ArlingtonHaus
Assisted Living

Assisted Living Application

NAME: _____ **APPLICATION DATE**: _____, 20____

INTERVIEW DATE: _____, 20____

DATE OF BIRTH: _____ **PHIN**: _____

PART A: GENERAL DATA

INFORMANT FOR INTERVIEW: Self _____ Spouse _____ Child _____
Home Care Worker: _____ Other: _____

1. CURRENT ADDRESS: _____
   _____
   _____
2. PHONE NUMBER: _____
3. APPLICANTS GENDER: ☐ Male ☐ Female
4. PRIMARY LANGUAGE: _____ OTHER LANGUAGES SPOKEN: _____
5. MARITAL STATUS:
   - ☐ Married
   - ☐ Divorced
   - ☐ Widowed
   - ☐ Separated
   - ☐ Single
   - ☐ Not answered or unknown

   Year Widowed and Adjustment _____
   _____
7. RELIGION: _____
8. OCCUPATION: _____
9. AGE AT RETIREMENT AND ADJUSTMENT TO RETIREMENT: _____
   ☐ Good adjustment ☐ Hard adjustment _____
   _____
10. STATUS OF DRIVER'S LICENSE AND, IF INACTIVE, DATE OF AND ADJUSTMENT TO LOSS:
    ☐ Never had one ☐ Active ☐ Inactive
    Date of Loss: _____, _____
    ☐ Good adjustment ☐ Difficult adjustment
    Comments: _____
    _____
11. VETERAN: ☐ Yes ☐ No DVA # _____

12. LIVING ARRANGEMENTS OF THE PARTICIPANT:

☐ Lives alone ☐ With hired caregiver

☐ Lives with spouse ☐ Other _____

☐ Lives with other relative _____

13. PRIMARY CAREGIVER: ☐ SPOUSE ☐ CHILD ☐ OTHER _____
14. PATTERN OF RELATING TO OTHERS:
☐ Extroverted ☐ Introverted ☐ Initiates ☐ Observes ☐ Withdraws
15. DOES PRIMARY CAREGIVER LIVE WITH APPLICANT?
☐ Yes ☐ No
16. WHO WOULD YOU SAY IS THE PERSON PRIMARILY RESPONSIBLE FOR APPLICANT?
Spouse _____ Child _____ Other _____
Name Name
17. HOW LONG HAS THE APPLICANT LIVED IN CURRENT RESIDENCE? _____ Years
18. TOTAL NUMBER IN THE HOUSEHOLD: _____
19. IS PRIMARY CAREGIVER CURRENTLY EMPLOYED?

☐ Full time ☐ Part time ☐ Does not work

Work Pattern: _____

20. PRIMARY CONTACT

NAME: _____

ADDRESS: _____

_____

PHONE: _____

21. SECONDARY CONTACT

NAME: _____

ADDRESS: _____

_____

PHONE: _____

22. FAMILY SUPPORT SYSTEMS:

		In Winnipeg	
		Yes	No
Spouse			
Children			
Sibling(s)			
Nieces / Nephews			
Grandchildren			
Other:			

23. DOES APPLICANT SUFFER FROM DEMENTIA? ☐ Yes ☐ No
24. PERSONS MOST OFTEN REMEMBERED: _____
25. DOES ANY OTHER FAMILY MEMBER HAVE DEMENTIA? ☐ Yes ☐ No

CURRENT HOME CARE SERVICES: ☐ Provincial Home Care Program ☐ Private ☐ None

Hours per day/week _____

Name of Case Coordinator _____

26. WHO PROVIDES TRANSPORTATION TO DOCTOR / MEDICAL APPOINTMENTS?

☐ Family ☐ Friend ☐ Other _____

Special Needs: _____

27. WHAT IS THE NAME AND ADDRESS OF THE FAMILY PHYSICIAN?

Name: _____ Phone #: _____

Address: _____

PART B: ACTIVITIES OF DAILY LIVING SKILLS:

28. DESCRIBE PARTICIPANT'S FUNCTIONING LEVEL WITH REGARD TO: (check all that apply)

A) Walking: ☐ Unassisted, ☐ Short distances, ☐ Long distances
☐ Steady on feet ☐ Risk for falls ☐ Needs standby assistance
Walking Aides: ☐ None ☐ Cane/quad cane ☐ Crutches
☐ Wheelchair ☐ Walker ☐ Power chair
Paralysis ☐ R Arm ☐ R Leg ☐ L Arm ☐ L Leg

B) Visual: ☐ i) No Impairment

☐ ii) Wears glasses
- ☐ For reading
- ☐ For distance
- ☐ Bi-focal

☐ iii) Legally blind
- ☐ Requires environmental land marking/cues to assist with way finding
- ☐ Needs suite near common room
- ☐ Needs table setting and meal plated in specific/consistent way

☐ iv) Cataracts ☐ L ☐ R

C) Hearing ☐ i) No impairment
☐ ii) Wears hearing aid(s)
- ☐ Right
- ☐ Left
- ☐ Both

☐ iii) Difficulty with hearing, has hearing aid but seldom uses it
☐ iv) Difficulty with hearing, no hearing aid

D) Eating: ☐ i) Independent,
☐ ii) Needs some assistance (cutting, pouring sugar, etc.)
☐ iii) Difficulty using/confusion with utensils
☐ iv) Needs reminders and cueing to focus on eating

E) Swallowing Problems: ☐ Yes ☐ No

F) Diet: ☐ Regular ☐ Diabetic ☐ Low Sodium ☐ Minced

G) Dentures: ☐ Has own teeth.

