENT MEDICATION LIST:			
1.	6.		
2.	7.		
3.	8.		
4.	9.		
5.	10.		
ALLERGIES/DRUG SENSITIVITY:			
PRESENT FUNCTIONAL ABILITY & CONDITION:			
(Please outline any ambulatory problems, cognitive problems, emotional/social concerns, difficulties			
carrying out activities of daily living, etc. Feel free to use the back of this sheet as well, if necessary.)			
y and y and we are used the back of this chicat as won, it moodsary.			
SPECIAL NEEDS (i.e., colostomy, special diet, oxygen, etc.). Please describe fully, including			
treatment or intervention required:			
In your opinion, does this patient's care requi on the attached information page about Kotital	rement exceed the admission criteria as described lo? Yes □ No □		
Physician's Signature:	Date:		
Physician's Name (Please print):			