635 McEwan
Windsor, ON, N9B 2E9
P: 519.254.1108 | F: 519.254.1869
info@lifeafterfifty.ca

# Application for Community Support Services

| ***OFFICE USE ONLY*** | | Reference # _____ |
|---|---|---|
| Information given by: | ☐ Client ☐ Third Party w/ permission of client | Nesda # _____ |
| | ☐ n/a – POA or SDM in effect | Novus # _____ |

## GENERAL INFORMATION – all fields are mandatory

Name (as it appears on Ontario Health Card):

First | Middle | Last | "Goes by"

Address: _____ PO Box: _____ Apt. #: _____

Town: _____ Postal Code: _____

Mailing Address (if different from above): _____

Home Phone: _____ Other Phone: _____

Health Card Number: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ (month/day/year) Current Age: _____

Languages Spoken: _____

Lives Alone? ☐ Yes ☐ No – lives with: _____

## EMERGENCY CONTACTS – all fields are mandatory

1st Emergency Contact: _____ Relationship: _____

Home Phone: _____ Other Phone: _____

2nd Emergency Contact: _____ Relationship: _____

Home Phone: _____ Other Phone: _____

## REQUESTED SERVICE(S)

| | Start Date (mmm/dd/yyyy) | Discharge Date (mmm/dd/yyyy) | Referred to other HSP? (specify) |
|---|---|---|---|
| ☐ Transportation – WECT | ___/___/___ | ___/___/___ | ☐ _____ |
| ☒ Meals on Wheels | ___/___/___ | ___/___/___ | ☐ _____ |
| ☐ Home Maintenance | ___/___/___ | ___/___/___ | ☐ _____ |
| ☐ Foot Care | ___/___/___ | ___/___/___ | ☐ _____ |
| ☐ Visiting – Social & Safety | ___/___/___ | ___/___/___ | ☐ _____ |
| ☒ Adult Day Program | ___/___/___ | ___/___/___ | ☐ _____ |
| ☒ Congregate Dining | ___/___/___ | ___/___/___ | ☐ _____ |
| ☐ Other: _____ | ___/___/___ | ___/___/___ | ☐ _____ |
| ☐ Other: _____ | ___/___/___ | ___/___/___ | ☐ _____ |

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**ELIGIBILITY CRITERIA – select one (if "Disabled" choose from options)**

☐ Senior (55+)

☐ Disabled: Permanently ☐ Describe: _____

Temporarily ☐ Describe: _____

Expected Duration: _____

Requires Certificate of Disability? ☐ No ☐ Yes: _____ Date Certificate Received

Requires Service Animal? ☐ No ☐ Yes: _____

☐ Other Specify: _____

**PAYMENT METHOD**

☐ Cash ☐ Invoice: ☐ Client or ☐ c/o: _____

☐ at address on page 1 or _____
House # Street Name Apt. #

_____
Town Prov. Postal Code

Phone: _____

☐ Veterans Affairs Canada Eligible: K-_____

**SOURCE OF REFERRAL – select one**

☐ Internal ☐ Family/friend ☐ CCAC: _____ ☐ Doctor/NP

☐ Saw vehicle ☐ Brochure/flyer ☐ Hospital: _____

☐ Other: _____

***OFFICE USE ONLY***

*Notes:*

_____

_____

_____

_____

_____

_____

*LAF PHI Brochure Sent to client* ☐

*Screener Complete* ☐ *Screener Date:* _____

*CHA Complete* ☐ *CHA Date:* _____

*Reassessment Date:* _____

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## HEALTH, MOBILITY, COGNITIVE & CHRONIC DISEASE ASSESSMENT

**The following information is required to help us complete your client records. Please circle your answer to the following questions:**

1. Would you consider yourself to be independent when making decisions regarding daily tasks – for example, when to get up, what to eat, or which clothes to wear? Yes No
2. Would you consider yourself independent to: bathe, manage personal hygiene, dress, and move around the house? Yes No
3. Do you get short of breath? Yes No
4. How would you rate your health? Excellent Good Fair Poor
5. Does a condition or disease make mood or behaviours unstable? Yes No
6. Are you experiencing an episode or flare up of a recurrent problem? Yes No
7. In the last three (3) days have you felt sad, depressed or hopeless? Yes No
8. Does your primary helper express feelings of distress, anger or depression? Yes No
9. Do close family or friends feel overwhelmed by your illness? Yes No

**Are you registered with a family doctor?** ☐ Yes Name: _____ Phone: _____
☐ No

| | | | | | |
|---|---|---|---|---|---|
| **Hearing** | ☐ Good | ☐ Fair | ☐ Poor | ☐ Aided | ☐ Hearing Impairment |
| **Vision** | ☐ Good | ☐ Fair | ☐ Poor | ☐ Aided | ☐ Visual Impairment |