☐ Upper: ☐ Full ☐ Partial ☐ None

☐ Lower: ☐ Full ☐ Partial ☐ Removable bridge

☐ Independent with removing and cleaning

☐ Needs assistance with removing and cleaning

H) Appetite: ☐ Good ☐ Poor ☐ Eats too fast

I) Food Preferences: _____ ☐ None

J) Food Dislikes: _____ ☐ None

K) Drinks: ☐ Tea ☐ Regular Coffee ☐ Decaffeinated Coffee ☐ Milk ☐ Juice

L) Allergies to Food: _____ ☐ none known

M) Diabetic ☐ Yes ☐ No

Blood Glucose Testing ☐ Never ☐ Rarely ☐ Daily ☐ More than Daily

Results Range _____low to _____ high

N) Other Medical Diagnosis

_____

_____

_____

_____

_____

☐ c) *Home Care Nursing required ☐ Yes ☐ No

**Any prescribed medications or treatments that are not in pill form (Inhalers, ointments, drops, patches, injections, etc) must be administered by home care nursing.*

P) Toileting/Elimination: ☐ a) Independent;

☐ b) Needs some assistance ☐ on/off toilet

☐ reminders ☐ supervision

☐ cueing ☐ assist with pad change

☐ c) Incontinent of bladder ☐ rare ☐ occasionally ☐ frequently

☐ d) Incontinent of bowel ☐ rare ☐ occasionally ☐ frequently

Q) Dressing: ☐ a) Independent;

☐ b) Needs some assistance:☐ lay out clothing ☐ verbal cueing

☐ reminders ☐ hands on assistance

R) Bathing: ☐ a) independent

☐ b) Needs some assistance:

☐ verbal cueing ☐ standby assist

☐ wash hair ☐ hands on assistance

S) Grooming: ☐ a) independent

☐ b) Needs some assistance

☐ verbal cueing ☐ standby assist

☐ wash hair ☐ hands on assistance

Grooming tasks requiring assistance:

☐ shaving ☐ denture care ☐ brushing teeth

☐ washing face ☐ applying deodorant ☐ cleaning eye glasses

☐ combing hair ☐ applying makeup ☐ other _____

PART C: BEHAVIOUR: *(exhibited during the previous twelve months)*

☐ 1. Communication barriers:
- ☐ Passive
- ☐ Anxious
- ☐ Substitutes words that sound like other words
- ☐ Difficulty word finding
- ☐ Hearing Impaired

Other _____

_____

☐ 2. Has difficulty concentrating on a task or activity.

☐ 3. Does not initiate activities

☐ 4. Needs lots of encouragement to attend activities.

☐ 5. Frequently loses or misplaces things.

☐ 6. Collects/hoards items

☐ 7. Will put soiled clothing/underwear in dresser/closet

☐ 8. Reluctant to care/assistance

☐ 9. Wanders away from home.

Describe: _____

_____

a) Wanderer's Alert Bracelet: ☐ Yes ☐ No ☐ Papers given

b) Medic Alert Bracelet _____

☐ 10. Cannot be left alone; must receive constant supervision.

☐ 11. Wakes up at night. _____

☐ 12. Prefers to be alone rather than with others

☐ 13. Believes others are stealing from them. ☐ Sometimes ☐ Often

☐ 14 Believes someone is coming into suite/home when they are not there.

☐ 15. Has become verbally aggressive towards caregivers (such as yelling, swearing)

☐ 16. Visual Hallucinations

☐ 17. Auditory Hallucinations

☐ 18. Easily becomes anxious

Describe _____

☐ 19. Easily becomes agitated

Describe: _____

_____

☐ 20. Do you smoke ☐ Yes ☐ No

Have you quit smoking in ☐ last six months ☐ last year ☐ more than a year ago.

2. CURRENTLY HOW DOES APPLICANT SPEND DAY? _____

_____

3. DOES APPLICANT ATTEND ANY DAY PROGRAM? ☐ Yes ☐No _____

_____

4. PUBLIC TRUSTEE ☐ Yes ☐No _____

5. POWER OF ATTORNEY ☐ Yes ☐No _____

PART E: SUITE PREFERENCE

DO YOU REQUIRE PARKING? ☐ YES ☐ NO

Application Recommended for Residency: ☐ **Yes** ☐ **No**

Application Priorized for Residency: ☐ **Yes** ☐ **No**

Any conditions placed on Residency: _____

_____

Home Care Nursing Services Required: _____

_____

Other Considerations (e.g. requires subsidy): _____

_____