PASQUA FIRST NATION INDEPENDENT LIVING COMPLEX
CONFIDENTIAL APPLICATION FOR TENANCY FORM

SECTION 1. PERSONAL INFORMATION

A. Applicant's Full Name: ______________________________

Current Address: ______________________________
Street City/Prov. Postal Code

Phone Number(s): ______________________________
Home Cell Other

Social Insurance Number: _____-_____-_____ Personal Health Number: ______________

Treaty Number: ______________ First Nation: ______________

Date of Birth: ______________

Spouse's Full Name (If Applicable) ______________________________

Immediate Family Members (If Applicable) ______________________________

B. Brief description of physical and/or cognitive challenges: ______________
____
____
____

C. Have you required psychiatric support? Yes _______ No _______

If yes, please describe the circumstances:
____
____
____

D. Please identify any medical issues that we should be aware of. (Hepititis C, HIV, Heart, etc)
____
____

E. Will you be having overnight guests? Yes _______ No _______

SECTION 2 FINANCIAL INFORMATION

A. What is/are your source(s) of income? (Check all sources) Canada Pension Plan ____

OAS ____ Social Assistance ____ Other ____ (Explain) ________________________________

B. What is your total monthly income from all sources? ____________________________

SECTION 3 EQUIPMENT NEEDS

A. Do you require assistance with mobility? Yes ______ No ______ If yes, please check the equipment you have or need in order to be as independent as possible.

Manual Wheelchair: Have _____ Need _____ Electric Wheelchair: Have _____ Need _____

Scooter: Have _____ Need _____ Walker: Have _____ Need _____

Crutches: Have _____ Need _____ Cane: Have _____ Need _____

Electric Bed: Have _____ Need _____ Wheel-in Shower: Have _____ Need _____

Commode: Have _____ Need _____ Other (Explain) _____________________________________

B. Do you require assistance with transfers? Yes ______ No ______

Do you use a Mechanical Lift? Yes ______ No ______ If yes, what type? _________________

C. Do you own a motor vehicle? Yes ______ No ______ If yes, please provide the following information.

Make ______________ Model _____________ Year _______ License Number ______________

D. Other Pertinent Information ____

____

____

SECTION 4 ALLERGIES

A. Please list all known allergies:

Medication ____

Food ____

____

Other ____

____

SECTION 5 MEDICATIONS

A. Please list all prescribed and over-the-counter medications you are currently using. Explain how they are administered (orally, IV, intramuscular, etc):

Prescription	Administering Method
1. ____________	____________
2. ____________	____________
3. ____________	____________
4. ____________	____________
5. ____________	____________

Over-the-Counter	Administering Method
1. ____________	____________
2. ____________	____________
3. ____________	____________
4. ____________	____________
5. ____________	____________

SECTION 6 CHEMICAL DEPENDENCIES

A. Do you have problems with dependency on alcohol and/or drugs presently or have you had problems with dependency on alcohol and/or drugs in the past (illicit or prescription/non-prescription medications)? Yes ______ No ______

If yes, please describe the circumstances: ____

____

____

____

SECTION 7 PERSONAL CARE REQUIREMENTS

A. Please indicate the assistance you require with the following routines:

ROUTINE	ASSISTANCE REQUIRED Full	Partial	None
1. Laundry	_____	_______	______
2. Housework	_____	_______	______
3. Meal Preparation	_____	_______	______
4. Medication Administration	_____	_______	______
5. Making Appointments	_____	_______	______
6. Telephone	_____	_______	______
7. Transportation Arrangements	_____	_______	______

B. Which do you prefer to use? Bath ______ Shower ______ Wheel-in Shower _______

SECTION 8 PROFESSIONAL SUPPORT

A. Employment and Assistance Worker/Financial Assistance Worker:

Name: ______________________________ Phone Number: __________________________________

Address: ____

B. All Doctors:

Name: ______________________________ Phone Number: __________________________________

