285 Pembina Hwy
Independent Living Application

NAME: APPLICATION DATE:

DATE OF BIRTH:

PART A: GENERAL DATA

1. **CURRENT ADDRESS:**

   _____

   _____

2. **PHONE NUMBER:**
3. **APPLICANTS GENDER:** ☐
4. **PRIMARY LANGUAGE:** _____ **OTHER LANGUAGES SPOKEN:** _____
5. **MARITAL STATUS:**

   ☐

6. **OCCUPATION:**

7. **AGE AT RETIREMENT AND ADJUSTMENT TO RETIREMENT:**

8. **STATUS OF DRIVER'S LICENSE:**

   ☐

   Date of Loss: , _____

   ☐ Good adjustment ☐ Difficult adjustment

9. **LIVING ARRANGEMENTS OF THE APPLICANT:**

   ☐

10. **PRIMARY CAREGIVER:** ☐ _____
11. **DOES PRIMARY CAREGIVER LIVE WITH APPLICANT?**

    ☐

12. **PATTERN OF RELATING TO OTHERS:**

    ☐

13. **HOW LONG HAS THE APPLICANT LIVED IN CURRENT RESIDENCE?** ☐ Years

14. PRIMARY CONTACT

NAME:

PHONE:

RELATIONSHIP:

15. SECONDARY CONTACT

NAME: _____

PHONE: _____

RELATIONSHIP: _____

16. FAMILY SUPPORT SYSTEMS:

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

17. DOES APPLICANT SUFFER FROM DEMENTIA?

18. CURRENT HOME CARE SERVICES

Hours per day/week _____

Name of Case Coordinator _____

Services Received: _____

19. WHO PROVIDES TRANSPORTATION TO DOCTOR / MEDICAL APPOINTMENTS?

20. WHAT IS THE NAME OF ALL PHYSICIANS INVOLVED?

Name: Phone #:

Type of Physician:

Name: _____ Phone #: _____

Type of Physician: _____

Name: _____ Phone #: _____

Type of Physician: _____

PART B: ACTIVITIES OF DAILY LIVING SKILLS:

DESCRIBE FUNCTIONING LEVEL WITH REGARD TO: (check all that apply)

A) Walking:

B) Walking Aides:

C) Visual:

D) Hearing:

E) Eating:

F) Swallowing Problems:

G) Diet:

H) Allergies to Food:

I) Diabetic

J) Other Medical Diagnosis:

K) Mental Health Diagnosis:

L) Toileting/Elimination:

M) Dressing:

N) Bathing:

O) Grooming:

P) Laundry:

PART C: BEHAVIOUR: *Select all exhibited behaviours during the previous twelve months.*

1. Communication barriers:

Anxious
Difficulty word finding
Hearing Impaired
Passive
Substitutes words that sound like other words
Auditory Hallucinations
Believes others are stealing from them - Often
Believes others are stealing from them - Sometimes
Believes someone is coming into suite/home when they are not there
Collect/hoard items
Doesn't not initiate activities
Frequently loses or misplace things
Has becom verbally agresssive towards caregivers (such as yelling, swearing)
Has difficulty contentrating on a task or activity
Needs lots of encouragement to attend activities
Prefers to be alone rather with others
Reluctant to care/assistance
Visual Hallucinations
Wanders away from home

Other

2. **Easily becomes anxious**

Describe

3. **Easily becomes agitated**

Describe:

4. **Do you smoke**

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

5. **CURRENTLY HOW DOES APPLICANT SPEND DAY?**

6. **DOES APPLICANT ATTEND ANY DAY PROGRAM/SUPPORT SERVICES OUTSIDE THE HOME?**

7. **PUBLIC TRUSTEE**

8. **POWER OF ATTORNEY**

9. **OTHER SUPPORT SERVICES THAT ARE IN PLACE/WILL BE IN PLACE:**

PART E: SUITE PREFERENCE

1. **DO YOU REQUIRE PARKING?**
2. **WHICH TYPE OF APARTMENT ARE YOU LOOKING FOR?**
3. **WILL YOU BE GOING ON THE MEAL PROGRAM?**

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Eligibility Point System Score: _____/175
Date of Interview : _____
Application Prioritized for Residency: ☐ Yes ☐ No Reason: _____
Application Recommended for Residency: ☐ Yes ☐ No