

8. CONTACT PERSONS: (List up to three; include nearest relative)

a) Name: _____ Relationship: _____

Mailing Address: _____ Postal Code: _____

Phone:_(_____)_____

b) Name: _____ Relationship: _____

Mailing Address: _____ Postal Code: _____

Phone:_(_____)_____

c) Name: _____ Relationship: _____

Mailing Address: _____ Postal Code: _____

Phone:_(_____)_____

9. DO YOU PRESENTLY USE ANY OF THE FOLLOWING EQUIPMENT:

a) Cane Yes [] No [] Wheelchair Yes [] No []

Scooter Yes [] No [] Walker Yes [] No []

b) Bath Bench Yes [] No [] Bath Chair Yes [] No []

c) TOILETING:

Raised Toilet Seat Yes [] No []

Support Frame Yes [] No []

Incontinence Supplies Yes [] No []

10. POWER OF ATTORNEY?: YES [] NO []

PERSONAL/HEALTH? []

PROPERTY/FINANCES? []

Name: _____ Relationship: _____

Mailing Address: _____ Phone: _____

11. INCOME: (Indicate your source(s) of income)

- | | |
|---|-------------------------------------|
| Old Age Security Pension [] | Veterans Affairs Canada Pension [] |
| Guaranteed Annual Income Supplement [] | G.A.I.N.S. [] |
| Provincial Family Benefits [] | Canada Pension Plan [] |
| Municipal Welfare [] | Employment [] |
| Private Pension [] | Trust Fund Payments [] |
| Worker's Compensation Pension [] | Other _____ [] |

12. LIVING SITUATION: (for 3 year period prior to application) From (year) To (year)

- | | | |
|--|-------|-------|
| a) Hospital | _____ | _____ |
| b) Nursing Home | _____ | _____ |
| c) Retirement Home | _____ | _____ |
| d) Living alone in apartment or home | _____ | _____ |
| e) Living with spouse in apartment or home | _____ | _____ |
| f) Living with other family member(s) | _____ | _____ |
| g) Other _____ | _____ | _____ |

13. CURRENT ACTIVITIES: (Please specify)

- a) Volunteer Work _____
- b) Recreational Activities _____
- c) Educational Activities _____
- d) Other Activities _____

14. WHO IS YOUR FAMILY PHYSICIAN?

Name: _____ Telephone: _____
Address _____

15. MAIN HEALTH DIFFICULTY/CONCERN:	DATE OF ONSET
1. _____	_____
2. _____	_____
3. _____	_____

16. PLEASE LIST YOUR REGULAR MEDICATIONS:

17. DO YOU REQUIRE ASSISTANCE WITH YOUR MEDICATIONS? Yes [] No []

If yes, explain: _____

18. WHAT ARE YOUR SUPPORT NEEDS IN EACH OF THE FOLLOWING ACTIVITIES?

a) DO YOU NEED ASSISTANCE WITH EATING/MEAL PREPARATION? Please Explain:

b) DO YOU NEED ASSISTANCE WITH HOUSEKEEPING, LAUNDRY? Please Explain

c) DO YOU NEED ASSISTANCE WITH DRESSING/GROOMING/BATHING? Please Explain.

d) **DO YOU NEED ASSISTANCE WITH BUDGETING, CHEQUE WRITING, MAKING APPOINTMENTS, ARRANGING TRANSPORTATION?** Please Explain.

19. YOUR CURRENT SOURCE OF SERVICE OR SUPPORT:

	<u>Frequency</u>		<u>Frequency</u>
Family	[] _____	Home Care	[] _____
Friends/Neighbours	[] _____	Visiting Nurse	[] _____
Meals on Wheels	[] _____	Homemakers	[] _____
Church	[] _____	Physio/Occupational/ Speech Therapist	[] _____
Veterans Affairs	[] _____	Social Worker	[] _____
Seniors Club	[] _____	Other (specify)	[] _____

20. TRANSPORTATION

- | | | | |
|--------------|-----|---------------------|-----|
| Own Car | [] | Regular Bus Service | [] |
| Mobility Bus | [] | CHATS Driver | [] |

Other (please explain) _____

21. WHAT ARE YOUR REASONS FOR WANTING TO LIVE IN AN APARTMENT WITH SUPPORT SERVICES? (Be specific)

22. ARE YOU ABLE TO RELOCATE ON SHORT NOTICE? Yes [] No []

23. WHICH LOCATION DO YOU PREFER?

(Please indicate in order of preference: 1st, 2nd, 3rd, choice etc.)

- Genesis Place, RICHMOND HILL []
- Keswick Gardens, KESWICK []
- Heritage East, NEWMARKET []
- Kitchen-Breedon Manor, SCHOMBERG []
- Hadley Grange, AURORA []
- Armitage Gardens, NEWMARKET []

24. HOW DID YOU HEAR ABOUT THE PROGRAM?

25. PERSON COMPLETING THIS FORM:

Name _____

Address _____

_____ Telephone _____

If necessary, may we contact this person? YES [] NO []

For more information on filling out this form and on the ACLP - contact us:
(905) 895-3628, ext. 297
or 1-866-967-5582
FAX: (905) 895-9001

email: diane.haynes@region.york.on.ca
or
jane.coulman@region.york.on.ca

26. **ADDITIONAL COMMENTS:**

I give my permission for the Alternative Community Living Program to release my name to the landlord, as required.

The information on the attached form is collected pursuant to the Long Term Care Act, and will be used in determining eligibility and service needs for the Alternative Community Living Program.

If you have any questions about the collection of this information, please contact the Manager of Community Programs, (905) 895-3628, or 1-866-967-5582, Ext. 290.

Signature of Applicant

Date

Updated: November 2003