Address: ____

Name: ______________________________ Phone Number: __________________________________

Address: ____

Name: ______________________________ Phone Number: __________________________________

Address: ____

C. Long Term Care Worker/Social Worker:

Name: ______________________________ Phone Number: __________________________________

Address: ____

D. Have you ever been assessed for Long Term Care? Yes ______ No ______

If yes, give date and assessment level (if known):

Date of Assessment ________________ Level of Assessment ______________________________

SECTION 9 EMERGENCY CONTACT

A. Please list two people as emergency contacts:

Name: ____ Relationship: ______________________

Address: ________________________________ Phone Number(s): _______________________

Name: ____ Relationship: ______________________

Address: ________________________________ Phone Number(s): _______________________

SECTION 10 AUTHORIZATION

I hereby authorize the Independent Living Complex Representative to obtain and use medical reports, social reports and other information as may be required to establish me with the most suitable level of care as a client in its Independent Living Complex. I also understand that this information will be used with the utmost discretion and regard for my privacy and will be treated as confidential information by the Representative.

____ ________________________

APPLICANT'S SIGNATURE DATE

____ ________________________

PFN ILC REPRESENTATIVE'S SIGNATURE DATE

____ ________________________

WITNESS'S SIGNATURE DATE

Independent Living Complex
Pasqua First Nation, SK

Medical Report- Assessment of Level of Care (Services)

Notes to Examining Physician
1. Unless specifically requested by Community Resources, the cost of this examination is the responsibility of the applicant.
2. Please return the completed form to:

Date issued: ____________
Year Month Day

Consent:
I give my consent for the release of the information contained in this medical Report to Community Resources.

Date: ____________ ____________ ____________
Year Month Day   Signature   Trustee (where applicable)

Name: ____________ Age:_____ Sex:_____
Address: ____________ Date examined: ____/____/____
Year Month Day
Examining Physician ____________
How long has this patient been under your care? ____________

Diagnosis:

History:

Diet:

Special Problems/or Needs: (e.g. Tube feeding, Oxygen Therapy, Skin Care, Physiotherapy, Occupational therapy, frequent episodes of acute illness, etc.)

Confidential once complete

Treatment and Management:

Please check off the Level of Care (Services) you feel is most appropriate for the applicant

_____ No Level

_____ Level I Care (Services)

Essentially independent but may need some guidance for supervision in the activities of daily living. staff time for care averages 20 minutes a day.

_____ Level II Care (Services)

Supervision and assistance may be needed with personal hygiene and grooming. Safely ambulant with or without mechanical aids or independent at wheelchair level. Usually content. Able to feed self. Some supervision and direction may be needed for behavioral problems: Staff time for care averages 45 minutes a day.

_____ Level III Care (Services)

All Degrees of supervision and assistance may be needed in the activities of daily living. Basic nursing care is usually required. Supervision and direction may be given for emotional and behavioral problems which do not endanger life or property: Care at this level is carried out under the supervision of a Registered Nurse or Registered Psychiatric Nurse as directed by attending Physician. Staff time for care averages two hours a day.

_____ Level IV (Services)

All patient care is carried out under continuing medical supervision and all nursing care is carried out under professional supervision.. Emergency and consultative medical services and highly skilled technical nursing services must be readily available with required. Staff time for care averages more than two hours a day.

_____ A. Specialized Supervisory Care- where the emphasis lies on the management of advanced mental deterioration with its attendant problems. Physical conditions requiring continuing medical supervision are likely to co-exist.

_____ B. Supportive Care- where the emphasis lies on skilled nursing care and specialized Techniques to arrest or retard deterioration.

_____ C. Restorative Care- where the emphasis lies on a slow paced restorative program designed to improve functional ability to the extent that care at home or at a Level I to III may be achieved.

_______________________________ Physician's Signature

_____/_____/_____ Year Month Day

_______________________________ Address