Ilarion Assisted Living Centre
2509 Louise Street, Saskatoon, Sask. S7J 3L7
Phone: 373-7011 or 955-1372 Fax: 373-7042
Email address: ilarion@sasktel.net

APPLICATION FOR ACCOMMODATION

Applicant's Name: _____ Date of Birth: ____/_____/____
Day/Month/Year

Address: _____

Postal Code: _____ Telephone: _____ Marital Status: _____

SHSP #: _____ Old Age Security #: _____

Doctor's Name: _____ Telephone #: _____

Co-Applicant's Name: _____ Date of Birth: ____/_____/____
Day/Month/Year

Address: _____

Postal Code: _____ Telephone: _____ Marital Status: _____

SHSP #: _____ Old Age Security #: _____

Doctor's Name: _____ Telephone #: _____

Religions Affiliation (optional): _____

Have you a **Spiritual Leader, Priest, Pastor, or Counselor**?

Name: _____ Telephone #: _____

Family Contact:

Name: _____

Address: _____

Telephone: _____

Power of Attorney:

Name: _____

Address: _____

Telephone: _____

Please notify if there is any change in status of application.

Applicants are asked to complete an **ASSESSMENT OF NEED AND ACTIVITY** form for each applicant.

I understand that acceptance of this application does not constitute an agreement by the *Assisted Living Centre* to provide me with accommodation.

I have read and understand the *GUIDELINES FOR RESIDENTS AND FAMILIES OF THE ASSISTED LIVING CENTRE.*

Applicants may from time to time be asked to update their monthly income information and/or their *ASSESSMENT OF NEED AND ACTIVITY.*

I declare that the information given in this application is correct and complete. I hereby authorize the Ukrainian Orthodox Senior Citizens Society to make any inquiries they deem necessary to verify the financial information reported in this application.

If I am accepted for accommodation in the *ASSISTED LIVING CENTRE,* I agree to sign the DECLARATION.

I agree to have all medical prescriptions bubble packed by my pharmacy.
I agree to allow the Assisted Living staff to supervise my medications. (open the bubble pack and give the medications to me at the assigned times)

Signed: _____

Applicant

_____

Co-Applicant

Witness: _____

Family Member or Power of Attorney

Date: _____

 Applicant's Name:_____

ASSISTED LIVING ASSESSMENT OF NEED AND ACTIVITY

A. Physical Health

1. Medical Conditions:

___Diabetes
___Effects of Stroke
___Cancer
___Other:
___Arthritis or Rheumatism
___Emphysema or Bronchitis
___Heart or Circulatory Problems
___Multiple Sclerosis

Effects:

2. Teeth:

___Own teeth only
___Dentures:
___Upper
___Lower
___Partial
___Implants
___No problems
___Some problems
___Significant problems

Effects:

3. Eyesight:

___Glasses
___Partly blind
___Totally blind
___Good
___Fair
___Poor

Effects:

4. Feet: (pain, swelling, etc.)

___No problems
___Some problems
___Significant problems

Effects:

5. Hearing:

___Hearing Aid:
___Left ear
___Right ear
___Other auditory aids
___Partly deaf
___Totally deaf
___No problems
___Some problems
___Significant problems

Effects:

6. Skin Conditions:
(pressure sores, etc.)

___No problems
___Some problems
___Significant problems

Effects:

B. ACTIVITIES FOR DAILY LIVING

1. Walking:

___Fully independent
___Independent with cane, walker, etc.
___Requires some assistance
___Wheelchair-independent
___Wheelchair-needs assistance
___Bedfast, or bed to chair only

Comments:

2. Transferring: Comments:	___No help ___Positioning required: ___Yes ___No	___Limited ___Unable to perform without help
3. Bathing: (including getting in and out of): Comments:	___No help ___Sponge bath: ___Yes ___No	___Limited ___Unable to manage (if limited or unable)
4. Dressing, Undressing: Comments:		___No help ___Limited ___Unable to perform without help
5. Feeding: Comments:		___No help ___Limited ___Unable to perform without help
6. Grooming: Comments:		___No help ___Limited ___Unable to perform without help
7. Sleep: Comments:	___Currently using medications for sleep: ___Yes ___No	___No problems ___Some problems ___Significant Problems
8. Continence: Comments:	Bladder: ___Continent ___Occasional problems ___Frequent problems ___Incontinent	Bowel: ___Continent ___Occasional problems ___Frequent problems ___Incontinent

9. Telephone: ___No help ___Limited ___Unable to use

Comments:

10. Medication Administration: ___Independent ___Supervision ___Full Assistance

Comments:

C. SUPPORT

Specialized Care

___ Physical/
___ Public Health Nurse
___ Nutritionist
___ Chiropodist
___ Speech Therapist
___ Adult Day Care
___ Social Worker
___ Psychiatrist
___ Mental Health Nurse
___ Home Care Nurse

Aids & Equipment Required

___ Cane
___ Crutches/Walker
___ Wheelchair
___ Leg Brace
___ Artificial Limb
___ Ostomy Equipment
___ Catheter
___ Oxygen Equipment
___ Pacemaker
___ Bath Bars
___ Commode
___ Raised Toilet Seat
___ Other_____

D. MANNER

1. Memory	1. ___ Yes	___ No
2. Judgement	2. ___ Yes	___ No
3. Behavior	3. ___ Yes	___ No
4. Co-operation	4. ___ Yes	___ No
5. Unusual Behavior	5. ___ Yes	___ No
6. Tendency to Wander	6. ___ Yes	___ No
7. Communication	7. ___ Yes	___ No
8. Social Interaction	8. ___ Yes	___ No

E. PERSONAL INFORMATION

Family Background:

Hobbies/Interests:

Comments:

F. Additional Comments

G. Dietary Information

Assistance with Eating _____Yes _____No

If yes, what type of help? ie cutting meat, etc., _____

_____

_____

Food Allergies, please list:_____

_____

_____

Food Preferences, please list:_____

_____

Food Dislikes, please list:_____

_____

Food Tolerance, please list any foods that cannot be tolerated:_____

_____

What diseases do you have, that affects your diet?

_____ Diabetes

_____ Colitis

_____ Irritable Bowel Syndrome

_____ Other, please list_____

_____