B·E·T·H·A·N·Y
RESIDENCE
Creative Community Care

Application/Intake Package Checklist

NAME: _____

	Page No.	Completed			Date Completed	Alternative Arrangements
Application for Residence and Care	1-5	Y	N	NA		
TB testing form	6	Y	N	NA		
Consent to disclose Health Information	7	Y	N	NA		
Consent to disclose ODSP, OW	8	Y	N	NA		
Red Cross Transportation info	9	Y	N	NA		
Additonal Health information, inc.		Y	N	NA		
Additonal Health information, inc.		Y	N	NA		
Additonal Health information, inc.		Y	N	NA		
Financial/Subsidy Forms	12-14	Y	N	NA		
Consent to disclose Halton Region	15	Y	N	NA		
Additional Financial information:		Y	N	NA		
Personal ID: SIN, Birth Cert., Immigration		Y	N	NA		
Proof of Income:		Y	N	NA		
Bank Statements 1 year		Y	N	NA		
Income Tax Assessment: Most recent		Y	N	NA		
Other relevant financial info:		Y	N	NA		
Tour of Bethany		Y	N	NA		
Meet with Care Team		Y	N	NA		
Residency Acceptance		Y	N	NA		
Financial Info sent to Halton Region		Y	N	NA		
VI SPDAT Completed by Halton Region						
Contact: Jennifer Rashford		Y	N	NA		
905-825-6000 x 2774						

2387 Industrial Street, Burlington, Ontario L7P 3A1 (905) 335-3463
www.bethanyresidence.ca Fax: 335-1202
info@bethanyresidence.ca

2387 Industrial Street,
Burlington, Ontario
L7P 3A1

Phone: 905-335-3463
Fax: 905-335-1202
Contact: Patti MacIntyre
Director of Care

APPLICATION FOR RESIDENCE & CARE

Date: _____ Male/Female

Name of Applicant:_____

Present Address:_____

Phone Number:_____ How long at above address:_____

Date of Birth:_____ Health Card No._____
Place of Birth:_____ Citizenship:_____
Immigrant Status:_____

S.I.N._____ Marital Status: S M Sep. Div. Widowed

Apply for subsidy: YES/NO

.....

Diagnosis:_____

Referral Source:_____ Phone No._____

Family Doctor:_____ Phone No._____
Psychiatrist:_____ Phone No._____
Eye Doctor: _____ Phone No._____
Dentist:_____ Phone No._____

.....

GUARDIAN/FAMILY INFORMATION

Next of Kin:_____ Phone No._____
Relationship:_____
Address:_____
E-Mail address; _____
Other Relative:_____ Phone No._____
Relationship:_____
Address:_____
E-Mail Address: _____

Privacy Policy Available Upon Request. Consent to disclose personal health information must be completed **See Page 7.**

Total number of pages enclosed 21

FUNCTIONAL ASSESSMENT
(MUST BE COMPLETED IN FULL)

AMBULATION	Fully Ambulatory On Level_____ On Stairs_____ Wanders_____	Indep. with Cane Walker	Wheelchair Indep.____ Ass't_____	Needs Assistance With_____ _____	Comments
TRANFER	Needs No Assistance	Supervision E.G. Bed to Chair	Assistance Lifting	Bedridden	
BLADDER	Resp. for Self	Rare Incontinence	Occasional Incontinence	Totally Incontinent	
BOWEL	Resp. for Self	Rare Incontinence	Occasional Incontinence	Totally Incontinent	
OSTOMY	No Ostomy	Resp. for Self	Minor Ass't.	Total Care	
ABILITY TO EAT	Without Ass't.	Minor Ass't	Considerable Ass't.	Total Care	
	DIFFICULTY CHEWING.....DIFFICULTY SWALLOWING.....				
ABILITY TO DRESS	Dresses Self	Supervision Only	Ass't. Co-operates	Un-Cooperative	
ABILITY TO BATHE	Without Ass't.	Supervision Only	Ass't. Co-operates	Un-Cooperative	

ASSISTANCE AT NIGHT? YES/NO.....

MENTAL FUNCTION:

MANAGE OWN DAILY AFFAIRS	Capable	Needs Guidance	Minor affairs only	Unable to Comprehend
MEDICATION	Will comply	Needs encouragement	May not comply	Uncooperative
IS APPLICANT	DEPRESSED	ANXIOUS		

ANY BEHAVIOURAL PROBLEMS?.....

VISION	Good	Wears Glasses	Adequate	Impaired
HEARING	Good	Wears Aids	Adequate	Impaired
SPEECH	Good	Adequate	Impaired	First Language _____
SELF-EXPESS (GESTURES ETC)	Good	Adequate	Impaired	

DOES APPLICANT SMOKE? YES/NO SUPERVISED/UNSUPERVISED

DOES APPLICANT USE ALCOHOL? RESTRICTED/UNRESTRICTED

.....
.....

Prior to admission a TB Mantoux (two step) screening is required. Obtain signed Doctors/Nurse note that the screening has occurred and is negative. See attached Doctors/Nurse Note to be signed on Page 8.

PSYCHIATRIC ASSESSMENT
(MUST BE COMPLETED IN FULL)

1) Primary Diagnosis:_____ Secondary Diagnosis:_____

2) Date of Onset of Illness:_____

3) Client behaviour prior to/during illness:

Interventions:

4) Past Psychiatric hospitalizations:

.....
Does the applicant have any of the following problems which may affect participation at Bethany?

a) Hallucinations? YES/NO If YES, visual / auditory

b) Delusions? YES/NO

c) Difficulty Sleeping? YES/NO Nightmares? YES/NO

d) Difficulty coping/communicating within a group setting? YES/NO

e) Fire Setting or Careless Smoking? YES/NO

f) Conflict with the Law? YES/NO TYPE: PAROLE/PROBATION
Probation Officer Name:_____ Phone No._____

e) Any unusual behaviour (fear, screaming, etc.)? YES/NO
If YES, please describe:

.....
Does Applicant have a history of acting-out and or inappropriate behaviour?

	Pattern	Frequency	Severity

Verbally aggressive: Y / N / SELF / OTHERS

Physically aggressive: Y / N / SELF / OTHERS

Suicide/Self Harm: Y / N / SELF / OTHERS

Sexual: Y / N / SELF / OTHERS

Allergies: (Medication and Dietary) _____

List Current Medications: Dosage: Frequency:

Consultation/Discharge Summary Yes/No

.....

Power of Attorney for Care: (Obtain copy of form)

Name_____ Phone No._____

Address:_____

List Any Specific Arrangements eg, Heroics (Obtain copy of arrangements)

.....

Lifestyle History:

Living situation prior to Admission or Hospitalization:

Living Alone: Y/N if yes, lived with whom?_____

Who will resident call in times of need?_____

Will Resident have overnight or other outside stays away from Bethany? Y/N

Whose permission will be needed?_____

.....

ANY OTHER NOTES RE: BEHAVIOUR/DIETARY/MEDICATION

LIFE HISTORY

Name:_____

Religious Affiliation:_____

Education:_____

Past Occupation:_____ Previous Occupation:_____

CURRENT INTERESTS/HOBBIES

Group Interests

- ❑ Cards
- ❑ Dancing
- ❑ Aromatherapy
- ❑ Discussion group
- ❑ Baking
- ❑ Exercise
- ❑ Bingo
- ❑ Religious study
- ❑ Other _____
  _____

Arts and Crafts

- ❑ Crafts
- ❑ Sewing
- ❑ Drawing
- ❑ Kinitting/Crochet
- ❑ Woodworking
- ❑ Painting
- ❑ Latchwork
- ❑ Weaving
- ❑ Other

Outdoor Activities

- ❑ Walking
- ❑ Shopping trips
- ❑ Bus trips
- ❑ Gardening
- ❑ Socials
- ❑ Picnics
- ❑ House of Worship
- ❑ Other _____
  _____

Reading/Music/Television

- ❑ Singing songs
- ❑ Books
- ❑ Watching television
- ❑ Listening to music
  Type of music_____
- ❑ Newpapers/magazines
- ❑ Likes the library
- ❑ Other

Bethany Residence

Client Name: _____

Date of final T.B. Mantoux test: _____

Where Administered: _____

Address: _____

Results, Please circle below:

Negative **Positive**

Doctor/Nurse signature: _____

Name, please print: _____

Date: _____

Consent to Disclose Personal Health Information
Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I, _____, authorize_____
(Print your name) *(Print name of health information custodian)*

to disclose

☐ **my personal health information consisting of:**
Completion of Bethany Residence Application for Residence and Care attached
And:_____

_____
(Describe the personal health information to be disclosed)

or

☐ **the personal health information of** _____
(Name of person for whom you are the substitute decision-maker)*

consisting of:_ Completion of Bethany Residence Application for Residence and Care attached
And: _____

_____
(Describe the personal health information to be disclosed)

to: **Bethany Residence, 2387 Industrial Street, Burlington, Ontario**
_____
(Print name and address of person requiring the information)

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

My Name:_____ Address:_____

Home Tel.:_____ Work Tel.: _____

Signature:_____Date:_____

Witness Name:_____Address:_____

Home Tel.:_____ Work Tel.:_____ _____

Signature:_____Date:_____

***Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**

Bethany Residence
2387 Industrial Street
Burlington, Ontario
L7P 3A1

Consent to Obtain Information

I _____Date of Birth_____ consent to the release to

Bethany Residence Staff any information regarding my eligibility/income with

Ontario Disability Support Program or Ontario Works Program.

Dated at _____this_____day of _____2013.

_____ _____
Signature of Witness Signature of applicant/Trustee

BETHANY RESIDENCE

RED CROSS

MEDICAL TRANSPORTATION INVOICING

RESIDENT NAME: _____

RESPONSIBLE PARTY NAME:_____

BILLING ADDRESS: _____

_____

POSTAL CODE: _____

HOME PHONE: _____

OFFICE PHONE: _____

CELL PHONE: _____

1,_____ give permission for the above
(Responsible Party)

information to be shared with the Red Cross for their medical transportation invoicing.

Housing with Related Supports
Application Form - Subsidy

Social & Community Services - Housing Services Division
690 Dorval Drive 7th Floor, Oakville ON L6K 3X9
Telephone: 905-825-6000 Fax: 905-825-8274

Program Overview:

Halton Region has service agreements with 3 Housing with Related Supports Housing Providers who provide residential care on a long-term basis, including board and lodging, to:

- People who are living with severe and chronic mental illness and/or cognitive difficulties/impairments
- Seniors who are frail and not eligible for Long-Term Care
- People with developmental disabilities

These homes provide 24-hour supervision and supports to vulnerable adults who require some assistance with daily living activities.

Services include: furnished rooms, medication management, meals, 24-hour urgent response, housekeeping and laundry services as well as social or recreational activities.

A subsidy is also offered by Halton Region to qualified applicants. Private pay beds may also be available.

How to Apply:

To apply for subsidized housing with a HWRS provider, please complete Sections 1-5 below and return to:

Housing with Related Supports Program
Housing Services Division
Region of Halton
690 Dorval Drive, 7th Floor
Oakville, ON L6K 3X9

HWRS providers in Halton Region

Bethany Residence, Burlington 2387 Industrial Street, Burlington, Ontario, L7P 3A1 130 Bed capacity	Millhouse Resthome, Acton 2 locations 34 Mill St., West Acton, Ontario L7J 1G4 (12 bed capacity – all male) & 14022 Third Line Halton Hills, Ontario L7J 2M1 (10 bed capacity)	Parkside Resthome, Acton 58 Main St N Acton, ON L7J 1W2 24 bed capacity

Before you Apply – Information you need to gather:	
Document Checklist	Example
Proof of Status in Canada	• Canadian Birth Certificate • Passport • Permanent resident card and documentation showing date and place of landing
Proof of identity	• Social Insurance Number
Proof of Assets	• Bank account information (bank statements, bank book) • Investment statements (RRSPs, GICs, RRIFs, etc.) • Pre-paid funeral or life insurance policies • Vehicle ownership • Property you own • Any other asset
Proof of Income	Statements from: • Ontario Disability Support Plan • Ontario Works • Old Age Security • Guaranteed Income Supplement or Guaranteed Annual Income System • Canada or Quebec Pension Plan • Employment pay stubs (8-12 weeks) • Employment insurance • Workplace Safety and Insurance Board • Other pensions, private or foreign • Support payments • Income Tax forms – Notice of Assessment • Any other type of income
Power of Attorney or Guardianship documentation	• Documentation to verify Power of Attorney or Guardianship arrangements

Section 1: Personal Information		
First Name:	Last Name:	Date of Birth (DD/MM/YY)
Social Insurance Number (SIN)	I identify my gender as… ☐Male ☐Female ☐_____ (fill in the blank)	
Current Address: Apt/unit number:	City/Town, Province, Postal Code	Do you? ☐Own ☐Rent ☐Other, specify _____
Home Phone Number:	Cell Number:	E-mail address:
Language spoken:	Do you require an interpreter or translator? ☐Yes ☐No If Yes, please specify language:	Status in Canada ☐Canadian Citizen ☐Permanent Resident ☐Refugee/Refugee Claimant ☐Sponsored Immigrant
Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Common-Law ☐Widowed		

Section 2: Next of Kin or Emergency Contact Information	
First Name:	Last Name:
Mailing Address: Apt/unit number:	City/Town, Province, Postal Code
Phone Number:	Relation to you:

Section 3: Do you have a Power of Attorney/Guardian or Responsible Party?

