

Confidential When Complete

**APPLICATION FORM FOR RESPITE UNIT
WITH SUPPORT CARE**

NAME _____
(Last Name) (First Name)

ADDRESS _____
(Street Name and Number) (Apt)

(City) (Province) (Postal Code)

TELEPHONE _____
(Home) (Office)

BIRTHDATE _____ AGE _____ FEMALE _____ MALE _____
(dd/mmm/yy)

ONTARIO HEALTH CARD # _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Relationship _____

Address _____

Phone (Day) _____ (Evening) _____

1. **What is your disability?** _____

Onset of Disability _____

How does this disability affect you? _____

2. **RESPITE SERVICES REQUESTED:**

From: _____ to _____
(dd/mmm/yy) (dd/mmm/yy)

Approximate Arrival Time: _____

Approximate Departure Time: _____

3. **REASON RESPITE SERVICES ARE BEING REQUESTED:**

Choose one of the following:

I will require attendant services during my respite stay.

I do not require attendant services during my respite stay

4. **I PRESENTLY LIVE:**

Please indicate your current living situation.

<input type="checkbox"/>	Retirement home / Long Term Care Facility
<input type="checkbox"/>	Acute Care or Rehab Hospital
<input type="checkbox"/>	Apartment with on-site 24-hour care available (Supportive Housing)
<input type="checkbox"/>	Transitional living
<input type="checkbox"/>	Apartment/house with visiting attendant services available
<input type="checkbox"/>	Apartment/house with services paid through insurance/WSIB
<input type="checkbox"/>	Apartment/house with services provided by family/friends/out of pocket
<input type="checkbox"/>	Other _____

**With reference to above, please indicate your living arrangement
(choose as many as are applicable)**

<input type="checkbox"/>	Living Alone	<input type="checkbox"/>	Living with dependent child(ren)
<input type="checkbox"/>	Living with parents	<input type="checkbox"/>	Living with spouse or other adult

(Please indicate the number of years you have been living there.) _____

5. a) **If accepted into the respite program, would you be living alone?**
 YES _____ NO _____ If no, with whom? _____
- b) **Do they have a disability?**
 NO _____ YES _____ if yes, explain: _____
- c) **Have you ever used respite services before? If yes, where?**

- d) **Have you ever lived independently before?**
 YES _____ NO _____
6. **Do you have speech or hearing difficulties? NO _____ YES _____**
 If yes, please describe: _____

7. **Please check the following aids you use:**

<input type="checkbox"/>	Manual Wheelchair	<input type="checkbox"/>	Braces
<input type="checkbox"/>	Power Wheelchair	<input type="checkbox"/>	Commode Chair
<input type="checkbox"/>	Walker	<input type="checkbox"/>	Transfer Board
<input type="checkbox"/>	Canes	<input type="checkbox"/>	Ceiling Track Lift
<input type="checkbox"/>	Other (please specify) _____		

8. a) **Can you direct your own care? YES _____ NO _____**
- b) **If you utilize a mobility device, can you operate your own mobility device independently?**
 YES _____ NO _____ N/A _____
- c) **Who presently provides your care?**

<input type="checkbox"/>	Attendant Care Staff	<input type="checkbox"/>	Nursing Staff
<input type="checkbox"/>	Family Member(s)	<input type="checkbox"/>	Other (please specify) _____

9. Please indicate the daily level of services you require.

<input type="checkbox"/>	less than 2 hours per day	<input type="checkbox"/>	4 to 6 hours per day
<input type="checkbox"/>	2 to 4 hours per day	<input type="checkbox"/>	more than 6 hours per day

10. Please indicate the approximate time of day you require service for the following. An example is provided in the first row:

	Time Of Day (provide range if possible)	Approximate time needed with the staff
<i>Breakfast</i>	<i>0700-0800</i>	<i>30 minutes</i>
Breakfast		
AM Care		
Lunch		
Dinner		
PM Care		
Other (please specify) _____		
Other (please specify) _____		

11. Do you require care between midnight and 6:00 AM?

_____ YES _____ NO

12. Power Outage Procedure

Choose option 1 or option 2:

Option 1

_____ It is my wish that during a power outage that The In Community attendant care staff will call the respite unit and advise me of the situation. If I can not be reached by telephone, I give the attendant care staff permission to enter the respite unit and inform me of the situation to establish an alternative means of communication.

I wish to be notified by the attendant care staff using the above policy, during the:

DAY	yes	no
EVENING	yes	no
NIGHT	yes	no

Option 2

_____ During a power outage I do not wish to be notified or checked on by the attendant care staff. I understand the possible risks of not being able to communicate with the staff and do not hold The In Community or any of its employees responsible for any consequences as a result of this decision.