**Have you been diagnosed with or suffer from any of the following health conditions or diseases, or do you have any other health conditions or concerns we should be aware of?**

| | | | |
|---|---|---|---|
| ☐ Aggression | ☐ Allergies: _____ | | ☐ Anxiety Attacks |
| ☐ Arthritis | ☐ Asthma | ☐ Balance Problems | ☐ Bipolar Disorder |
| ☐ Cancer | ☐ Cerebral Palsy (CP) | ☐ CHF | ☐ COPD |
| ☐ Delusions | ☐ Dementia | ☐ Depression | ☐ Developmental Delay |
| ☐ Diabetes | ☐ Dialysis | ☐ Disorientation | ☐ Dizzy Spells |
| ☐ Epilepsy | ☐ Epi-Pen | ☐ Fibromyalgia | ☐ Haemophilia |
| ☐ Hallucinations | ☐ Heart Attack | ☐ Hypertension | ☐ Hypotension |
| ☐ Kidney Disease | ☐ Medic Alert Tag/Bracelet | ☐ Memory Loss | ☐ Mental Illness |
| ☐ Multiple Sclerosis (MS) | ☐ Non-Verbal (Aphasia) | ☐ Osteoporosis | ☐ Panic Attacks |
| ☐ Portable Feeding Tube | ☐ Portable Oxygen | ☐ PTSD (Post-Traumatic Stress) | ☐ Renal Disorder/Failure |
| ☐ Safety Risk to Self or Others | ☐ Seizures | ☐ Stroke | ☐ Tourette's Syndrome |
| ☐ Verbal Outbursts | ☐ Wandering Risk | ☐ Other: _____ | |

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## TRANSPORTATION – WINDSOR-ESSEX COMMUNITY TRANSIT

**Do you use any of the following mobility aids or assistive devices?**

☐ Cane ☐ Walker ☐ Folding Wheelchair ☐ Transfer Wheelchair
☐ Standard Wheelchair ☐ Bariatric Wheelchair ☐ Large Wheelchair ≥30" ☐ Scooter
☐ Combined weight of person + chair ≥ 700 lbs.
☐ Independent/Ambulatory – no mobility aids or assistive devices

Do You Require an Attendant in Order to Travel? ☐ No ☐ Yes

**Is the Transportation for Dialysis?** ☐ No ☐ Yes – please complete info below

Main Location: ☐ Windsor Regional Hospital – Ouellette Campus
☐ Satellite Renal Dialysis Clinic – 300 Tecumseh Rd. E., Ste. 330
☐ Leamington District Memorial Hospital Satellite

Days Transportation is Required: M Tu W Th F Sa Su

Appointment Time: _____ a.m./p.m. to _____ a.m./p.m.
start end

Alternate Location: ☐ Windsor Regional Hospital – Ouellette Campus
☐ Satellite Renal Dialysis Clinic – 300 Tecumseh Rd. E., Ste. 330
☐ Leamington District Memorial Hospital Satellite

Days Transportation is Required: M Tu W Th F Sa Su

Appointment Time: _____ a.m./p.m. to _____ a.m./p.m.
start end

## MEALS ON WHEELS

Desired day(s) of MOW delivery: M Tu W Th F Sa* Su* 7 days/wk*

Meal Requirement: ☐ Regular ☐ Diabetic ☐ Low Fat ☐ No Salt Added ☐ Other: _____

Texture Modification: ☐ None ☐ Chopped ☐ Pureed ☐ Liquefied

Food Allergies: ☐ No ☐ Yes: _____

Food Sensitivities: ☐ No ☐ Yes: _____

Dislikes: ☐ No ☐ Yes: _____

Delivery Instructions: _____

_____

Pets: ☐ No ☐ Yes Smoker: ☐ No ☐ Yes

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## HOME MAINTENANCE

☐ Home Repairs (specify): _____

☐ Snow Removal

☐ Yard Work: ☐ Grass Cutting ☐ Raking/Bagging Leaves ☐ Weeding
☐ Other (specify): _____

☐ Housecleaning
☐ Cleaning under/behind furniture/appliances
☐ Washing Walls ☐ Washing Windows
☐ House/pressure washing (exterior)
☐ Other (specify): _____

☐ Moving Assistance
☐ Packing/Unpacking ☐ Booking moving services/van
☐ Organizing, cleaning and/or staging for sale
☐ Large item disposal ☐ Other (specify): _____

☐ Odd Jobs
☐ Carpet/upholstery cleaning ☐ Pumping flooded basement
☐ At-home furniture assembly ☐ Painting (interior / exterior)
☐ Changing furnace filter ☐ Changing light bulbs
☐ Changing smoke detector battery ☐ Housesitting (water plants, check mail)
☐ Pet sitting/walking/clean-up ☐ Other: _____

Comments: _____
_____

***IMPORTANT NOTICE – PLEASE READ CAREFULLY:***

For and in consideration of being part of the Life After Fifty (LAF) Home Maintenance service, I hereby undertake to be present on my property when services arranged through LAF are performed and do hereby remiss, release and forever discharge the LAF and their respective agents and employees of and from all manner of actions and causes of action, suits, debts, dues, accounts, bonds, covenants, contracts, claims and demands whatsoever against the LAF, their respective agents, employees and any contractor or service provider referred to me. By signing and returning the required documents to register for services, I acknowledge that I have read and agreed to the above conditions.

