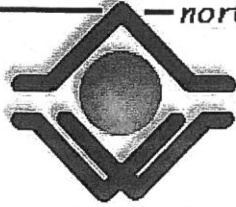


ADMISSION/SERVICE INITIATION – R-I-2

POLICY:

Consideration for filling any residential vacancy will be determined by OPTIONS' ability to meet the needs of the individuals being considered within the current resources available, as well as their compatibility with other people being supported in the area with the vacancy.

The candidate must be a least 18 years of age at the time of admission, and have a primary diagnosis of developmental disability. Exceptions to this will be the decision of the Executive Director. Admission shall not be denied on the basis of race, religion, ethnic origin, sex or handicap except in extenuating circumstances i.e. the vacancy is at a male only or female only location.

All admissions to a residential setting, purchased services, and respite placements, will be initiated through an identified coordinated process.

The successful candidate and their family members will receive an orientation to the organization, will participate in developing his or her support plan and will be encouraged to give direction regarding the required supports.

PURPOSE:

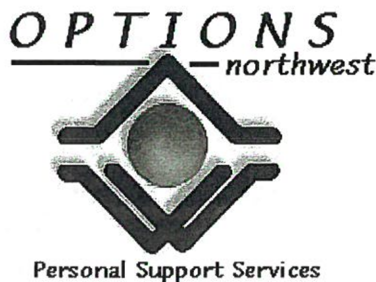
1. To ensure a smooth transition for the recipient of service and their family/chosen advocate.

2. To ensure all required information is available prior to admission.

3. To provide a complete and comprehensive profile to staff who will be supporting the individual.

4. To ensure everyone involved with the individual is notified of their move.

5. To comply with Ministry of Community and Social Services Legislation, Regulation 229/10.



PROCEDURE:

NOTE: Two Admission packages with appendices are referred to in this policy – one for Group Living/Respite and one for Purchase Services. These packages/forms are available at the Administrative Office in the Reception area.

A) Admission for Group Living/Respite:

Supervisor's Responsibilities:

1. Notify Developmental Services Ontario (DSO) of the expected date of admission once an individual accepts a vacancy/group living resource.

2. Provide the individual/person acting on their behalf with the following forms:
   a) Applicant Contact Information Form (see Appendix A)
   b) Personal History form (see Appendix B).
   c) Admission Medical Examination Form (see Appendix C)
   d) Admission Dental Examination Form (see Appendix D)

N.B. - All individuals accepting a residential vacancy are required to have a Medical/Dental Examination within six months prior to their admission. Exceptional circumstances will be considered at the time of admission.

3. Completed forms once obtained will be submitted to the Director of Finance who will initiate a personal binder for the new recipient of service.

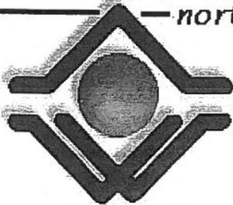
4. Obtain all medication and treatment prescriptions from the individual's physician and submit to the pharmacy.

5. Establish timeframes for day visits and possible overnight visits depending on the needs of the individual.

6. If the admission is in a home owned by Independence Plus Housing Corporation ensure an application form is completed (see Appendix E).

7. Assign a Primary Counsellor and a Secondary Counsellor to coordinate all supports and services for the new Recipient of Service.

8. Obtain the individual's Health Card, Immunization Record, ODSP Dental and Drug Cards and, if in place, a copy of a Power of Attorney for Personal Care and Finances.



9. The Supervisor, and Primary and/or Secondary Counsellor will schedule a meeting with the individual and their family member(s) to complete the Orientation Checklist for New Recipients of Service (see Appendix F). The information will be reviewed with the individual in a manner and language they can understand with their family member/advocate present as they choose. All information discussed in this meeting will be found in the Recipient's Orientation Handbook which will be distributed for future reference. Place all documents in the appropriate location in the individual's personal binder. The following forms will be reviewed completed and signed as required:
   a) OPTIONS Service Agreement (see Appendix G)
   b) Financial Support Plan (see Appendix H)
   c) Authorization to Collect/Disclose Personal Information form (see Appendix I)
   d) OPTIONS northwest Feedback Outline (see Appendix J)
   e) Medical Visit Record (see Appendix K)
   e) Natural Support Network-Individual's Questionnaire (see Appendix L)
   f) Natural Support Network Plan-Family and Friends Questionnaire (see Appendix M)
   g) Feedback on Orientation Process form (see Appendix N)

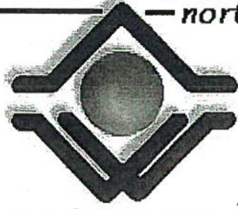
10. Ensure the appropriate referrals have been completed and submitted as required. (i.e. referral to CRT for O.T. assessment-if this is a recipient of service new to CRT the referral will need to be submitted to DSO).

11. Initiate petty cash for the individual.

12. Identify furniture and personal needs required with the individual.

13. Establish a date of admission and make the following notifications as required:
   a) The Executive Director, Director of Personal Support Services, Director of Finance and Administration, and Director of Human Resources
   b) Director of Clinical Services if CRT is involved
   c) The Public Guardian and Trustee for Financial and Treatment Decisions.
   d) Independence Plus Housing Corporation if the admission is in a home they own.
   e) Pharmacy
   f) ODSP, Revenue Canada, Physician, Dentist, V.O.N., Hagi, and have address changed on Health Card

14. Ensure all equipment needs are in place and arrange for staff training as required.



Primary/Secondary Counsellor Responsibilities:

1. The Primary/Secondary Counsellor will complete the following:
   a) Individual Support Plan using information from the Personal History form and all other relevant documentation (see policy Individual Support Plan R-I-6).
   b) Personal/Medical Data Form (see Appendix O)
   c) Recipient's Valuables List (see Appendix P)
   d) Medication and Treatment Purpose Form (see Appendix Q)
   e) Health Appointment Record/Log (see Appendix R)
   f) Take a picture of the individual and place it in their section of the Medication Record Book and in their Individual Support Plan binder.
   g) Determine mode of transportation the individual will use and ensure the appropriate forms are completed and submitted i.e. Hagi-complete application form
   h) Ensure community programs continue by making necessary arrangements.
   i) Complete baseline vital signs and weight and record them on the Personal/Medical Data form.
   j) Determine and document if the individual's Power of Attorney for personal care/family member would like to receive the monthly summary update.

2. The team will continue to monitor and review the admission and within six months the Primary/Secondary Counsellor will coordinate a planning meeting according to Annual Support Planning Policy R-I-5.

B) Purchased Services:

1. Requests for purchased services will be processed on an individual basis as requested by the individual, and/or the person or agency acting on their behalf.

2. A meeting will be scheduled with the person requesting service to complete the Purchased Service Orientation Checklist (see Appendix S) and, if the Recipient is new to the agency, a Purchased Service Contact Information form (see Appendix T) will be forwarded for completion prior to the initiation of service. Information will be discussed with the individual in a manner and language they can understand.

3 2. The nature of the supports and services requested will be determined at this meeting. A Support Service Plan (see Appendix U) indicating the required supports, a Memorandum of Understanding (see Appendix V), and an OPTIONS Purchased Service Agreement (see Appendix W) will be completed, signed and forwarded to the Director of Finance and Administration.

4. A Personnel Allocation Request (see Appendix X) form will be submitted to Human Resources, along with a copy of the Support Service Plan, to assist with the appropriate recruitment and selection process. The individual and their family member will participate in the interview and hiring process if desired.

5. The successful candidate(s) will meet with the individual and/or their family member to review the requirements of the agreement.