13. Fire Alarm Procedure

After a fire alarm sounds do you wish to be contacted during the:

DAY	yes	no
EVENING	yes	no
NIGHT	yes	no

BREAKDOWN OF CARE REQUIREMENTS

CLIENT: _____	DATE: _____
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The Breakdown of Care Requirements is in the following three sections:

Section A – Clients with Weight Bearing Transfers

Section B – Clients with Non-Weight Bearing Transfers

Section C – All Other Care Requirements

SECTION A

Yes, client weight bears for transfers.
Proceed to SECTION A directly
BELOW

SECTION B

No, client does not weight
bear for transfers. Proceed
to SECTION B directly
BELOW

	SECTION A – Weight Bearing Transfers					SECTION B – Non- Weight Bearing Transfers/ Lifts				
	Independent	One Person Assisted Transfer	Two Person Assisted Transfer	N/A		Independent	One Person Assisted Transfer	Two Person Lift	Lift Device	N/A
TRANSFERS										
a) In to bed										
b) Out of bed										
c) On to Toilet/commode										
d) Off of toilet/commode										
e) In to mobility device										
f) Out of mobility device										
g) In to bathtub/shower										
h) Out of bathtub/shower										
i) Other										

SECTION C – ALL OTHER CARE REQUIREMENTS

ACTIVITY OF DAILY LIVING	INDEPENDENT	SOME ASSISTANCE REQUIRED	FULL STAFF ASSISTANCE	NOT APPLICABLE
1. Meals & Eating Assistance				
a) Cooking				
b) Cutting up food				
c) Splints				
d) Feeding Self				
e) Tube feedings				
2. Personal Hygiene				
a) Bathing/Showering				
b) Brushing teeth				
c) Washing hands/face				
d) Shaving				
e) Make-up				
f) Deodorant				
g) Hair				
h) Other				
3. Bowel & Bladder Care				
a) Leg Bag - empty				
- clean				
- connect/disconnect				
b) Night drainage- empty				
- clean				
- connect/disconnect				
c) Condom - application				
d) Ileo-conduit care				
e) Urinal/Bedpan				
f) Bowel - suppositories				
g) Bowel - disimpaction				
h) Bowel – digital stimulation				
i) Stoma Care				

ACTIVITY OF DAILY LIVING	INDEPENDENT	SOME ASSISTANCE REQUIRED	FULL STAFF ASSISTANCE	NOT APPLICABLE
j) Sanitary pads/ Tampons				
k) Attends / Incontinence Pads				
l) Toileting at night				
m) Toileting on demand				
n) Assistance with accident clean-up				
o) Other				
4. Dressed & Undressed				
a) Pullover				
b) Shirt/Blouse				
c) Trousers/Slacks/Skirts				
d) Underwear				
e) Sox/Stockings				
f) Shoes				
g) Buttons/Zippers/Hooks				
h) Braces/Prosthesis				
i) Jackets/Coats				
5. Specialized Care				
a) Turning/Repositioning				
b) Special Skin Care/Treatments				
c) Range of Motion Exercises				
d) Lung Augmentation Exercise (Assistive Coughing, Ambu Bag)				
e) Bi-PAP or C-PAP Machines				
f) Other				
6. Housekeeping				
a) Dusting & Pick-up				
b) Floors & Windows				
c) Mop/Broom/Vacuum				
d) Dishes - wash				
- dry				
- put away				

ACTIVITY OF DAILY LIVING	INDEPENDENT	SOME ASSISTANCE REQUIRED	FULL STAFF ASSISTANCE	NOT APPLICABLE
e) Laundry - washer				
- dryer				
- hand				
f) Bed - make				
- change				
g) Garbage				
h) Recycled Material				
i) Other				
7. Miscellaneous				
a) TV/ Radio/Stereo				
b) Locks				
c) Money				
d) Windows – open/close				
e) Thermostat				
f) Medications				
g) Doors				
h) Gathering mail				
i) Opening mail, filing, correspondence etc.				
j) Battery Charging				
k) Wheelchair maintenance – ie. Cleaning wheelchair				
l) Other				

Any other activities or requirements needed from the attendant care staff?

DECLARATION

I certify that the information provided in this application is accurate and complete. I am aware that the information provided will be relied upon to assess my suitability for placement in the respite care unit.

DATE

APPLICANT

DATE

WITNESS

STATEMENT OF RELEASE RESPITE CARE UNIT

I, _____, hereby authorize the following people
to release my records and information to The In Community.

DATE SIGNATURE

WITNESS

PRIMARY PHYSICIAN _____

Telephone _____ Fax _____

ADDRESS _____
(Street Name and Number)

(City) (Postal Code)

OCCUPATIONAL THERAPIST _____ Telephone _____

ADDRESS _____
(Street Name and Number)

(City) (Postal Code)

Please return this completed application form to: