Whitby | Mental Health Centre

APPLICATION TO HOMES FOR SPECIAL CARE (HSC)

Please follow the instructions set out below:

- This application must be completed upon referral to Homes for Special Care.
- The Community Nurse Clinician will arrange for an interview with the referring staff and the applicant.
- A pre-placement visit to an HSC home/homes will be arranged after this interview. This is essential for the applicant, home operator and the HSC staff, to determine placement suitability.
- When the applicant has been accepted for placement, referring staff will be notified and a placement date will be negotiated. It is expected that the applicant will be placed initially on a LOA basis to assess placement suitability.

PRIOR TO PLACEMENT, THE FOLLOWING IS REQUIRED:

☐ **Completion of this Application**

☐ **Information Source**:
- ☐ Interview(s) with Applicant or Substitute Decision Maker
- ☐ Interview with Family
- ☐ Interview with Friends
- ☐ File Review
- ☐ Other relevant Information (eg, External Agency)

☐ **Medication:**
Original prescription - accompany client to the home
Provide a supply of medication to cover one week until the homeowner can fill the prescription.

☐ **Medical Fees:** Ensure Health Card accompanies the client to the home. If Health Card has been lost, make an application for a replacement card prior to admission to HSC.

☐ **Leave of Absence**: Authorized approval for a minimum one week LOA.

☐ **Consents: (x2)** Homes for Special Care / Home Operator

☐ **Incompetent:** Require a copy of "Certificate of Capacity" (Form #33) " + "Certificate of Continuance" (Form #24), where applicable.

☐ **Competent:** Require the following HSC forms to be completed and signed by Applicant:
"Financial Responsibility Acknowledgement Form" and "Financial Status"

☐ **Financial:**
- ☐ Personal Finances – Funds should accompany the applicant at the time of admission.
- ☐ ODSP income support validation

Note: HSC in collaboration with applicant, Substitute Decision Maker, family and core service providers will develop a Community Living Plan.

Ontario

Ministry of Health and Long-Term Care
Homes for Special Care
Ministère de la Santé et des Soins de longue durée
Foyers de soins spéciaux

Housing Program Referral Profile
Profil de renvoi au Programme de logement

Patient Information / Renseignements sur la patiente ou le patient

Date of Referral (yyyy/mm/dd) Date du renvoi (aaaa/mm/jj)	Date of Admission (yyyy/mm/dd) Date d'admission (aaaa/mm/jj)	Casebook Number Numéro du recueil de cas
Patient's Last Name Nom de famille de la patiente ou du patient	Patient's First Name & Initial Prénom et initiale de la patiente ou du patient	Date of Birth (yyyy/mm/dd) Date de naissance (aaaa/mm/jj)

Address Prior to Admission (include Street, City/Town, Province, Postal Code)
Adresse avant l'admission (rue, ville, province,

Birthplace Lieu de naissance	Religion Religion	Father's Name Nom du père	Mother's Maiden Name Nom de jeune fille de la mère

Marital Status/État matrimonial
☐ Single Célibataire ☐ Married Marié(e) ☐ Separated Séparé(e) ☐ Divorced Divorcé(e) ☐ Widowed Veuf(ve)

Sex
☐ Male Masculin ☐ Female Féminin

Language(s) Spoken
Langue(s) parlée(s)

Social Insurance No. Numéro d'assurance sociale	Health Card No. Numéro de carte Santé	Drug Eligibility No. Numéro d'admissibilité au programme de médicaments	Public Guardian & Trustee No. Numéro du tuteur et curateur public

List Financial Resources
Énumérer les ressources financières

Has applicant ever been on any kind of financial aid program? *Please specify*
L'auteur de la demande a-t-il déjà été bénéficiaire de programmes d'aide financière? *Veuillez préciser.*

Who to contact in case of an emergency / Personne à qui s'adresser en cas d'urgence

Name Nom	Relationship Lien

Address
Adresse

Work Telephone Number (include area code) N° de téléphone au travail (y compris l'indicatif régional)	Home Telephone Number (include area code) N° de téléphone à la maison (y compris l'indicatif régional)

Substitution Decision Maker If/When Incapable
Personne qui prend les décisions au nom de la patients ou du patient, s'il y a lieu

☐ Same as above *or* / Comme ci-dessus *ou*

Name of Referring Agency/Hospital
Nom de l'organisme ou de l'hôpital qui a fait le renvoi

Address (include Street, City/Town, Province, Postal Code) Adresse (rue, ville, province, code postal)	Phone No. (incl. Area Code) Téléphone (y compris l'ind. rég.)