RECOMMENDED BY: Director, Personal Support Services **APPENDICES:** 24

OPERATIONAL ACCOUNTABILITY: Administration, Human Resources, Finance and Administration, Personal Support Services Administration, Personal Support Services

ORIGINAL POLICY DATE: March 2006

AUTHORIZED BY: Director, Personal Support Services

SIGNATURE: ______________________

- OPTIONS northwest -
APPLICANT CONTACT INFORMATION

ADMISSION ☐ **DISCHARGE** ☐ **TRANSFER** ☐

PERSONAL INFORMATION

SURNAME: ______________________ GIVEN NAMES: ______________________

DOB: ______________________ HEALTH CARD #: ______________________

RELIGION: ______________________

RELIGIOUS PRACTICES: ______________________

BAND #: ______________________ STATUS #: ______________________

CONTACT INFORMATION

PRIMARY CONTACT:

NAME: ______________________ RELATIONSHIP: ______________________

ADDRESS: ______________________

____

____

TELEPHONE: HOME: ____________ WORK: ____________ CELL: ____________

IL ADDRESS: ______________________

SECONDARY CONTACT:

NAME: ______________________ RELATIONSHIP: ______________________

ADDRESS: ______________________

____

____

TELEPHONE: HOME: ____________ WORK: ____________ CELL: ____________

EMAIL ADDRESS: ______________________

THIRD CONTACT:

NAME: ______________________ RELATIONSHIP: ______________________

ADDRESS: ______________________

____

____

TELEPHONE: HOME: ____________ WORK: ____________ CELL: ____________

IL ADDRESS: ______________________

CONSENT INFORMATION

Is the applicant capable of giving informed consent for Medical Treatment: YES: ☐ NO: ☐

Is there a Legal Power of Attorney for Personal Care: YES: ☐ NO: ☐

IF YES: Provide a copy Attached ☐ Pending ☐

IF NO: Name and Address of person(s) who give Medical Consent on behalf of the applicant:

	NAME	ADDRESS	RELATIONSHIP	PHONE #
FIRST PERSON				
SECOND PERSON				
THIRD PERSON				

Is the applicant capable of making financial decisions: YES: ☐ NO: ☐

Is there a Legal Power of Attorney for Property: YES: ☐ NO: ☐

IF YES: Provide a copy Attached: ☐ Pending: ☐

IF NO: Name and address of person(s) who will make financial decisions.

	NAME	ADDRESS	RELATIONSHIP	PHONE #
FIRST PERSON				
SECOND PERSON				
THIRD PERSON				

PERSONAL FINANCE INFORMATION

WHO IS RESPONSIBLE FOR PERSONAL FINANCES: ______________________________
(Cannot be OPTIONS northwest)

BANKING INFORMATION (IF REQUIRED TO SUPPORT INDIVIDUAL): ______________________________

SOURCES OF INCOME: (Check all that apply)

O.D.S.P.: ☐ Insurance: ☐ ADP: ☐ Incontinence Grant: ☐

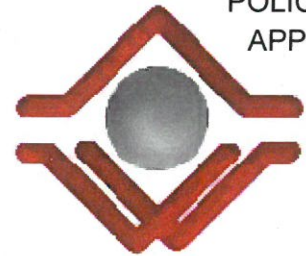
OTHER INFORMATION: (i.e. Any other funding programs applicable) ______________________________

____

____

OPTIONS northwest

Personal Support Services



PERSONAL HISTORY

☐Transfer ☐ Admission ☐ Discharge

PERSONAL INFORMATION

Name:			
Telephone:	Home:	Health Card #:	
	Cell:	Date of Birth:	/ /
Address:		S.I.N.:	

FAMILY INFORMATION

IMMEDIATE FAMILY

MOTHER: ____________________ FATHER: ____________________

FOSTER/STEP MOTHER: ____________________

FOSTER/STEP FATHER: ____________________

BROTHERS: ____________________ SISTERS: ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

GRANDMOTHERS: ____________________ GRANDFATHERS: ____________________

____________________ ____________________

Do any family members not have visitation/custody rights? ☐ YES ☐ NO

NAME(S):

____

____

EXTENDED FAMILY AND CLOSE PERSONAL FRIENDS

The applicant has close relationships with the following people (Family and/or Friends). Please list the names, relationships, addresses and phone numbers and a brief description of the nature of the relationship.

NAME	RELATIONSHIP	ADDRESS	PHONE #	NATURE OF RELATIONSHIP

MEDICAL INFORMATION

A Complete medical/physical is required prior to admission/discharge. The individual's Family Physician is to complete an Admission/Discharge Medical Examination Form.

FAMILY PHYSICIAN: ______________________________

ADDRESS: ______________________________

____

____

PHONE #: ______________________________

Medical Exam Form Completed and Returned: ☐ YES, DATE______________ ☐NO

Medical Exam Appointment Booked: ☐ YES, DATE______________ ☐NO

ALLERGIES

'TEM ALLERGIC TO	USUAL REACTION	USUAL CORRECTIVE ACTION

Height: ______________ Weight: __________________

IMMUNIZATION RECORD REQUIRED: Provided ☐ Date: ______________

To Be Obtained ☐ Must Be Provided By: ______________

RECORD OF CURRENT MEDICATIONS

DRUG NAME	DOSAGE	TIMES ADMINISTERED	USE/PURPOSE OF MEDICATION

SELF ADMINISTERED: ☐ YES ☐ NO

COMMENTS/SUGGESTIONS FOR ADMINISTERING MEDICATIONS

____

____

____

PAST MEDICAL HISTORY

Hospital Admissions/Surgeries/Illnesses (Include dates if known):

CONSULTANT: ____________ SPECIALTY: ____________

ADDRESS: ____________ TELEPHONE: ____________

____________ LAST APPOINTMENT: ____________

REASON FOR CONSULT: ____________

CONSULTANT: ____________ SPECIALTY: ____________

ADDRESS: ____________ TELEPHONE: ____________

____________ LAST APPOINTMENT: ____________

REASON FOR CONSULT: ____________

CONSULTANT: ____________ SPECIALTY: ____________

ADDRESS: ____________ TELEPHONE: ____________

____________ LAST APPOINTMENT: ____________

REASON FOR CONSULT: ____________

DENTIST INFORMATION

DENTIST: ______________________________

ADDRESS: ______________________________ TELEPHONE: ___________________________

______________________________________ LAST APPOINTMENT: ____________________

COMMENTS/CONCERNS AND SUGGESTIONS WHEN DOING DENTAL CARE:

____

____

____

____

NOTE: All new admissions/discharges are to have had a dental exam at least six (6) months prior to their admission/discharge. The Family Dentist is to complete an Admission/Discharge Dental Examination Form.

Dental Exam Form Completed and Returned: ☐ YES, DATE: _______________ ☐ NO

Dental Exam Appointment Booked: ☐ YES, DATE: _______________ ☐ NO

SUPPORT REQUIRED BY APPLICANT

Bathing:

Independent: ☐ Requires Assistance: ☐

Comments/Suggestions/Support Required:

____

____

____

____

Feminine Hygiene:

Independent: ☐ Requires Assistance: ☐ Last Menstrual Period: ______________________

Comments/Suggestions/Support Required:

Eating:

Independent: ☐ Requires Assistance: ☐

Comments/Suggestions/Support Required:

Dressing:

Independent: ☐ Requires Assistance: ☐

Comments/Suggestions/Support Required:

Mobility:

Ambulatory: ☐ Non-ambulatory: ☐ Requires Assistance: ☐

Comments/Suggestions/Support Required:

ACTIVITIES OF DAILY LIVING

Meal Preparation:

Independent: ☐ Requires Assistance: ☐

Comments/Suggestions/Support Required:

Toileting:

Independent: ☐ Requires Assistance: ☐

Comments/Suggestions/Support Required:

ACTIVITIES OF DAILY LIVING

Tooth Brushing Skills:

Independent: ☐ Requires Assistance: ☐

Comments/Suggestions/Support Required:

Shopping Skills:

Independent: ☐ Requires Assistance: ☐

Comments/Suggestions/Support Required:

Household Skills:

Independent: ☐ Requires Assistance: ☐

Comments/Suggestions/Support Required:

GENERAL HEALTH & WELL BEING

Special Diet considerations:

Yes: ☐ No: ☐

Comments/Explain:

____

____

____

____

Food Likes:

____

____

Food Dislikes:

____

____

Physical Activity - Do you participate in regular activities such as exercise, walking, swimming, etc.?

Yes: ☐ No: ☐

Comments/Explain:

____

____

____

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____

GENERAL HEALTH & WELL BEING

Are there concerns with elimination?

Yes: ☐ No: ☐

Comments/Explain:

Are there any vision concerns?

Yes: ☐ No: ☐

Comments/Explain:

Are there any hearing concerns?

