



**Oxford County Program:**  
373 Blossom Park Road  
Woodstock, ON N4S 7J3

Tel: 519-539-2917  
Toll Free: 866-529-0454  
Fax: 519-539-3564

**Main Office:**  
Unit A - 249 Caroline St. S.  
Hamilton, ON L8P 3L6

## Housing Application Form

Thank you for your interest in the ministry of Homestead Christian Care. Please take the time to thoroughly complete this application, as the information provided will help us assess how best to support you.

The application must be filled out completely before an admission date will be scheduled. Please pay particular attention to the items related to your specific medical conditions, including listing any clinical/medical and community-based supports.

For applications to our Residential Care programs, municipal regulations require that we receive a discharge summary and assessment reports before we can accept clients into our programs. Thank you for providing these as requested.

If you have any questions, please do not hesitate to contact the Oxford Program at 539-2917, or to speak to the Oxford Program Manager call 866-529-0454, ext. 430.

Thank you again for your interest in Homestead Christian Care.

Sincerely,

Danielle Paluska M.Sc  
Oxford Program Manager  
Homestead Christian Care



Main Office:  
Unit A - 249 Caroline St. S.  
Hamilton, ON L8P 3L6

Tel: 905-529-0454  
Toll Free: 866-529-0454  
Fax: 905-529-0355

**HOUSING APPLICATION FORM**

**GENERAL INFORMATION**

Applicant's name:

\_\_\_\_\_ (First) \_\_\_\_\_ (Last)

Date of Birth: \_\_\_\_\_ Gender: Male  Female

Aboriginal  Non-Aboriginal  Bilingual: Yes  No

Preferred language spoken: \_\_\_\_\_

Health Card Number: \_\_\_\_\_ version code: \_\_\_\_ Social Insurance Number: \_\_\_\_\_

Marital Status: Married/common law  Divorced  Never married  Separated  Single  Widowed

Number of dependents (with ages): \_\_\_\_\_

Religious affiliation or spiritual background (if applicable): \_\_\_\_\_

**Referred by:** Self Referral by Applicant  or \_\_\_\_\_

(Referring person's name and organization)

**CONTACT INFORMATION**

Current address of Applicant (If currently hospitalized, please give previous address):

\_\_\_\_\_

Home telephone number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

If necessary, may we you contact at the above address or phone number and leave a message?

Yes  No

If currently hospitalized:

Hospital name: \_\_\_\_\_

Admission Date: \_\_\_\_\_ Contact Number: \_\_\_\_\_

**EMERGENCY CONTACT**

Name of Emergency Contact \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

**ADDITIONAL CONTACTS:**

Family Physician: \_\_\_\_\_

Address and Telephone: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_

Address and Telephone: \_\_\_\_\_

Social Worker: \_\_\_\_\_

Address and Telephone: \_\_\_\_\_

Case Manager: \_\_\_\_\_

Address and Telephone: \_\_\_\_\_

Other Supports: \_\_\_\_\_

Address and Telephone: \_\_\_\_\_

**PERSONAL HISTORY**

Please describe social supports available (family, friends, etc.): \_\_\_\_\_

\_\_\_\_\_

**LIVING ARRANGEMENTS/HOUSING**

Which best describes applicant's current (or most recent) living arrangements? (Who does applicant live with?)

- Self
- Spouse/partner
- Spouse/partner and others
- Children
- Parents
- Relatives
- Non-relatives

Which best describes applicant's current (or most recent) residence type?

- |   |  |
|---|--|
| <input type="checkbox"/> Private house or apartment           | <input type="checkbox"/> No fixed address                      |
| <input type="checkbox"/> Hostel or Shelter                    | <input type="checkbox"/> Domiciliary Hostel                    |
| <input type="checkbox"/> Long term care facility/Nursing home | <input type="checkbox"/> Hospital                              |
| <input type="checkbox"/> Retirement home/Seniors' residence   | <input type="checkbox"/> Non profit housing                    |
| <input type="checkbox"/> Rooming/Boarding house               | <input type="checkbox"/> Supportive housing- Congregate living |

Other (Please describe): \_\_\_\_\_

\_\_\_\_\_

How long has applicant been in your current living situation? \_\_\_\_\_

Which best describes applicant current residence support level?

- Independent living
- Assisted/supported
- Supervised, Non-facility
- Supervised, Facility

**LEGAL STATUS**

Is applicant currently on a Community Treatment Order:  yes  no

If "Yes" please describe:

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Is applicant currently on any other type of court order? (i.e., probation)  Yes  no

If "Yes" please describe:

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**FINANCIAL**

What is your current source of income?

- Employment:
- Employment Insurance (E.I.)
- Pension
- Ontario Disability Support Program (O.D.S.P)
- Ontario Works (O.W.)
- No Source of Income
- Other

If you currently have no source of income, have you applied for any social assistance?  yes  no

Do you have assets which would disqualify you from receiving social assistance?  yes  no

Do you manage your own finances?  yes  no

If not, do you have a trustee?  yes  no

If so, please provide trustee's name and contact details:

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**EMPLOYMENT**

Describe current type of employment:

- Employed. ( Circle one: full-time, part-time, seasonally, occasionally)
  - No employment of any kind.
  - Assisted/Supportive
  - Sheltered workshop
  - Non-paid work experience
  - Casual/sporadic
  - Other
- 

If not employed, when were you last able to work? \_\_\_\_\_

**EDUCATION**

Are you currently in school or education? Yes  No

If currently in school, where?

\_\_\_\_\_

- Highest level of Education  No formal schooling
- Some elementary/Jr. high school
- Elementary/Jr. high school
- Some secondary/high school
- Secondary/high school
- Some college/university
- College/university

**BRIEF MEDICAL OVERVIEW and CURRENT PHYSICAL HEALTH STATUS**

Does applicant have problems with:

- Vision  no  yes, specifically: \_\_\_\_\_
- Hearing  no  yes, specifically: \_\_\_\_\_
- Diet  no  yes, specifically: \_\_\_\_\_
- Allergies  no  yes, specifically: \_\_\_\_\_
- Mobility  no  yes, specifically: \_\_\_\_\_
- Diabetes  no  yes, specifically: \_\_\_\_\_
- Epilepsy  no  yes, specifically: \_\_\_\_\_

Other health issues, including cognitive concerns:

\_\_\_\_\_

Currently taking any medications?  no  yes, specifically: \_\_\_\_\_

\_\_\_\_\_

Are all medications being taken as prescribed?  yes  no

**PSYCHIATRIC STATUS**

Primary Diagnosis: \_\_\_\_\_

Secondary Diagnoses: \_\_\_\_\_

(Please attach any relevant documents related to psychiatric admissions)

Age of onset for mental illness \_\_\_\_\_

Age of first hospitalization for mental illness \_\_\_\_\_

**Other medical conditions: (Check all that apply)**

- Concurrent disorder (substance abuse)
- Dual diagnosis (developmental disability)
- Mobility/physical/complex needs
- Other chronic illnesses and/or physical disabilities

**PERSONAL SAFETY ASSESSMENT**

- |                     |  |                            |  |
|---------------------|--|----------------------------|--|
| History of violence | <input type="checkbox"/> no <input type="checkbox"/> yes | Non-compliance with meds   | <input type="checkbox"/> no <input type="checkbox"/> yes |
| Verbal abuse        | <input type="checkbox"/> no <input type="checkbox"/> yes | Conflict with the Law      | <input type="checkbox"/> no <input type="checkbox"/> yes |
| Physical abuse      | <input type="checkbox"/> no <input type="checkbox"/> yes | Verbal or physical threats | <input type="checkbox"/> no <input type="checkbox"/> yes |
| Substance abuse     | <input type="checkbox"/> no <input type="checkbox"/> yes | Fire setting               | <input type="checkbox"/> no <input type="checkbox"/> yes |
| Suicide attempts    | <input type="checkbox"/> no <input type="checkbox"/> yes | Careless smoking           | <input type="checkbox"/> no <input type="checkbox"/> yes |
| Suicide ideations   | <input type="checkbox"/> no <input type="checkbox"/> yes | Stalking, or being stalked | <input type="checkbox"/> no <input type="checkbox"/> yes |
| Self-harm           | <input type="checkbox"/> no <input type="checkbox"/> yes | Aggression                 | <input type="checkbox"/> no <input type="checkbox"/> yes |

**(If you have checked “yes” for any of the above concerns, please provide additional information)**

**PERSONAL STRENGTHS, CAPABILITIES, and AREAS NEEDING DEVELOPMENT**

**Please mark each category according to the following scale:**

- 1 –independently capable
- 2 –assistance is needed
- 3 –unable to complete at this time

	<b>1</b>	<b>2</b>	<b>3</b>
<b>Knowledge of Disability:</b> Knowledge of impact of illness Knowledge of negative impact of alcohol and drug use Adherence to prescribed medication Self-administration of medications			
<b>Skills for Living:</b> Self-adherence to a healthy personal schedule Awareness of time Able to arrive on time for appointments/work			
<b>Personal Care:</b> Able to maintain personal hygiene (bathing and grooming regularly) Laundry (weekly) Able to dress appropriately for weather conditions or occasions			
<b>Maintenance of Self in Home:</b> Meal planning Create a shopping list and purchase groceries Meal preparation Budget funds for one-month periods Manage and pay monthly expenses on time Safely operate household equipment (kitchen appliances, vacuum, etc.) Maintain an adequate cleanliness of apartment			
<b>Maintenance of Self in Community:</b> Able to identify safety issues and respond appropriately Awareness of responsibilities and rights as a tenant Act conscientiously towards other people Able to locate and access community resources Able to manage on available income			
<b>Social Skills:</b> Able to make needs clearly known Show consideration for others: personal space, property, finances Willing to accept support where and when needed			

**If a formalized assessment of personal functioning has been prepared, please attach documentation.**



## Medical Assessment Cover Sheet

Prior to admitting an individual as a tenant of our programs, we are required to obtain an up-to-date assessment from a physician or other member of a regulated health profession employed by a referring agency designated under Municipal guidelines, which provides an opinion as to whether or not the individual requires a level of care services which the operator is authorized, or able, to provide in the facility.

The Medical Assessment may be completed by an authorized professional as outlined below.

- A “regulated health professional” means a discipline under the Regulated Health Professions Act, 1991.
- The up-to-date assessment, which provides an opinion, shall be performed and obtained from one of the following disciplines regulated under the Regulated Health Professions Act, 1991: medicine, nursing, physiotherapy, or occupational therapy. In the alternative, the up-to-date assessment may be obtained from a social worker provided that it has been completed by a regulated health professional.
- In the case of the individual being referred on an emergency basis by an emergency service, for example a hospital or COAST, the up-to-date assessment, which provides an opinion, shall be obtained within one week of placement.
- A “referring agency” includes a hospital, a community agency, or a private clinic.
- The regulated health professional employed by a referring agency or the physician completing the assessment, shall have specific knowledge of the individual’s care needs.
- An assessment shall be done not more than 30 days before the tenant is accepted into the facility. It shall include information on the mental and physical function of the individual in regards to activities of daily living, such as maintaining sufficient personal nutrition, hygiene, warmth, rest, and safety.
- The written assessment which is obtained by the operator shall include an opinion as to whether or not the individual requires a level of care services that the operator is able to provide in the facility. The operator shall not admit an individual if the opinion is that the individual requires a level of care services that the operator is not able to provide.

Homestead Christian Care will use the opinion provided in this assessment to help determine whether we can provide the level of care services required by the applicant. We will not admit any tenant who we are unable to adequately serve.



## Medical Assessment Form

Residential Care Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Name of Tenant: \_\_\_\_\_ Gender: \_\_\_\_\_  
Surname First Name

Date of Birth: \_\_\_\_\_ Admission Date \_\_\_\_\_

Allergies: \_\_\_\_\_ Language Spoken: \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Brief Medical History: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Diagnosis: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Medications Currently Prescribed: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tenant: \_\_\_\_\_ is able \_\_\_\_\_ is NOT able to self-medicate

Ambulation: (check all that apply)

1. Fully Ambulatory \_\_\_\_\_ On the level \_\_\_\_\_ on the stairs \_\_\_\_\_ wanders
2. Independent with aids \_\_\_\_\_ cane \_\_\_\_\_ walker \_\_\_\_\_ wheelchair
3. Requires Assistance \_\_\_\_\_ on the level \_\_\_\_\_ on the stairs

Bladder \_\_\_\_\_ responsible for self (not incontinent)  
\_\_\_\_\_ rare incontinence (use of briefs)  
\_\_\_\_\_ frequent incontinence

Bowels \_\_\_\_\_ responsible for self (not incontinent)  
\_\_\_\_\_ rare incontinence (use of briefs)  
\_\_\_\_\_ frequent incontinence

Nutrition: Able to eat: \_\_\_\_\_ independently \_\_\_\_\_ with supervision \_\_\_\_\_ assistance

Special Diet? \_\_\_\_\_ No \_\_\_\_\_ Yes, specify \_\_\_\_\_

Hygiene: \_\_\_\_\_ independent \_\_\_\_\_ supervision \_\_\_\_\_ assistance

Dressing: \_\_\_\_\_ independent \_\_\_\_\_ supervision \_\_\_\_\_ assistance

**Mental Health:**

Oriented to: Person, place and time \_\_\_\_\_ Yes \_\_\_\_\_ No (specify): \_\_\_\_\_

Confusion: \_\_\_\_\_ Never \_\_\_\_\_ Occasionally \_\_\_\_\_ frequently

Cognitive Impairment: Impedes functional ability \_\_\_\_\_ Never \_\_\_\_\_ Occasionally \_\_\_\_\_ frequently

Agitation: \_\_\_\_\_ Never \_\_\_\_\_ Occasionally \_\_\_\_\_ frequently

Aggression: \_\_\_\_\_ Never \_\_\_\_\_ Occasionally \_\_\_\_\_ frequently

Significant recent mental or physical changes/incidents/hospitalizations: \_\_\_\_\_

\_\_\_\_\_

TB Skin Test (must be completed within 14 days of admission)

Date: 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ Result: 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_

If TB test positive, result of chest x-ray and doctor'

Please Give Opinion: The Individual requires a level of care services that the operator \_\_\_\_\_ is able \_\_\_\_\_ is NOT able to provide in the facility.

**Date completed:** \_\_\_\_\_

**Physician's | Health Professional's Name (print):** \_\_\_\_\_

**Physician's | Health Professional's Signature:** \_\_\_\_\_