Housing Program Referral Profile
Profil de renvoi au programme de logement

Patient's Last Name Nom de famille de la patiente ou du patient	Patient's First Name & Initial Prénom et initiale de la patiente ou du patient	Casebook Number Numéro du recueil de cas

Diagnostic Information / Renseignements diagnostiques

Psychiatric Diagnosis
Diagnostic psychiatrique

Secondary Diagnosis
Diagnostic secondaire

Highest School Grade Achieved Scolarité	Type of Program / Genre de formation ☐ Academic / Générale ☐ Commercial / Commercials ☐ Vocational / Professionnelle

Brief outline of applicant's work history (*where, what, performance, etc.)*
Bref compte rendu des antécédents professionnels de l'auteur de la demande *(lieu, fonctions, rendement, etc.)*

Future rehabilitation goals and plans
Buts et plans en matière de réadaptation

Applicant's motivation for placement
Motivation de l'auteur de la demande quant au placement

Comments *Additional pertinent information that would warrant special attention)*:
Observations *(renseignements supplémentaires qui demandent une attention spéciale)*

Referring Worker's Name Nom de la travailleuse ou du travailleur qui a fait le renvoi	Patient Care Unit *(if applicable)* Unité de soins du patient ou de la patiente *(s'il y a lieu)*	Telephone no. (incl. Area code) Téléphone (y compris l'indicatif régional)

I have explained the Housing Program to the applicant and I feel that he/she is an appropriate candidate. It is understood that should the applicant be accepted in the Housing Program, I will be expected to continue to be involved in a consultative role.
J'ai expliqué le programme de logement à l'auteur de la demande et je crois qu'il est un candidat approprié. Il est entendu que si l'auteur de la demande est admis dans le programme de logement, je m'attends à continuer de jouer un rôle consultatif.

Signature Date (yyyy/mm/dd)(aaaa/mm/jj)

I have discussed the Housing Program with my worker and my physician. I understand and agree to abide by the rules and regulations of the program.
J'ai discuté du programme de logement avec ma travailleuse (mon travailleur) et mon médecin. Je comprends les règles et règlements du programme et j'accepte de les observer.

Signature Date (yyyy/mm/dd)(aaaa/mm/jj)

Patient Profile / Profil de la patiente ou du patient

Speech / Discors	☐ Rational / Rationnel	☐ Clear / Clair	☐ Initiates / lace des converstions	☐ Responds / Répond
Voice / Voix	☐ Quiet / Faible	☐ Average / Moyenne	☐ Loud / Forte	☐ Other *(specify)* Autre *(préciser)*

Comments:
Observations :

Housing Program Referral Profile
Profil de renvoi au programme de logement

Patient's Last Name Nom de famille de la patiente ou du patient	Patient's First Name & Initial Prénom et initiale de la patiente ou du patient	Casebook Number Numéro du recueil de cas

Patient Profile / Profil de la patiente ou du patient

Memory
Mémoire

Past Events Événements passée		☐ Good Bonne	☐ Some Partielle	☐ Little or None Minime ou nulle
Recent Events Événements récents		☐ Good Bonne	☐ Some Partielle	☐ Little or None Minime ou nulle
Orientation Orientation	Time Temps	☐ Good Bonne	☐ Some Partielle	☐ Little or None Minime ou nulle
	PLACE	☐ Good Bonne	☐ Some Partielle	☐ Little or None Minime ou nulle
	PERSON	☐ Good Bonne	☐ Some Partielle	☐ Little or None Minime ou nulle