Yes: ☐ No: ☐

Comments/Explain:

GENERAL HEALTH & WELL BEING

Are there any respiratory concerns?

Yes: ☐ No: ☐

Comments/Explain:

How does the individual communicate?

Words: ☐ Non-traditional Communication: ☐ Other: ☐

Include type of communication (i.e. Sign language, pictures, etc.), and what each behaviour means (ie. hits head when he has a headache, paces when anxious, etc.).

Are there circulatory concerns?

Yes: ☐ No: ☐

Comments/Explain:

GENERAL HEALTH & WELL BEING

Are there concerns related to sleep?

Yes: ☐ No: ☐

Usual Bedtime: ____________________

Include any routine that should be followed (i.e. favourite blanket, position, night light, etc.)

____

____

____

____

Usual Waking Time: ____________________

Include any routine that should be followed (i.e. slow riser, grumpy when first waking up, etc.)

____

____

____

____

Special Equipment Required:

Yes: ☐ No: ☐

Include type of communication (i.e. Sign language, pictures, etc.), and what each behaviour means (i.e. hits head when he has a headache, paces when anxious, etc.)

____

____

____

____

GENERAL HEALTH & WELL BEING

"re there any emotional concerns?

Yes: ☐ No: ☐

Comments/Explain:

____

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____

____

BEHAVIOUR INFORMATION

Are there any repetitive or recurring behaviours? Yes: ☐ No: ☐

"o you have any written strategies for these situations? Yes: ☐ No: ☐
(. yes, please provide these strategies)

Do certain behaviours correlate to specific problems?
(i.e. crying at the onset of menses, rubbing head to indicate headache or discomfort, etc.)

Yes: ☐ No: ☐

Comments/Explain:

____

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____

BEHAVIOUR INFORMATION

Describe any repetitive or recurrent behaviour exhibited by the applicant:

Below give a detailed description of the behaviours:

ow are these Behaviours prevented and supported if required? Please comment in detail:

oes the applicant have Behaviour habits, which should be monitored closely to prevent injury to self or others? (e.g.: biting, pinching of self or others)

Yes: ☐ No: ☐

Comments/Explain:

PERSONAL CARE INFORMATION

Please list and comment on any likes (besides food) and favourite Leisure Activities.

Please list and comment on any dislikes (besides food).

Does the applicant have any routines or a schedule currently in effect? Please comment and provide copies of these routines or schedules if available.

PERSONAL CARE INFORMATION

. ersonal Needs:

Is the applicant's clothing in good repair?

Yes: ☐ No: ☐

Does the applicant need to purchase any of the items listed below prior to admission/discharge?

	Yes	No		Yes	No
Bed	☐	☐	Toiletry Items	☐	☐
Mattress	☐	☐	Hair Dryer	☐	☐
Dresser	☐	☐	Shaver	☐	☐
TV	☐	☐	Shampoo	☐	☐
DVD Player	☐	☐	Perfume	☐	☐
Stereo	☐	☐	Makeup	☐	☐
Winter Clothing/Boots	☐	☐	Jewelry	☐	☐
Summer Clothing	☐	☐	Hair Accessories	☐	☐
Linens	☐	☐	Other: ______________	☐	☐

Will briefs, hygiene items, etc. be sent with applicant?

Yes: ☐ No: ☐

If so please state brand name and size used:

____

____

____

____

DAILY ROUTINE

TIME	ACTIVITY

DAILY ROUTINE

ocational Involvement (AVE II, Integration Services, etc.)

Please state person's level of involvement with other agencies.
(e.g.: Number of times per week at placement, location and a brief description of placement, pay if applicable and continuation of service)

____

____

____

____

____

____

Transportation

State current transportation used by person and any pertinent information related to transporting applicant to and from various locations.
(e.g.: wheelchair, walker, should not be placed close to another person due to behaviours, etc.)

____

____

____

____

____

____

Has transportation been arranged to new residence?

____

____

____

OPTIONS northwest

Personal Support Services

ADMISSION: ☐ **DISCHARGE: ☐**

ADMISSION/DISCHARGE MEDICAL EXAMINATION FORM

NOTE: All new admissions are required to have a physical examination at least six months prior to admission at OPTIONS northwest. Please have the Physician complete this form and return it to the Supervisor.

INDIVIDUAL: ______________________________

NAME OF PHYSICIAN: ______________________________

ADDRESS: ______________________________

____

____

TELEPHONE: ______________________________

DATE OF LAST PHYSICAL EXAMINATION: ______________________________

EXISTING MEDICAL CONDITIONS:

____

____

____

____

____

____

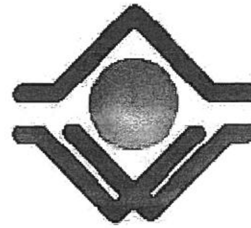
*** PROVIDE A PRESCRIPTION FOR ALL MEDICATIONS AND TREATMENTS**

PHYSICIAN'S SIGNATURE: ______________________________

DATE: ______________________________

OPTIONS northwest

Personal Support Services



ADMISSION: ☐ **DISCHARGE:** ☐

ADMISSION/DISCHARGE DENTAL EXAMINATION FORM

NOTE: All new admissions are required to have a dental examination at least six months prior to admission to OPTIONS northwest.

INDIVIDUAL: ______________________________

NAME OF DENTIST: ______________________________

ADDRESS: ______________________________

____

____

TELEPHONE: ______________________________

DATE OF LAST APPOINTMENT: ______________________________

COMMENTS:

____

____

____

____

____

____

DENTIST'S SIGNATURE: ______________________________

DATE: ______________________________

Independence Plus Housing Corporation

Mailing Address: 1100 Memorial Avenue, Suite 188
Thunder Bay, Ontario, Canada P7B 4A3

Tel: (807) 346-0662
Fax: 1-866-299-3416

Housing Type Applied For: ☐ Senior ☐ Single

1. APPLICANT

Last Name	First Name	Date of Birth YYYY MM DD	Sex M ☐ F ☐	Social Insurance No.
Street Number	Street Name	Apartment No.		Are you/do you have ☐ Canadian Citizen(ship) ☐ Landed Immigrant Status
Town/Municipality	Postal Code	Telephone No.		Present Marital Status ☐ Single ☐ Widowed ☐ Separated ☐ Married ☐ Divorced ☐ Common-law
Person to contact in your absence	Name	Telephone		☐ Friend ☐ Relative ☐ Interpreter ☐ Other

2. PRESENT ACCOMMODATION

Present Number of Bedrooms:

☐ Group Home Unit (Bedroom) ☐ Furnished Rooms ☐ Flat ☐ Apartment ☐ Other (Specify) ☐ Unfurnished Rooms ☐ Own Home ☐ Board with Relatives	
Present Landlord's Name	Address
How long have you lived at present address? _______ Year(s) ______ Month(s)	

3. STATEMENT OF MONTHLY INCOME BEFORE DEDUCTIONS (Income from ALL sources must be declared by all persons/family members to live in the accommodations)

Source of Income	Gross Monthly Income (Before Deductions)		
	Applicant	Co-Applicant	Other Family Members
Old Age Security (OAS)			
Federal Guaranteed Income Supplement (GIS)			
Provincial Guaranteed Annual Income System (GAINS)			
Canada Pension Plan (CPP)			
Old Age Security - Other Countries			
Worker's Compensation Pension/Other Disability Pensions			
Department of Veteran's Affairs Allowance			
War Pension - Other Countries			
Private Pensions (Specify)			
Transferred Assets			
Employment Income - Full or Part-Time			
Ontario Social Assistance (Ontario Works, ODSP)			
Alimony/Support			
Employment Insurance			
Band Allowance			
Other (Specify)			

TOTAL GROSS ANNUAL INCOME $

4. ASSETS

Bank Account - Give Bank Name, Branch Address and Account Number

	Bank Accounts	Amount		Monthly Income (Interest)	
		Applicant	Co-Applicant	Applicant	Co-Applicant
Are you a property owner? ☐ Yes ☐ No If "Yes", give type, value and location	Savings	$	$	$	$
	Chequing				
	Other Accounts				
	Bonds/Savings Certificates, RRSPs				
Do you have an interest in a business? ☐ Yes ☐ No If "Yes" give details	Annuities, Shares, Stocks, Securities, Debentures				
	Rent Revenue				
	Other (Specify)				
		Total Monthly Income		$	$

STATEMENT OF NON-INCOME PRODUCING ASSETS

Property Owned	Value	
	Applicant	Co-Applicant
A) House	$	$
B) Summer Cottage		
C) Other Real Estate		
Sub-Total		
Less: Amount of Mortgage Outstanding		
Net Assets - Real Estate		
Business Assets (Partnership, etc.)		
Monies Owed to You (Amounts over $500.00)		
Paid-up Life Insurance		
Other (Specify)		
Total	$	$
If any assets have been transferred, indicate:		

Assets transferred within the **Past 3 Years**
Date of Transfer: Transferred to:

5. PREVIOUS APPLICATION/PREVIOUS TENANCY IN SUBSIDIZED RENTAL ACCOMMODATION IN ONTARIO

Have you previously resided in subsidized rental accommodation in Ontario? ☐ Yes ☐ No

If "Yes", specify "Applicant" or "Co-Applicant" and name used	Occupancy Dates From (YY/MM) To (YY/MM)	Address

Reason for Leaving

6. HOUSING PREFERENCES

Are you applying for subsidized unit ☐ Full regular market rent unit☐?

I wish to apply for the following: Group Home Unit (Bedroom)☐ Apartment☐ Townhouse☐ House or Duplex only☐
Bachelor☐ 1 Bedroom☐ 2 Bedroom☐ 3 Bedroom☐ 4 Bedroom☐ 5 Bedroom☐

I wish to have my/our name on the waiting list for the following unit types only:
Senior's only☐ Elevator access☐ Ground floor☐ Corefloor☐ Balcony☐ No Preference☐
(If you check one of these boxes, your name will be on a list for units with these features only)

I require a modified/wheelchair-accessible unit: Yes☐ No☐

I require to live in a project where essential support services are provided: Yes☐ No☐
If "yes", please specify the type of care and/or devices you need:

I prefer to live in the following geographic areas and locations: Northward ☐ Southward ☐
Location Preferred: ____________________

7. ADDITIONAL REQUIREMENTS (Optional)

Please check one or more of the boxes that apply to you or other persons listed on the application:
☐ I currently live in or recently moved from an unsafe or abusive relationship.
(If you check this box, other information will be requested to verify the abuse)
☐ I have no permanent address (e.g. Live in a hostel, hotel, on the street, etc.)
Please specify:
☐ I have applied for housing within one year of entering Canada.
Please specify date of entry (month/day/year)
(If you check this box, verification is required)

8. ADDITIONAL COMMENTS (Optional)

____
____
____
____

9. DECLARATION, RELEASE AND CONSENT TO INFORMATION

I declare that all information given in this application is correct. I declare that all information given in this application form is complete to the best of my knowledge. The application and supporting documents become the property of Independence Plus Housing Corporation. Copies of the application and supporting documents may be given to housing providers that I have selected for placement on the waiting lists in locations where I wish to live.
I under stand that if rental accommodation is provided to me, it will be occupied by me .
I understand that this application does not constitute an agreement on the part of Independence Plus Housing Corporation to provide me with rental accommodation.
Personal information contained on this form or in attachments is collected by Independence Plus Housing Corporation pursuant to the Freedom of Information and Protection Act, (R.S.O. 1990, c.F. 31) or the Municipal Freedom of Information and Protection of Privacy Act, (R.S.O. 1990, c.M. 56). This information will be used to determine eligibility for housing applied for, continuation of housing and may be used for the appropriate rent-geared-to-income charge.
Pursuant to the Provincial/Municipal *Freedom of Information and Protection of Privacy Act;* I give my consent and authorization to Independence Plus Housing Corporation:

To make inquiries to verify the information given in this application and I authorize any person, corporation or any social agency having knowledge of any such required information to release to Independence Plus Housing Corporation. I agree to provide any supporting material required for my application.
To disclose the information given on this form to non-profit housing corporations/co-operatives, local housing authorities, the Ministry of Municipal Affairs and Housing, the Ministry of Community and Social Services, and other municipal, provincial and federal departments and agencies that assist in the provision of affordable housing and social services providing social assistance to me and persons on this application.

Questions about this collection should be directed to:

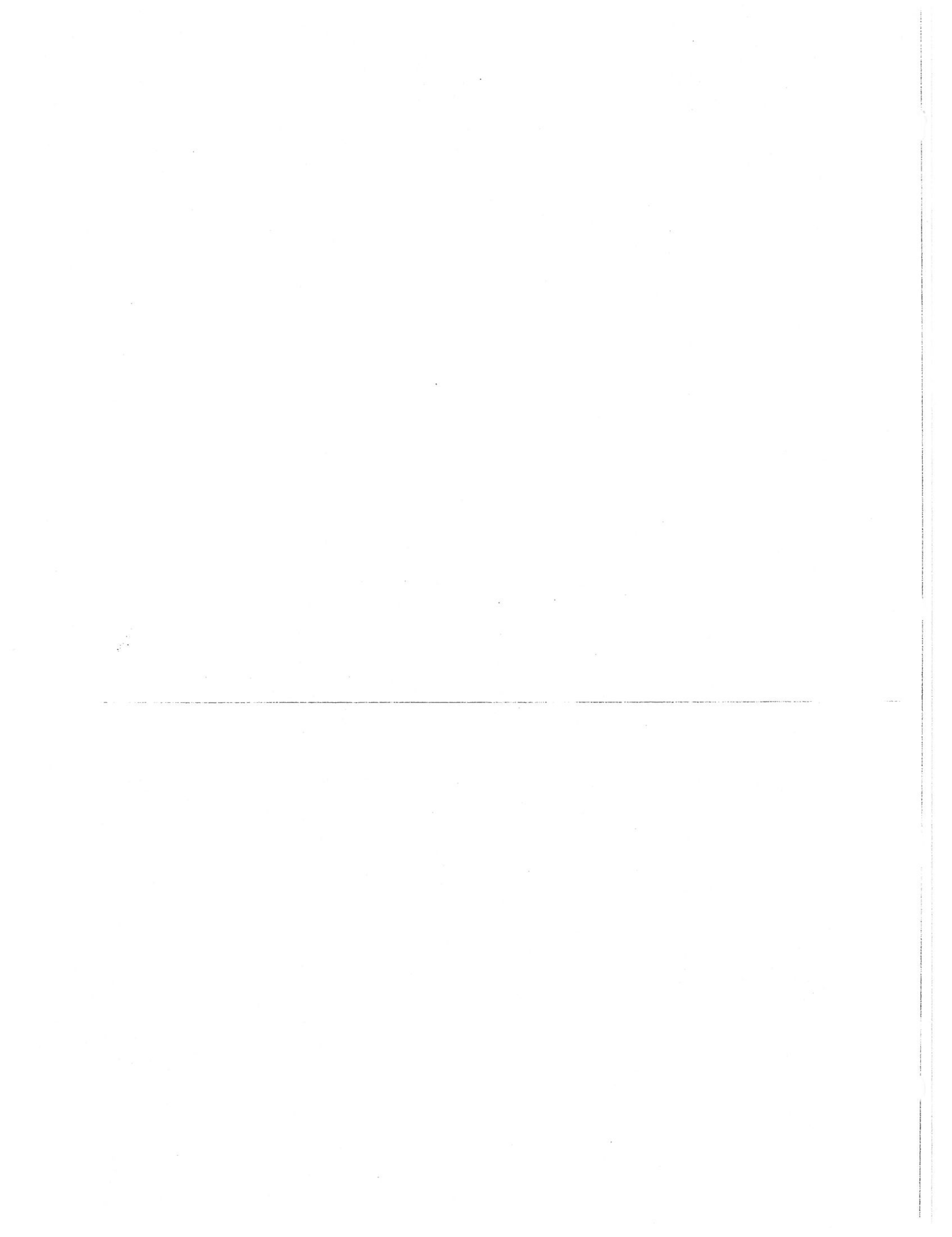
Independence Plus Housing Corporation
188 - 1100 Memorial Avenue, Thunder Bay, Ontario, P7B 4A3
Tel : (807) 346-0662 / Fax # 1-866-299-3416

Date: ____________ Applicant ____________

[1]Parent/Guardian/Trustee ____________

Witness ____________

([1]*if applicable)* Parent/Guardian/Trustee Name *(print name)*: ....
Parent/Guardian/Trustee Address (line 1): ....
Address (line 2): ....
City: ....
Province; ....
Postal Code: ....
Phone (1): ....
Phone (2): ....



- OPTIONS northwest -
ORIENTATION CHECKLIST FOR NEW RECIPIENTS OF SERVICE

Prior to the initiation of services, the Residential Supervisor along with the assigned Primary/Secondary Counsellor will meet with the individual, and if the individual chooses, the person acting on their behalf to review required documents and policies. The Recipient's Orientation Handbook will be distributed for future reference and this completed form will be placed at the front of the individual's support plan binder and uploaded to CIMS.

Date of Meeting: ______________________________

Name of Individual: ______________________________

Name of Person Acting on their Behalf: ______________________________

Name of Supervisor: ______________________________

Name of Primary & Secondary Counsellors: ______________________________

Any other(s) Present: ______________________________

PRIOR TO MEETING

Ensure the following documents have been received from Developmental Services Ontario (DSO) and are filed as indicated:

Document	Date original document placed in the individual's support plan binder	Document uploaded onto CIMS ✓
Application for Developmental Services and Supports		
Support Intensity Scale		
All planning documents		
Budget information/type of funding		
Any other applicable info from DSO (specify): ____________ ____________		

MEETING WITH THE INDIVIDUAL AND PERSONS ACTING ON THEIR BEHALF

SUPERVISOR TO INITIAL WHEN FOLLOWING DOCUMENTS OBTAINED:

Copy of Birth Certificate ____________

Health Card ____________

ODSP Dental Card ____________

Copy of Power of Attorney for Personal Care (if in place) ____________

Immunization Record ____________

ODSP Drug Benefit Card ____________

Copy of Power of Attorney for Finances (if in place) ____________

THE FOLLOWING DOCUMENTS AND INFORMATION WILL BE REVIEWED WITH THE INDIVIDUAL AND PERSONS ACTING ON THEIR BEHALF AT THE TIME OF THIS MEETING.

Information Discussion Regarding:	**Date Discussed/ Completed**	**Signature of the Individual/Person Acting on their Behalf**
• All Admission forms Completed and Returned		
• Review Organizational Chart		
• Information on the Family Network		
• Review Service Agreement and Sign		
• Process for Personal Planning and Annual Meeting		
• Process for Handling of Recipient's Personal Finances; payment of Monthly Fees; complete Financial Support Plan		
• Ministry of Community and Social Services Compliance (share A Guide to the Regulation on Quality Assurance Measures)		
• Annual process for Collection and Disclose of Recipient's Personal Information; sign form		
• Process for Rights Assessment/Management and Annual review of the same		
• Process for Risk Assessment/Management and Annual review of the same		
• Feedback Process; Review Outline of OPTIONS northwest Feedback Process and sign		
• Process for Health Appointment, Hospitalization and Emergency Medical Care; Review Medical Visit Record Form		
• Process for Residential Fees		
• Process for Natural Support Networks; Natural Support Network Plan for Recipient and Family and Friends to complete		
• Feedback on Orientation Process for completion		
• Other		
• Questions from Recipient: __________ __________ __________ • Questions from the Person Acting on their behalf: __________ __________ __________		

Information Review of the following policies (not limited to):	**Date Discussed/ Completed**	**Signature of the Individual/Person Acting on their Behalf**
• Mission and Philosophy Statement		
• Service Principles and Recipients' Bill of Rights (AD-III-10)		
• Privacy Statement (AD-I-8)		
• Consent (AD-I-9)		
• Confidentiality of Information (HR-II-2)		
• Abuse Policy (AD-III-1)		

INFORM RECIPIENT AND PERSONS ACTING ON THEIR BEHALF, THE FOLLOWING DOCUMENTS WILL BE REVIEWED WITH THEM ANNUALLY:

Philosophy and Mission Statement		
Service Principles and Recipients' Bill of Rights		
Abuse Policy		

COMPLETE AN INDIVIDUAL VALUABLES LIST AND PLACE THE ORIGINAL ON THE FRONT OF THE INDIVIDUAL SUPPORT PLAN BINDER AND A COPY WILL BE UPLOADED TO CIMS.

SIGNATURES UPON COMPLETION

RECIPIENT OF SERVICE

Signature: ______________________________ Date: ____________________________

FAMILY MEMBER(S) OR OTHERS, ACTING ON RECIPIENT'S BEHALF

Signature: ______________________________ Date: ____________________________

Signature: ______________________________ Date: ____________________________

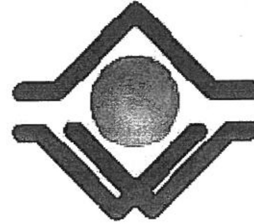
SUPERVISOR

Signature: ______________________________ Date: ____________________________

NEXT MEETING:
(2-3 months from the orientation)

Date: ___________ Time: ___________________ Location: _______________________

OPTIONS northwest



Personal Support Services

Service Agreement

I, ______________________________, wish to use the services of OPTIONS
(RECIPIENT OF SERVICE/SUBSTITUTE DECISION MAKER)

northwest for myself/my family member ____________________________.
(RECIPIENT OF SERVICE)

I understand and agree to the following:

- OPTIONS Northwest is funded through the Ministry of Community and Social Services to provide supports under the Services and Supports to Promote Social Inclusion for Persons with a Developmental Disability Act 2008 and Regulations 299/10.
- OPTIONS will strive to accommodate my/my family member's strengths, needs and preferences regarding the services provided. Based on my preferences and aspirations, OPTIONS will develop an Individual Support Plan tailored specifically for me.
- I will be required to pay monthly residential fees at the beginning of each month.
- I accept the services provided by OPTIONS northwest in compliance with their Mission, Philosophy, Service Principles and Recipients' Bill of Rights.
- All OPTIONS employees and volunteers are sufficiently qualified and are carefully screened and trained prior to employment. OPTIONS support providers are required to maintain current certification in First Aid with CPR; however, they are not regulated health care professionals and are not bound by the standards associated with any professional classification. Support staff will provide health care as recommended by health care professionals in consultation with and in agreement with myself/my family member.
- All OPTIONS employees and volunteers are required to abide by clearly defined policies and procedures.
- OPTIONS employees and volunteers are required to support recipients of service and their family in a manner which respects the dignity and individuality of all people. Similarly, families are expected to treat OPTIONS support providers with courtesy and respect.
- I am responsible to keep OPTIONS support providers informed about all details relevant to the care and support I require. I will inform support staff about any relevant changes that may occur that I or my family member are aware of and agree to complete any forms OPTIONS uses to accomplish this.

- OPTIONS will inform me of all recommendations made by health care professionals in a language and manner I can understand and will respect my decision to follow through with these recommendations. If applicable, OPTIONS will contact the person acting on my behalf at the current telephone number indicated in my personal binder, to inform them of all health professional recommendations. These medical recommendations will be followed until such time that OPTIONS receives notification from the health professional to change them.

- I authorize OPTIONS to deal with emergency situations which may arise.

- I have received a copy of the *Recipient's Orientation Handbook and Orientation Checklist*, which contains important information about OPTIONS. The Handbook also outlines key points about the delivery of services and supports and the responsibilities and expectations of Recipients, Families and the Organization. The Recipient's Orientation Handbook explains essential policies and procedures, such as the privacy of personal health information, our Mission, Philosophy, Recipient's Bill of Rights and Abuse Prevention. OPTIONS will provide updates to this handbook as needed and I understand that many of these documents will be reviewed with me/my family annually.

- OPTIONS Northwest respects the privacy of Recipients of Service and their Families and safeguards the confidentiality and security of all personal information. With regard to privacy, I understand and agree that:
    - By choosing OPTIONS as a service provider, I have given my implied consent to allow OPTIONS to collect, use, maintain and disclose my personal health information in order to provide quality support.
    - Unless I tell OPTIONS not to, OPTIONS may disclose essential information to other health care providers who are part of my "Circle of Care" (i.e. other services who need to know this information to provide supports.)
    - OPTIONS will always ask for my express consent before disclosing information to anyone who is not in my "Circle of Care".
    - I may withdraw or limit my consent at any time. For example, I may give express instructions that specific information cannot be used or disclosed. However, if I decide not to allow OPTIONS to collect, use, maintain or disclose information that is necessary for my care, OPTIONS may be unable to provide service.
    - OPTIONS will only disclose information without consent if required by law.

