Residential Services Application/Referral - Part 2

Part 2- Health Information (Form CS-RS 894E)

Overview :

Residential Services, also known as domiciliary hostels, are private or non-profit residences that provide long-term housing to vulnerable adults who require some supervision and services to maintain their independence in the residence. Services include: furnished rooms, 24-hour urgent response, medication management, meals and snacks, housekeeping and personal laundry, social and/or recreational activities.

Read the Instruction Guide (Form CS-RS 892E) found on ottawa.ca before completing the application form. The guide provides detailed information and step by step instruction on how to fill out the application.

To apply for a Residential Services subsidy, a person must complete an application form. The application is divided into two parts:

- Part 1: Applicant Information (Form CS-RS 893E)
- **Part 2: Health Information (Form CS-RS 894E)**
  - The applicant must consent to the release of information by completing and signing Section 2A of the Health Information form
  - **Sections 2B to 2D must be completed by a health care professional** such as a doctor (for example family doctor, psychiatrist, neurologist), nurse or social worker.

If you need help to find a health care professional, you may contact your local community centre.

If you do not have a health care professional, a case manager from the Community Care Access Centre (CCAC), Canadian Mental Health Association (CMHA) or other outreach worker, can complete the Health Information of the application.

If you are unable to print the application (Part 1- Applicant Information and Part 2 - Health Information), you may request a paper copy by e-mailing CommunitySupports@ottawa.ca or by calling 613-580-2424, extension 26586 and one will be mailed to you.

Send the completed application to the City of Ottawa Community Supports

Once you have both the Applicant Information (Sections 1A to 1E) and the Health Information (Sections 2A to 2D) completed, submit both forms to Community Supports by e-mail, fax or mail.

E-mail (scan copy): CommunitySupports@ottawa.ca
Fax: 613-580-2790
Mail: Community Supports, 370 Catherine Street, Ottawa, ON K1R 5T5

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Section 2A - Consent to release health information

TO BE COMPLETED BY THE APPLICANT

(Applicant name)

I, _____, consent to the collection and release of personal information about me as it is collected on this form to an authorized representative of the City of Ottawa for the sole purpose of determining or verifying my eligibility for the Residential Services (Domiciliary Hostel) Program.

Signature of applicant : _____

Witness : _____

Date : _____

Personal information is collected under the authority of the Municipal Act, 2001, S.O. 2001, c. 25, sections 8 and 10. Personal information will be used by the City of Ottawa for the purposes of determining eligibility for and the administration of the Residential Services Program. Questions about this collection and use of your personal information may be directed to the Administrative Support Clerk at 370 Catherine St., 3rd Floor, Ottawa, Ontario, K1R 5T5, 613-580-2424 ext. 43511.

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TO BE COMPLETED BY A HEALTH CARE PROFESSIONAL

A health care professional such as a doctor, (for example family doctor, psychiatrist, neurologist) , nurse or social worker must complete Section 2B "Referral Source", Section 2C "Medical Information" & Section 2D "Additional Medical Information"

Section 2B - Referral Source

Applicant name:

Who is referring and or supporting the applicant with the application?

◯ Family Doctor ◯ Psychiatrist ◯ Neurologist ◯ Nurse ◯ Social Worker

◯ Other , please specify :

Referral source information

Agency / name:

Referral completed by:
(print full name)

Telephone number :

Fax number :

Address:

Apartment / unit number :

City: Province: Postal code:

E-mail address:

Doctor/Referral source signature :

Date (DD/MM/YYYY

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Section 2C - Medical Information

Medical diagnosis (provide doctor's physical, mental and or developmental diagnosis for example schizophrenia, diabetes)

What are the applicant's limitations?

Mobility

Walking / standing	◯ Independent ◯ Independent with aids ◯ Requires assistance Should the applicant need assistance, please select all that applies: ☐ Walking outside ☐ Walking inside ☐ Standing for longer then 15 minutes ☐ Sitting ☐ Going up and down the stairs
Lifting	In regards to applicants' ability to lift, please select all that applies: ☐ No lifting ☐ Some lifting for example shopping bags ☐ Heavy lifting for example 24 cans of cola
Gripping	Should the applicant have limitations with the following tasks, please select all that applies: ☐ Eating utensils ☐ Opening lids
Reaching up	Should the applicant have limitations with the following tasks, please select all that applies: ☐ Above shoulders ☐ Items from cupboard
Bending, twisting / repetitive movement	Should the applicant have limitations with the following tasks, please select all that applies: ☐ Making a bed ☐ Folding laundry and or putting away clothes ☐ Picking items on the floor ☐ Sweeping / moving / vacuuming / washing floors

Specify if adaptive aids would help with any of the tasks, for example bath aids. Please specify:

Additional information / comments:

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Personal Care

Dressing	◯ Independent ◯ Needs assistance ◯ Cueing Should the applicant need assistance, please select all that applies: ☐ Putting on footwear ☐ Buttoning a shirt/pant
Bathing / other	◯ Independent ◯ Needs assistance ◯ Cueing Should the applicant need assistance, please select all that applies: ☐ Getting in and out of the shower/tub ☐ Feeding ☐ Standing in shower
Incontinence / bladder	◯ Yes ◯ No ◯ Unknown If yes, is applicant independent with use of products/supplies? ◯ Yes ◯ No
Incontinence / bowel	◯ Yes ◯ No ◯ Unknown If yes, is applicant independent with use of products/supplies? ◯ Yes ◯ No
Special needs	☐ Speech ☐ Vision ☐ Hearing ☐ Other (details)

Dietary Requirements

Allergies	◯ Yes ◯ No ◯ Unknown Details:
Special dietary requirements	◯ Yes ◯ No ◯ Unknown Details:
Any other limitations? Comments	

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Section 2D - Additional Medical Information

Social history / presenting problem:

Does the applicant have a substitute decision maker?	◯ Yes ◯ No ◯ Unknown
Has the applicant been deemed incompetent? If yes, please provide details/contact information regarding Public Guardian and Trustee, Power of Attorney for example	◯ Yes ◯ No ◯ Unknown
Is the applicant receiving any community support services? (for example CCAC, ACT, CMHA)	◯ Yes ◯ No ◯ Unknown If yes, provide details / contact information:
Does the applicant have a substance use?	◯ Yes ◯ No ◯ Unknown ◯ Yes - Past If yes, provide details:
Does the applicant have: • Community Treatment Order? • Court disposition order? • Criminal involvement? • Probation/parole? • Probation parole officer?	◯ Yes ◯ No ◯ Unknown ◯ Yes ◯ No ◯ Unknown ◯ Yes ◯ No ◯ Unknown ◯ Yes ◯ No ◯ Unknown ◯ Yes ◯ No ◯ Unknown If yes to any of the above please provide details:

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Signs and symptoms of the illness based on the medical diagnosis Select the applicable areas listed below and provide details	
Area:	**Details:**
☐ Anxiety **or** ☐ not applicable	
☐ Aggression **or** ☐ not applicable	
☐ Apathy withdrawal **or** ☐ not applicable	
☐ Cognitive function **or** ☐ not applicable	
☐ Communication **or** ☐ not applicable	
☐ Delusional thinking **or** ☐ not applicable	
☐ Depression **or** ☐ not applicable	
☐ Inappropriate sexual behaviour **or** ☐ not applicable	
☐ Obsessive/ compulsive behaviour **or** ☐ not applicable	
☐ Paranoia **or** ☐ not applicable	
☐ Safety issues **or** ☐ not applicable	

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◯ Suicidal thoughts/ behaviours **or** ◯ not applicable	
◯ Wandering/ confusion **or** ◯ not applicable	
☐ Other	

Current medication	
Name of medication(s)	**Dosage / Frequency (for example; daily, weekly, monthly)**

Current pharmacy name and location:

Hospitalizations (over the past 2 years)			
Date of admission	**Duration**	**Institution**	**Presenting problem**

Print Form Reset Form