## FOOT CARE

* Patient Information Chart to be completed by Foot Care Nurse

☐ Office/Clinic visits Please select preferred Clinic location:
☐ Amherstburg ☐ Essex
☐ Harrow ☐ Lakeshore
☐ Leamington ☐ McGregor
☐ Tecumseh ☐ Windsor

☐ Home visits (not available in all communities)

Comments: _____
_____
_____

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## VISITING – SOCIAL & SAFETY

Preferred day(s) of calls: M Tu W Th F Sa Su

Preferred time of calls: ☐ Mornings ☐ Afternoons

Any reminders required: ☐ No ☐ Yes: _____

Special interests: _____

Comments/notes on family situation: _____

Preferred day(s) of visits: M Tu W Th F Sa Su

Preferred time of visits: ☐ Mornings ☐ Afternoons ☐ Evenings

Are you a smoker? ☐ No ☐ Yes

Do you have any pets? ☐ No ☐ Yes (specify: _____)

Is your driveway, walkway and home clear of debris, in good repair and well lit? ☐ Yes ☐ No

Is the general state of common rooms (living room, kitchen) clean and sanitary? ☐ Yes ☐ No

Is your home in a rural or remote area? ☐ Yes ☐ No

Please list hobbies, interests or other information to help find a suitable volunteer visitor for you:

_____

Do you understand that Friendly Visiting is not a homemaking, personal support worker, nor a transportation service? ☐ Yes ☐ No

If required or deemed necessary will you allow an agency staff member to visit you at your home to verify the information above? ☐ Yes ☐ No

## ADULT DAY PROGRAM

Desired day(s) of attendance: M Tu W Th F 5 days/week

Transportation: ☐ Windsor-Essex Community Transit (complete "Transportation" section & fax copy to most appropriate WECT agency)
☐ Family/other to transport

Is there a Power of Attorney (POA) or Substitute Decision Maker (SDM) currently in effect? ☐ No ☐ Yes If yes, who: _____
↳ ☐ POA for Personal Care
↳ ☐ POA for Property

Is there an Advanced Directive of DNR? ☐ No ☐ Yes

Have you ever been diagnosed with or treated for Tuberculosis (TB)? ☐ No ☐ Yes

* Additional information and forms to be collected and completed by ADP staff

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## CONSENT/AUTHORIZATION FOR SERVICES

I authorize Life After Fifty (LAF) to provide the services requested. I also authorize LAF to forward my contact information to other organizations for services requested by me but not offered by LAF. I understand that all information gathered is confidential and that I may withdraw my consent at any time.

In case of emergency, I give permission to LAF staff to:

a) Notify the emergency contacts listed within this application for services;
b) Release pertinent information to medical personnel selected by staff to transport, hospitalize, secure proper treatment or surgery;
c) Share information with other service/health provider(s) to provide assistance.

I agree to pay any expense incurred during the medical emergency (i.e., ambulance).

I agree not to seek damages for any action taken by employees of LAF, its volunteers or agents in their efforts to obtain proper medical treatment or emergency services.

## SHARING OF YOUR PERSONAL HEALTH INFORMATION
## COMMUNITY CARE INFORMATION MANAGEMENT (CCIM) ASSESSMENT PROJECTS

The Assessment Projects include a Common Assessment Project (CAP) in the following community care sectors:

- **Community Support Services (CSS)**
- Community Mental Health (CMH)
- Long-Term Care Homes (LTCH)
- Community Care Access Centres (CCAC)

The CCIM Assessment Project Stream also includes the Integrated Assessment Record (IAR) project. Through the IAR, health service providers who are providing care to the same client can access previous assessment information to support collaborative care planning and service delivery.

Objectives of CAP:

- Support implementation of common assessment tools within each of these sectors, along with related standards and business processes, that enable client-focused delivery of care
- Provide secure access to information through the automation of assessment data management to aid benchmarking, policy development and sector planning
- Facilitating the secure sharing of assessments through consistent privacy-protective practices

I, _____, hereby understand that my Personal Health Information will be a part of the Integrated Assessment Record which allows for seamless care across various health service providers.

Client Signature: _____ Date: _____

POA/SDM Signature: _____ Date: _____

☐ Verbal consent/authorization received over telephone by client or POA/SDM or third party with client's permission

LAF Staff Signature: _____ Date: _____

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