Signature – RECIPIENT OF SERVICE	Date
Signature – PERSON ACTING ON BEHALF OF RECIPIENT	Date
Signature - OPTIONS NORTHWEST	Date

FINANCIAL SUPPORT PLAN

Recipient of Service: ______________________________

Location: ______________________________

Level of Financial Support Required:

☐ **Independent** ☐ **Independent with Support**

☐ **Family Support** ☐ **Public Trustee Support**

☐ **Supervisor Support**

Provide details for the level of support you require to manage your finances:

____
____
____
____
____
____
____

Name of Person who assists you to make financial decisions:

______________________________ **Phone number:** ____________________

I bank at:

Financial institution: __________________ **Branch/Location:** __________________

Account #(s): ____

PIN# (if required) ______________

Name of Person who signs on my account(s): ______________________________

I use a: ☐ **Bank Book or receive a** ☐ **Bank Statement to balance my account monthly (check one)**

RECIPIENT ANNUAL BUDGET

MY INCOME:

ODSP		$	________
CPP			________
OAS			________
OTHER (specify)	________		________
	________		________
	________		________
TOTAL INCOME:		$	________

MY EXPENSES:

OPTIONS FEES	$______ x 12 months	$	________
CLOTHING	________		________
PERSONAL NEEDS	________		________
EQUIPMENT	________		________
FURNITURE	________		________
ACTIVITIES	________		________
OTHER(specify)	________		________
	________		________
	________		________
	________		________
TOTAL EXPENSES:		$	________

________________________ Recipient/Person Acting on their Behalf Signature

________________________ Supervisor Signature

Date ________________

Date ________________

FD280/DEC 2013

OPTIONS northwest
95 N. Cumberland Street Thunder Bay ON P7A 4M1
Tel: (807) 344-4994 Fax: (807) 346-5811

AUTHORIZATION TO COLLECT / DISCLOSE PERSONAL INFORMATION

I hereby authorize OPTIONS northwest to ☐collect ☐ disclose the personal information of: ______________________________
(print full name of person to whom information applies)

Specifically: ______________________________

____

____

____

____

____

____
(Describe the personal information to be disclosed and the purpose)

From / To: ______________________________
(Print name and address of person, agency, or facility having / requiring the information)

I understand the purpose for obtaining / disclosing this information from / to the person/agency/ facility noted above. I understand that I can refuse to sign this consent form.

______________________________ ______________
Signature of Individual or authorized representative/ substitute decision-maker* Date

______________ ______________ ______________
Witness Name (Print) Witness Signature Date

*If signed by an authorized representative/substitute decision-maker, print name and indicate relationship: ______________________________

This authorization will be obtained yearly for individuals who remain on the Community Resource Team's caseload and for Client Services, at the time of the annual planning meeting.

Important Information. Please read:

An individual can withdraw their authorization at any time by writing to the Privacy Officer of OPTIONS northwest, subject to legal and contractual restrictions and reasonable notice. The withdrawal of authorization, however, shall not have a retroactive effect.

OPTIONS northwest's Privacy Officer is available to provide information on our Privacy Policy and to respond to any questions you may have.

OPTIONS northwest
FEEDBACK FORM

SECTION A

Date: ____________________

(PRINT) Name of Individual providing feedback: ____

Please provide preferred contact information: ____

Phone Number(s): 1) ________________ **2)** _____________ **Email Address:** ________________________

Mailing Address: ____

(PRINT) Name of Person completing this form if different than above: ____________________________

Phone Number(s): 1) ________________ **2)**_____________ **Email Address:** ________________________

Feedback: Please describe the circumstances that led to your complaint or feedback and provide specific detailed information, where possible i.e. dates, names, what happened.

____
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____

(If more space is required attach additional pages)

Signature of Person Providing Feedback: ____

Signature of Person completing form if different from above: ____________________________________

SECTION B

A) Supervisor/Director follow – up (to be completed within 10 business days of receipt):

1. **Date Received by Supervisor/Director:** ______________________
2. **Date Supervisor/Director Contacted Person Providing Feedback:** ______________________
3. **Details of Discussion:** ______________________
4. **Recommendations:** ______________________
5. **Follow-up:** ______________________

B) Executive Director Follow – up as required: (to be completed within 5 days of date of contact by Supervisor/ Director):

1. **Date Received by Executive Director:** ______________________
2. **Date Executive Director Contacted Person Providing Feedback:** ______________________ ☐ **N/A**
3. **Details of Discussion:** ______________________
4. **Recommendations:** ______________________
5. **Follow-up:** ______________________

Once this form has been completed, scan to Feedback folder on shared Administration directory.

- OPTIONS northwest -
MEDICAL VISIT FORM

'AME OF RECIPIENT: ____________________

REASON FOR VISIT/HISTORY OF PRESENTING PROBLEM: ____________________

QUESTIONS FOR THE HEALTH PROFESSIONAL FROM INDIVIDUAL/PERSON ACTING ON THEIR BEHALF: ____________________

HEALTH PROFESSIONALS RECOMMENDATIONS: ____________________

DATE OF FOLLOW UP APPOINTMENT IF REQUIRED: ____________________

PERSON ACTING ON THE INDIVIDUAL'S BEHALF INFORMED OF APPOINTMENT RESULTS:

YES: ☐ NO: ☐

.AME OF PERSON NOTIFIED: ____________________ DATE: ____________________

IF THE APPOINTMENT HAS RESULTED IN ANY CHANGES FOR THE INDIVIDUAL'S MEDICATIONS, TREATMENT, OR CARE, INFORM ANY OTHER AGENCIES/PEOPLE PROVIDING SUPPORT FOR THE INDIVIDUAL; RECORD BELOW.

AGENCY	NAME OF THE PERSON WHO TOOK THE INFORMATION	DATE INFORMATION WAS SHARED

COMMENTS:____

APPOINTMENT AND/OR TREATMENT REFUSED BY THE INDIVIDUAL: YES: ☐ NO: ☐

COMMENTS/EDUCATION PROVIDED: ________________________________

DOCUMENT THE COMPLETION OF THIS FORM IN THE PROGRESS NOTES IN THE INDIVIDUAL'S PERSONAL BINDER

FILE THIS FORM IN THE MEDICAL SECTION OF THE INDIVIDUAL'S PERSONAL BINDER

Support Network Plan-Questionnaire for Individual

Name: ____________________

Date: ____________________

When supporting people to have a good life, we understand and respect the value of family and friends. Please tell us what we can do to help nurture and support your natural support networks.

A) To be completed by the Individual/Person acting on their Behalf/Support Team:

1. Current Relationships: Please list family and friends who are important to you and, if you wish, the type of relationship you have with them. Also include their contact information: ____________________

2. Communication:

a) How would you like to communicate with your family/friends and what support do you require to ensure this communication happens?: ____________________

b) Do you have a preferred method of communication? (ie: email, phone): ____________________

c) Anything else you would like to tell us about how you communicate with people who are important to you: ____________________

3. Involvement: Tell us what your ideal involvement with your family and friends would be and what support you require to do this: ________________________________

____

____

____

____

____

____

____

____

4. Expanding Your Support Network: Tell us how we can support you to add more people to your support network and what education and/or skills you think you would require to have safe and healthy relationships: ____________________________

____

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____

____

To be reviewed annually.

Please file in the recipient of service's I.S.P binder and a copy sent to reception to scan and upload to the individual's CIMS file.

Support Network Plan-Questionnaire for Family and Friends

Name of Individual: ____

Name of Family Member/Friend: ______________________________

Date: ____________________

When supporting people to have a good life, we understand and respect the value of family and friends. Please tell us what we can do to help nurture and support this individual's relationship with you.

1. How would you like to communicate with your family member/friend, and their support staff and supervisor? ____

2. Is there an ideal time of day to communicate with you? ______________________

3. Do you have a preferred method of communication? (for example, do you prefer email or the phone):____

4. Tell us more about your ideal involvement with your family member/friend. For example, some families like to come to monthly team meetings, and meet with the support staff and supervisor on a regular basis, and others may choose to do this every few months. ____

To be reviewed annually.