Anger **Colère**	☐ Not a problem Pas un problème	☐ If provoked Si provoqué(e)	☐ Verbal Outbursts Emportements verbaux	☐ Aggressive behaviour Comportement agressif
	☐ Frequent Fréquente	☐ Unpredictable Imprévisible	☐ Strikes Out Donne des coups	☐ Breaks/throws objects Brise/lance des objets

Comments:
Observations :

Activity Level **Activité**	☐ Underactive Peu Actif(ve)	☐ Average Moyenne	☐ Quite Active Très actif(ve)	☐ Restless Agité(e)
Mood Disorders **Troubles de l'humeur**	☐ Not Apparent Non apparents	☐ Occasional Sadness Tristesse occasionnelle	☐ Cries Frequently Pleure souvent	☐ Has tried to hurt self A tenté de se blesser

Comments:
Observations :

Bizarre Ideas **Idées bizarres**	☐ Of Persecution Idés de persécution	☐ Of Importance Idées de grandeur	☐ Makes Up Events Fabule	☐ Stories From The Past Ressasse le passé
	☐ Not Apparent Non apparentes	☐ Hallucinations Hallucinations	☐ Audio Auditives	☐ Visual Visuelles

Comments:
Observations :

Social Adjustments **Adaptions sociales**	☐ Friendly Amical	☐ Reserved Réservé(e)	☐ Withdrawn Replié(e) sur soi	☐ Gregarious Grégaire
	☐ Loner Solitaire	☐ Independent Indépendant(e)	☐ Attention Seeker Veut attirer l'attention	☐ Other Autre

Comments:
Observations :

Habits **Habitudes**	☐ Smoking Fume	☐ Pilfering Commet des larcins	☐ Hoarding Accumule	☐ Poor Budgeting Skills A peine à gérer un budge

Comments
Observations :

Sexuality **Sexualité**	☐ Masturbates Se masturbe	☐ Exposes Self S'exhibe	☐ Suggestive Touching Fait des attouchements suggestifs

Comments
Observations :

Housing Program Referral Profile
Profil de renvoi au programme de logement

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Caution
Avertissement

- ☐ Elopement — Fait des fugues
- ☐ Careless Smoker — Fumer imprudent
- ☐ Substance Abuse — Toxicomane
- ☐ Criminal Charges — Accusations criminelles
- ☐ Sets Fires — Allume des incendies
- ☐ History of Medication Non-compliance — Ne prend pas toujours ses médicaments
- ☐ Alcohol — Consomme de l'alcohol
- ☐ Other — Autre

Comments:
Observations :

Mobility
Mobilité

- ☐ Walks Unaided — Marche sans aide

Comments:
Observtions :

Specific Recommendations or Comments:
Recommandations ou observations particuléres

Transfer Summary / Résumé du transfert

Briefly outline conditions limiting applicant's function:
Résumer les troubles qui limitent le fonctionnement de l'auteur de la demande :

MEDICATIONS / MÉDICAMENTS

Generic Name / Nom générique	Dosage / Posologie	Frequency / Fréquence	Route / Voie
PLEASE REFER TO "MEDICATION RECORD" ATTACHED.			

☐ **Requires PRN Regularly / PRN souvent requir**

Generic Name / Nom générique	Dosage / Posologie	Frequency / Fréquence	Route / Voie

Diet
Régime alimentaire

- ☐ Regular — Ordinaire
- ☐ Other *(specify)* — Spécial *(veuillez ptréciser)*

Medical Problems ***(i.e. incontinence)***
Problèmes médicaux ***(c.-à-d. incontinence)***

- ☐ Acute — Aiguë
- ☐ Chronic — Chronique

Dates for Completed Investigations
Dates des investigations terminées

Chest X-ray Radiographie pulmonaire	Dental Examination Examen dentaire	Urinalysis Analyse d'urine	VDRL VDRL	Other Autre

In my opinion, this patient does not require further hospital care and any medical care required can be carried out by a community physician

A mon avis, cette patients ou ce patient n'as pas besoin de soins hospitaliers supplémentaires et les soins médicaux requis pourront être dispensés par un médecin de la collectivité.

Signature

Date (yyyy/mm/dd)(aaaa/mm/jj)

Housing Program Referral Profile
Profil de renvoi au programme de logement

Patient's Last Name Nom de famille de la patiente ou du patient	Patient's First Name & Initial Prénom et initiale de la patiente ou du patient	Casebook Number Numéro du recueil de cas

To be completed by the Housing Program / Réservé au programme de logement

The applicant was accepted
La demande a été acceptée

☐ Yes / Oui ☐ No / Non

If not accepted, specify reasons why
Si elle a été refusée, raisons

If accepted, address of Home
Si elle a été acceptée, adresse du foyer

Name of Worker Nom du travailleur ou de la travailleuse	Date of Placement Date du placement

Whitby | Mental Health Centre

HOMES FOR SPECIAL CARE
HOUSING APPLICATION

Preferred Location:

Any ☐ 1st Available Vacancy ☐ … or … (see table below ⇓)

DURHAM REGION	YORK REGION	TORONTO	KAWARTHA
Whitby ☐	Newmarket ☐	East End ☐	Lindsay ☐
Oshawa ☐		West End ☐	Fenelon Falls ☐
Bowmanville ☐			Kirkfield ☐
Hampton ☐			
Port Perry ☐			
Beaverton ☐			

If recently admitted to hospital, please describe behaviours:

_____

_____

Symptoms that are evident prior to breakdown:

- ☐ Responding to voices
- ☐ False Beliefs
- ☐ Incoherent Speech
- ☐ Fixed Ideas
- ☐ Aggressive Behaviour
- ☐ Angry Outburst
- ☐ Restlessness, Anxiety, Tension, Agitation
- ☐ Physical Complaints
- ☐ Excessive Spending
- ☐ Alcohol/Drug Abuse
- ☐ Social Withdrawal
- ☐ Depression
- ☐ Suicidal Thoughts/Homicidal
- ☐ Apathy/Lack of Motivation
- ☐ Changes in Sleeping Habits
- ☐ Changes in Eating Habits
- ☐ Wandering/Confusion
- ☐ Other

Give Details: 1) Identify triggers that cause onset of symptoms
2) Identify any known preventative measures and/or symptom management

_____

_____

Does applicant understand his/her diagnosis? Yes ☐ No ☐
If "No", What is applicant's perception?

_____

_____

_____

Clinical Indicators and Risk Management:

Identify Clinical Indicators/Applicant Vulnerabilities and Corresponding Management Recommendations:

1. Criminal History (Theft Risk)

Relates to Factual/Historical information (e.g., charges/convictions, current charges, court pending, etc.)
Recommended management plan:

2. Fire Hazard

Factual/Historical Comment on historical nature of fire hazards (e.g., frequency, last known occurrence, intent, etc.).
Recommended management plan:

NCR: Yes ☐ No ☐

IF NCR: Is there a community living clause in the Disposition Order? Yes ☐ No ☐

Index Offense, if incurred (explain): _____

Additional Information: _____

_____

HISTORY OF COMMUNITY LIVING (Last 5 years) [including incarceration]			
Type Of Accommodation	**Name/Location**	**Dates**	**Reason For Leaving**

Recommended Management Plan:

_____

_____

_____

_____

October 4, 2006
/jjo

Medication Record

Applicant's Name: _____ **Date**: _____

Current Medication	Dosage/ Frequency	Date Started	Date Reviewed	Reported/ Observed Side Effects

***** Please complete and return with application package.*****

Psychiatric History Record

Applicant's Name: _____ **Date**: _____

Date of Last Psychiatric Assessment: _____

Psychiatric Assessment Completed by: _____

Signs and Symptoms of Decompensation: _____

_____

_____

Name of Facility	Admission Date	Discharge Date	Diagnosis	Residence on Discharge	Follow-up

***** Please complete and return with application package.*****

Ontario

Ministry of Health
and Long-Term Care

Financial Responsibility Acknowledgement for Residents of Homes for Special Care

In return for admission into a Home for Special Care as a resident the undersigned agrees and accepts to the following:

Resident and/or Lawful Substitute Decision Maker Liability

A resident of a Home for Special Care who is eighteen (18) years of age or older and who has assets or a resident's lawful substitute decision maker, is liable for payments made by the Ministry of Health on his or her behalf.

Where a resident in a Home for Special Care is unable to pay for his or her care and maintenance, the Minister of Health may pay to a licensee of a Homes for Special Care an amount for care and maintenance in accordance with Part IX of Regulation 636 of the *Homes for Special Care Act.*

In addition to the said care and maintenance payment the Minister may pay for any medical care, clothing, toiletries or other personal necessities required by and supplied to a resident of Home for Special Care. The Ministry of Health reserves the right to determine the amounts, the personal items, and manner of such payments.

Any monies so paid will be applied to a resident's account by the Ministry of Health and recovered under the authority of Part IX of Regulation 636 of the *Homes for Special Care Act.*

The amounts recovered by the Ministry of Health will be reduced by a resident's entitlement under the *Family Benefits Act* and the *Health Insurance Act.*

The resident, the resident's spouse or a resident's lawful substitute decision maker accepts full responsibility for payment of expenses associated with residency in a Home for Special Care upon receipt of the account statement(s) from the Ministry of Health.

Liability and Indemnification

The Crown in right of Ontario will not be liable for any claim, damages or otherwise to the resident or a resident's lawful substitute decision maker arising from or connected with this financial responsibility acknowledgement form.

The resident and/or a resident's lawful substitute decision maker, will during and following this acknowledgement form, indemnify and save harmless the Crown in right of Ontario from and against all costs, looses, damages, judgements, claims, demands, suits, actions, complaints or other proceedings in any manner based uon, occasioned by or attributable to anything done or omitted to be done by the resident, the resident's spouse or the resident's lawful substitute decision maker in connection with services provided by a Home for Special Care, purported to be provided or required to be provided by the Home for Special Care.

Term

This acknowledgement form will be in force while the resident is a resident in a Home for Special Care. The ministry reserves the right to pursue recoveries from the resident, resident's spouse or the resident's lawful substitute decision maker while the resident is a resident in a Home for Special Care and after a resident is discharged from a Home for Special Care.

Freedom of Information

Any information collected by the Ministry of Health under this financial responsibility acknowledgement form is subject to the provisions of the *Freedom of Information and Protection of Personal Privacy Act* R.S.O. 1990, C.F. 31.

Collection of the information on this form is necessary for the proper administration of authorized activity payment and recovery of recoverable amounts under the *Homes for Special Care Act.* For information about the payment and collection process contact the Manager of Supply and Financial Services Branch, 5700 Yonge Street, 10th Floor, Toronto ON M2M 4K5, Telephone (416) 327–7972.

In Witness Whereof this acknowledgement form has been signed by the resident, the resident's spouse and/or the resident's lawful substitute decision maker.

Date			Date		
Name of resident			Name of spouse		
Signature of resident			Signature of spouse		
Home address			Home address		
City / Town	Province	Postal code	City / Town	Province	Postal code
Date			Date		
Name of Lawful Substitute Decision Maker			Name of Witness		
Signature of Lawful Substitute Decision Maker			Signature of Witness		
Home address			Home address		
City / Town	Province	Postal code	City / Town	Province	Postal code

Ontario **Ministry of Health and Long-Term Care**

Confidential

Financial Status

Homes for Special Care

Instructions: To be completed by an individual who is applying for admission to a Home for Special Care and/or and individual's lawful substitute decision maker.

The Ministry of Health and Long-Term Care reserves the right to pursue recoveries from a client of a Home for Special Care and/or the client's lawful substitute decision maker while a client is in the Homes for Special Care Program after a client is discharged from a Home for Special Care. **Recoveries** are in accordance with the *Homes for Special Care Act.*

Client name	Social insurance number	Date of birth *yyyy/mm/dd*

Income	$ Monthly	$ Annually
Family Benefits (ODSP)		
Ontario Works		
Net wages and salaries and tips		
Gross revenue from self-employment		
Investment-interest revenue		
Disability pension		
Retirement pension		
Workers compensation pension		
Unemployment insurance		
Alimony - support		
Insurance lump sum and periodic payments		
Income tax or pension plan refund		
Capital Gains		
Receipts from Sale of Assets		
Inheritances and Bequests		
Spouse's income, *net*		
Rental income		
Other, *specify*		
Total income	$	$