First Name:	Last Name:
Mailing Address:	City/Town, Province, Postal Code
Phone Number:	Relation to you:

Section 4a: Income

Select the following income sources that are applicable to you and provide proof of the income.

Income Source	Monthly Gross Income	Attach as Proof
☐ **Ontario Works (OW)**	$	Statement of Assistance OR a letter from your caseworker confirming benefits received
☐ **Ontario Disability Support Plan (ODSP)**	$	Statement of Assistance OR a letter from your caseworker confirming benefits received
☐ **Employment earnings**	Name of Employer: Gross Monthly Income:	8 weeks of pay stubs OR a letter from the employer confirming gross income.
☐ **Old Age Security (OAS)**	$	Letter from source (i.e. Service Canada) OR Bank statements AND applicable T4 slips from the most recent income tax return
☐ **Guaranteed Income Supplement (GIS)**	$	
☐ **Guaranteed Annual Income (GAINS)**	$	
☐ **Canada Pension Plan (CPP)**	$	
☐ **CPP – Disability**	$	
☐ **WSIB**	$	
☐ **Employment Insurance (EI)**	$	
☐ **Other Income** (e.g. sponsorship, private or foreign pensions etc.)	Source: $	
☐ **Notice of Assessment** (most recent)	Must include a copy of your most recent Notice of Assessment from Revenue Canada	
Total Income	$	

Section 4b: Assets

Select the following that are applicable to you and provide proof of the asset

Assets:	Value/Balance:	Asset Owner:
☐ Bank Account	$	☐ Applicant ☐ Spouse/common-law ☐ Other, specify _____
☐ Bank Account	$	☐ Applicant ☐ Spouse/common-law ☐ Other, specify _____
☐ Bank Account	$	☐ Applicant ☐ Spouse/common-law ☐ Other, specify _____
☐ Investments (example: stocks, bonds, GIC, RRSP, mutual funds, RRIF)	$	☐ Applicant ☐ Spouse/common-law ☐ Other, specify _____
☐ Investments (example: stocks, bonds, GIC, RRSP, mutual funds, RRIF)	$	☐ Applicant ☐ Spouse/common-law ☐ Other, specify _____
☐ Vehicle	$	☐ Applicant ☐ Spouse/common-law ☐ Other, specify _____
☐ Pre-paid Funeral	$	☐ Applicant ☐ Spouse/common-law ☐ Other, specify _____
☐ Property	$	☐ Applicant ☐ Spouse/common-law ☐ Other, specify _____
☐ Life Insurance Policy	$	☐ Applicant ☐ Spouse/common-law ☐ Other, specify _____
☐ Trust Account	$	☐ Applicant ☐ Spouse/common-law ☐ Other, specify _____
☐ Other, specify	$	☐ Applicant ☐ Spouse/common-law ☐ Other, specify _____
☐ Other, specify	$	☐ Applicant ☐ Spouse/common-law ☐ Other, specify _____
☐ Other, specify	$	☐ Applicant ☐ Spouse/common-law ☐ Other, specify _____
Total Assets	**$**	

Section 5: Consent

- I, (applicant name) _____ consent to the collection and release of applicant information about me as it is collected on this form to an authorized representative of the Region of Halton and the Housing with Related Supports provider for the sole purpose of determining or verifying my eligibility for the Housing with Related Supports program.
- I understand that Halton Region and the Housing with Related Supports provider may use the information in this application to determine my eligibility for a subsidy.
- I consent to the collection of any information by Halton Region relating to household finances and assets from any financial institution or corporation regarding any bank accounts, safety deposit boxes, and assets of any kind held by me or on my behalf.
- I declare that everything I have written in this document is true and that no information that is required to be given has been withheld or omitted.

Signature of Applicant: _____

Witness: _____

Date: _____