Please file in the recipient of service's I.S.P binder and a copy sent to reception to scan and upload to the individual's CIMS file.

- OPTIONS northwest -

FEEDBACK ON ORIENTATION PROCESS

NEW RECIPIENT OF SERVICE AND THE PERSON ACTING ON THEIR BEHALF

We would like to know how to continually improve our orientation process for newly supported people and their families/friends. We would greatly appreciate hearing from you and receiving your feedback.

* Please bring this back to the Supervisor at your follow up meeting.

Name: ______________________________ Date: ____________________

1. Did the orientation meet your expectations?

- ☐ Not at all
- ☐ Somewhat
- ☐ Expectations met
- ☐ Exceeded my expectations

Comments:

____

____

____

____

____

____

____

____

2. Please let us know how we can improve the orientation:

____

____

____

____

____

____

____

Thank you!

* Supervisor to place the original in the individual support plan binder and forward a copy to the Director of Personal Support Services.

- OPTIONS northwest -
PERSONAL/MEDIAL DATA

POLICY: R-I-2
APPENDIX O

NAME:	**PERSON ACTING ON THEIR BEHALF:**
ADDRESS:	
TELEPHONE:	**TELEPHONE:**
DOB:	**CONSENT/SUBSTITUTE DECISION MAKER:**
HEALTH CARD:	
SUPERVISOR:	**TELEPHONE:**
SUPERVISOR CONTACT NUMBER:	**FAX:**
SUPERVISOR ON CALL CONTACT NUMBER:	**FAMILY PHYSICIAN:**
ALLERGIES:	**SPECIALISTS:**
	DENTIST:
	DENTAL SURGEON:
	OPHTHALMOLOGIST:
SPECIAL PRECAUTIONS:	**OPTOMETRIST:**
	DIETICIAN:
	COMMUNICATION:
	HEARING:
MEDICAL/PHYSICAL CONDITIONS:	
	VISION:
	ADAPTIVE AIDS:
NORMAL BP: **NORMAL T P R**	
WEIGHT: **HEIGHT:**	**COGNITIVE ABILITY:**
IMMUNIZATION RECORD-DATE LAST DONE:	
FLU VACCINATION:	
TETNUS:	**MOTOR SKILLS:**
TETNUS/DIPTHERIA:	
POLIO:	
MMR:	
PERTUSIS:	
HEPATOVAX:	
TB TEST:	

SPECIAL BEHAVIOUR CONSIDERATIONS:	DIET/SPECIAL CONSIDERATIONS:

- OPTIONS northwest -	NAME: ____________________
RECIPIENT'S VALUABLES INVENTORY	ADDRESS: ____________________

PURCHASE DATE	DESCRIPTION	MODEL/SERIAL NUMBER	APPROXIMATE VALUE	DATE AND REASON FOR REMOVAL

NAME: ____________________ **ADDRESS:** ____________________________

PURCHASE DATE	DESCRIPTION	MODEL/SERIAL NUMBER	APPROXIMATE VALUE	DATE AND REASON FOR REMOVAL

PSS110/FEB 2014

- OPTIONS Northwest -
MEDICATION/TREATMENT PURPOSE FORM

INDIVIDUAL'S NAME: ______________________________

NAME OF MEDICATION/ TREATMENT	DATE STARTED	DATE COMPLETED	DATE EXPLAINED TO RECIPIENT	REASON MEDICATION/TREATMENT IS GIVEN

NAME OF MEDICATION/ TREATMENT	DATE STARTED	DATE COMPLETED	DATE EXPLAINED TO RECIPIENT	REASON MEDICATION/TREATMENT IS GIVEN

- OPTIONS northwest -
Health Appointment Record & Log

D/M/YEAR	APPOINTMENT WITH	REASON FOR APPOINTMENT	FINDINGS/RECOMMENDATIONS

D/M/Year	Appointment With	Reason For Appointment	Findings/Recommendations

- OPTIONS northwest –

ORIENTATION CHECKLIST FOR PURCHASED SERVICE

Prior to the initiation of purchased services the appropriate Supervisor and/or Director will meet with the individual, and if the individual chooses, the person acting on their behalf to review required documents and policies.

Date of Meeting: ______________________________

Name of Individual: ______________________________

Name of Person Acting on their Behalf: ______________________________

Name of Organization Supporting Individual: ______________________________

Name of Supervisor/Director: ______________________________

Any other(s) Present: ______________________________

PRIOR TO MEETING:

Ensure a copy of the following documents has been received:

Document	Date Received
Application for Developmental Services and Supports	
Support Intensity Scale	
All necessary planning documents	
Any other applicable info from DSO (specify): ______________________________ ______________________________	

MEETING WITH THE INDIVIDUAL AND PERSONS ACTING ON THEIR BEHALF:

Information Discussion Regarding:	Date Discussed	Signature of the Individual/Person Acting on their Behalf
• Review, complete and sign OPTIONS Support Service Plan, and Memorandum of Understanding Purchased Service Agreement		
• Review Feedback Process Outline and sign		
• Distribute Purchased Services Contact Information form for completing		
• Review process for the Collection, Use and Disclose of Service Recipient's Personal Information; Sign authorization form		
• Questions from Recipient: ______________________ ______________________ ______________________ • Questions from Person Acting on their Behalf: ______________________ ______________________ ______________________		

Information Review the following policies:	Date Discussed	Signature of the Individual/Person Acting on their Behalf
• Mission and Philosophy Statement		
• Service Principles and Recipients' Bill of Rights (AD-III-10)		
• Privacy Statement (AD-I-8)		
• Consent (AD-I-9)		
• Confidentiality of Information (HR-II-2)		
• Abuse Policy (AD-III-1)		

INFORM RECIPIENT AND PERSONS ACTING ON THEIR BEHALF, THE FOLLOWING DOCUMENTS WILL BE REVIEWED WITH THEM ANNUALLY:

Philosophy and Mission Statement		
Service Principles and Recipients' Bill of Rights		
Collection, Use and Disclose of Service Recipient's Personal Information		
Abuse Policy		

Monthly Invoices to be directed to: ______________________________

____

____

____

SIGNATURES UPON COMPLETION:

RECIPIENT OF SERVICE:

Signature: ______________________ Date: ______________________

FAMILY MEMBER(S) OR OTHERS, ACTING ON THEIR BEHALF:

Signature: ______________________ Date: ______________________

Signature: ______________________ Date: ______________________

SUPERVISOR:

Signature: ______________________ Date: ______________________

- OPTIONS Northwest -
Purchased Service Contact Information

BASIC INFORMATION

Name:

Telephone: Home: Health Card #:

Cell: Date of Birth: / /

Address: S.I.N.:

Emergency Contacts

Name: Name:

Telephone: Home: Telephone: Home:

Cell: Cell:

MEDICAL INFORMATION

Please list all **Medical Conditions** on the lines provided below.

Please list all **Medications** you are currently taking.

Medication Name	Dosage	Times per Day

Please list all **Food and Drug Allergies** on the lines provided below.

Please list all **Dietary Needs** (i.e. gluten free, diabetes etc.) on the lines provided below.

Please continue on the back of the page if more space is required for any of the above questions.

- OPTIONS Northwest -
Purchased Service Contact Information

PERSONAL SUPPORT NEEDS

Please list any **Assistive Devices** (i.e. wheelchair, walker, hearing aid etc.) you use on the lines provided below.

___

___

___

Do you require any support in the washroom?

___

___

What is your most common method of transportation (i.e. Lift Plus, City Transit etc.)

___

___

COMMUNICATION NEEDS

How do you communicate your wants and needs?

___

___

___

___

If you become upset, angry, or frustrated how do you communicate these emotions?

___

___

___

___

What helps keep you calm in these situations?

___

___

___

___

Do you have any written strategies for these or other situations? Please check one box.

☐ Yes ☐ No If yes, please provide these strategies.

Do you use any communication devices or sign language?

___

___

Please continue on the back of the page if more space is required for any of the above questions.