Assets	
Bank deposits, *specify:*	$
Term deposits, *specify:*	
Land - actual value	
- equity	
House - actual value	
- equity	
Car/truck - actual value	
Stocks - bonds	
Registered retirement savings plan	
Other, *specify:*	
Total income	$

If you are not eligible for social assistance, please complete the following:

A monthly payment of $ _____ . _____ towards expenses associated with residency in a Home for Special Care will be paid upon receipt of the account statements from the Ministry of Health and Long-Term Care and the undersigned acknowledge that this is subject to review annually or as may be determined by the Ministry of Health and Long-Term Care.

- The documentation to support the figures provided on this form may be required.
- All information provided is subject to verification.

The undersigned individual who is the subject of this application for admission to a Home for Special Care and/or the individual's spouse *where the spouse has joined in this consent* or the individual's lawful substitute decision maker consent to the release of information relating to any bank account, safety deposit box assets, assets of any nature or kind whatsoever held by the individual who is the subject of this application for admission to a Home for Special Care or on this individual's behalf or by or on behalf of this individual's spouse *where the spouse has joined in this consent.*

The undersigned further consent to an authorized representative of the Minsitry of Community and Social Services, disclosing to the Ministry of Health and Long-Term Care's Homes for Special Care Porgram personal information about me, my spouse *where my spouse has joined in this consent* for the purpose of verifying the initial or ongoing elegibility for social assistance of the individual who is the subject of this application for admission to a Home for Special Care.

Freedom of Information and Protection of Privacy

Personal information collected in this form is necessary for the proper administration of the Homes for Special Care Act, R.S.O. 1990, c.H.12 and Regulation 636 R.R.O. 1990 as amended. The principal purpose of the collection is to assist with assessment, treatment and program planning for the resident.

For information about this collection, please contact the Homes for Special Care Regional Officer through the Regional Offices – Hospitals, Long-Term Care and Mental Health Services:

For **Central East, Central West and Toronto** contact:
Central East office
465 Davis Drive
Newmarket ON L3Y 8T2
Telephone: 905 954-4690

for **South West, Central South and Central West** contact:
South West office
231 Dundas Street
London ON N6A 1H1
Telephone: 519 675-7680

for **North and East regions** contact:
North office
159 Cedar Street
Sudbury ON P3E 6A5
Telephopne: 705 564-3130.

Date *yyyy/mm/dd*	Signature of **client**	Telephone ( )
Home address *number, street name*	City / Town	Province / postal code
Date *yyyy/mm/dd*	Signature of **spouse**	Telephone ( )
Home address *number, street name*	City / Town	Province / postal code
Date *yyyy/mm/dd*	Signature of **Lawful Substitute Decision Maker**	Telephone ( )
Home address *number, street name*	City / Town	Province / postal code
Date *yyyy/mm/dd*	Signature of **witness**	Telephone ( )
Home address: *number, street name*	City / Town	Province / postal code

Whitby | Mental Health Centre

Consent to the Disclosure of Personal Health Information

I, _____
(print full name of person or Substitute Decision-Maker)

of _____
(address)

hereby authorize _____
(print name of person / facility releasing information)

to disclose personal health information of _____ _____
(name of patient) (date of birth)

to _____
(print name of person / facility requesting information)

of _____
(address)

Specify information to be released ☐ verbally ☐ copies of record of personal health information

_____

_____

_____

_____

_____

_____

I understand the purpose for disclosing the personal health information to the person / facility noted above.

_____ _____
(print name of witness) (signature of patient / Substitute Decision-Maker)

_____ _____
(signature of witness) (if other than the patient, state relationship to the patient)

_____
Date (year / month / day)

For an active patient / client, this consent will remain in effect until discharge from facility or at the conclusion of outpatient / community treatment or for one year, whichever is the shortest period of time.

I understand that I may withdraw this consent at any time by contacting a member of my treatment team or Clinical Information Services.

This consent will become null and void if I become incapable of consenting to the disclosure of personal health information.