PSS2030/FEB 2014

- OPTIONS Northwest -
Purchased Service Contact Information

DEGREE OF INDEPENDENCE

Are you able to...? Please check all that apply

☐ Read ☐Write

Please rate your telephone skills?

☐ Excellent ☐ Good ☐ Poor ☐ Not Applicable

Do you have any supports required with safety (i.e. Street safety, water safety etc.)?

____

____

____

LIKES AND DISLIKES

What are your likes and interests?

____

____

____

____

What are your dislikes?

____

____

____

____

GOALS AND ASPIRATIONS

What are some of the goals you would like to work on while receiving support from OPTIONS northwest?

____

____

____

____

What are your parents' or caregivers' expectations of the support you will be receiving from OPTIONS northwest?

____

____

____

____

Please continue on the back of the page if more space is required for any of the above questions.

- OPTIONS Northwest -

Purchased Service Contact Information

ADDITIONAL SUPPORT

How would you like to be involved in the community (i.e. Employments, recreation etc.)?

____

____

____

____

What other supports do you have or have you had in the past?

____

____

____

____

Would it be okay to contact them to help us get to know you better?

☐ Yes ☐ No

If yes, please provide the name of the support person/people we can contact.

Support Person	Agency	Telephone Number

Are there any other issues or concerns that we should be aware of while you are participating in service with OPTIONS northwest?

____

____

____

____

Name of Recipient	Signature of Recipient Or Signature of Person Acting on Behalf of the Recipient	Date

Please continue on the back of the page if more space is required for any of the above questions.

POLICY: R-I-2
APPENDIX U

- OPTIONS northwest –
SUPPORT SERVICE PLAN

Purchaser: ____

Provision of Services to: ______________________________________

Date: ______________________________

Support Requested: (include frequency and number of hours)

____

____

____

____

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____

Expectations and Goals:

____

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REVIEW DATE:

- OPTIONS northwest -

MEMORANDUM OF UNDERSTANDING
FOR
PURCHASED SERVICE AGREEMENT

Between OPTIONS northwest Personal Support Services Thunder Bay
and

____
(PURCHASER NAME)

for the provision of supports for

____
(NAME OF RECIPIENT OF SERVICE)

OPTIONS northwest agrees to provide support services in accordance with the Mission and Philosophy Statement and Service Principles and Recipients' Bill of Rights of OPTIONS northwest. These personal support services will be provided based on the expectations and goals set out in the attached Support Service Plan.

The Purchaser will be billed and agrees to pay OPTIONS northwest an hourly rate of $________ for all hours providing support including orientation, training and meeting time as required. If a request is made to provide services on a Statutory Holiday the Purchaser agrees to pay the hourly rate plus the required statutory premium. Support staff's cost for recreational activities and transportation will be additional and billed to the Purchaser. Support services may be suspended or terminated at the sole discretion of OPTIONS northwest if the account remains unpaid.

OPTIONS northwest agrees to provide support services as scheduled, however, we reserve the right to cancel or vary scheduled services due to circumstances beyond our control. Every effort will be made by OPTIONS northwest to inform you when supports will be cancelled or rescheduled giving as much advance notice as possible. In the event that the services are cancelled and not rescheduled, the Purchaser will not be billed.

This agreement is in effect from ____________________ to ____________________.

The agreement may be terminated by either party with two (2) months written notice.

____
Purchaser

____
Director of Personal Support Services

____
Date

OPTIONS northwest

Personal Support Services

Purchased Service Agreement

I, ____, wish to use OPTIONS
(RECIPIENT OF SERVICE/SUBSTITUTE DECISION MAKER)

northwest services for myself/family member______________________________.
(RECIPIENT OF SERVICE)

I understand and agree to the following:

- OPTIONS northwest is funded through the Ministry of Community and Social Services to provide supports under the Services and Supports to Promote Social Inclusion for Persons with a Developmental Disability Act 2008 and Regulations 299/10.
- OPTIONS will strive to accommodate my/my family member's strengths, needs and preferences regarding the services provided. Based on my preferences and aspirations, OPTIONS will develop a Support Service Plan tailored specifically for me.
- I will be required to pay OPTIONS at the beginning of each month.
- I accept the services provided by OPTIONS northwest in compliance with their Mission, Philosophy, Service Principles and Recipients' Bill of Rights.
- All OPTIONS employees and volunteers are sufficiently qualified and are carefully screened and trained prior to employment. OPTIONS support providers are required to maintain current certification in First Aid with CPR, however, they are not regulated health care professionals and are not bound by the standards associated with any professional classification. Support staff will provide health care as recommended by health care professionals in consultation with and in agreement with myself/my family member.
- All OPTIONS employees and volunteers are required to abide by clearly defined policies and procedures.
- OPTIONS employees and volunteers are required to support recipients of service and their family in a manner which respects the dignity and individuality of all people. Similarly, families are expected to treat OPTIONS support providers with courtesy and respect.
- I am responsible to keep OPTIONS support providers informed about all details relevant to the care and support I require. I will inform support staff about any relevant changes that may occur that I, or my family member(s), am aware of.
- I authorize OPTIONS to deal with emergency situations which may arise.

- I have received a copy of the *Recipient's Orientation Handbook and Orientation Checklist*, which contains important information about OPTIONS. The Handbook also outlines key points about the delivery of services and supports and the responsibilities and expectations of Recipients, Families and the Organization. The Recipient's Orientation Handbook explains essential policies and procedures, such as the privacy of personal health information, our Mission, Philosophy, Recipient's Bill of Rights and Abuse Prevention. OPTIONS will provide updates to this handbook as needed and I understand that many of these documents will be reviewed with me/my family annually.
- OPTIONS northwest respects the privacy of Recipients of Service and their Families and safeguard the confidentiality and security of all personal information. With regard to privacy, I understand and agree that:
    - By choosing OPTIONS as a service provider, I have given my implied consent to allow OPTIONS to collect, use, maintain and disclose my personal health information in order to provide quality support.
    - <u>Unless I tell OPTIONS not to</u>, OPTIONS may disclose essential information to other health care providers who are part of my "Circle of Care" (i.e. other services who need to know this information to provide supports.)
    - OPTIONS will always ask for my express consent before disclosing information to anyone who is not in my "Circle of Care".
    - I may withdraw or limit my consent at any time. For example, I may give express instructions that specific information cannot be used or disclosed. However, if I decide <u>not</u> to allow OPTIONS to collect, use, maintain or disclose information that is necessary for my care, OPTIONS may be unable to provide service.
    - OPTIONS will only disclose information without consent if required by law.

______________________________	______________________
Signature – RECIPIENT OF SERVICE	Date
Signature – PERSON ACTING ON BEHALF OF RECIPIENT	Date
Signature - OPTIONS northwest	Date

POSTING NO: ______________________
(To be completed by HR if applicable)

POLICY: R-I-2
APPENDIX X

OPTIONS northwest
PERSONNEL ALLOCATION REQUEST FORM

CLASSIFICATION: ______________________ **STATUS:** __________ **NU/UNION:** __________

PRIMARY AREA OF ASSIGNMENT: ______________________________ **NO. OF POSITIONS TO BE FILLED:** ________

DURATION OF POSITION: ______________________ **Temporary** ______________________ **Permanent**

START DATE & COMPLETION DATE **EFFECTIVE DATE**

REASON FOR ALLOCATION:

____

____

JOB REQUIREMENTS/PARTICULARS:

____

____

____

____

____

____

REQUESTED BY: ______________________ **DATE:** __________

APPROVED BY: ______________________ **DATE:** __________

HUMAN RESOURCES REVIEWED: ______________________ **DATE:** __________

HUMAN RESOURCES ONLY	**METHOD OF ADVERTISING** ______________________ **DATES:** ______________________

NAME OF SUCCESSFUL APPLICANT(S):

____

____

DATE OF HIRE:

____

HR010/AUG 2009

POSTING CHECKLIST

- ☐ Name of successful applicant recorded on Personnel Allocation Request Form
- ☐ Date of hire recorded on Personnel Allocation Request Form
- ☐ Applicant Listing complete (below)
- ☐ Application pulled for Personnel file
- ☐ EM-HR-1 processed and copy sent to Finance, Employee called to sign
- ☐ Update CAW job posting list as required

Applicant Listing: