АПЛІКАЦІЯ / APPLICATION FOR ADMISSION

3058 Winston Churchill Blvd.
Mississauga ON L5L 3J1
Tel: 905-820-0573 Fax: 905-820-8134
E: info@ivanfrankohomes.com
www.ivanfrankohomes.com

ІМ'Я ТА ПРІЗВИЩЕ / FULL NAME

МОЯ АДРЕСА / MY PRESENT ADDRESS

ДАТА НАРОДЖЕННЯ / DATE OF BIRTH

МІЙ ТЕЛЕФОН / PHONE NUMBER

МІСЦЕ НАРОДЖЕННЯ / PLACE OF BIRTH

МІЙ ІМЕЙЛ / EMAIL

ПОДРУЖНІЙ СТАН / MARITAL STATUS

КОНТАКТНА ІНФОРМАЦІЯ ОПІКУНА / POA 1

NAME:
TEL:
EMAIL:
ADRESS:

ГРОМАДЯНСТВО / CITIZENSHIP

РЕЛІГІЯ / RELIGION

КОНТАКТНА ІНФОРМАЦІЯ ОПІКУНА / POA 2

NAME:
TEL:
EMAIL:
ADRESS:

ONTARIO HEALTH CARD #

MEDICAL INSURANCE

ОПІКА / TYPE OF CARE SERVICES REQUIRED

___ ASSISTED LIVING (PKG #1)
___ INDEPENDENT LIVING (PKG #2)
___PARTIAL ASSISTED LIVING (PKG #3)
___SHORT TERM STAY (PKG #4)

АПАРТАМЕНТ / ACCOMODATION DESIRED

___ ASSISTED LIVING PRIVATE SUITE
___ BACHELOR APARTMENT
___ 1-BEDROOM APARTMENT
___ 2-BEDROOM APARTMENT

Я ХОЧУ ЗАЇХАТИ / I WANT TO MOVE IN (DATE)

I understand that the Ivan Franko Home at 3058 Winston Churchill Blvd. is not a nursing home and that, if I should need more care than this Home can provide, I (or my POA) will make an application to the Ministry of Health (Ontario Health) for my transfer to the Ivan Franko Home Long Term Care Home at 767 Royal York Road or to any other long-term care home of my choice.

DATE:________________________________ SIGNATURE:___________________________

Health Assessment Form
for application for admission to
Ivan Franko Homes, Mississauga ON

Name of applicant (Surname)		(given names)			
☐ Smoker ☐ Non-smoker	Sex	Date of birth	Height	Weight	Ontario Health Card #

Section A - Assessment of General Care Needs

1. Skin — Check each question -

	Yes	No
(a) Ulcers	☐	☐
(b) Rash	☐	☐
(c) Bruises	☐	☐
(d) Abrasions	☐	☐
(e) Other abnormalities	☐	☐

explain:

2. Mental State — Check each question -

	Yes	No
(a) Occasional brief periods of recent memory loss and confusion	☐	☐
(b) Marked confusion and disorientation with brief periods of being alert	☐	☐
(c) persistent confusion and disorientation	☐	☐
(d) Organic brain syndrome and/or senile dementia	☐	☐
(e) Mental Retardation	☐	☐

3. Behaviour — Check each question

	Yes	No
(a) Quiet and co-operative	☐	☐
(b) Unco-operative	☐	☐
(c) Abnormally talkative	☐	☐
(d) Emotional lability	☐	☐
(e) Suspicious	☐	☐
(f) Noisy	☐	☐
(g) Quarrelsome	☐	☐
(h) Requires restraint	☐	☐

4. Functional Activity — Check each question

	Yes	No
(a) Bladder control normal	☐	☐
(b) Bowel control normal	☐	☐
(c) Able to speak normally	☐	☐
(d) Registered Blind person	☐	☐
(e) Able to read	☐	☐
(f) Able to hear speech at normal level	☐	☐
(g) Able to wash face and hands	☐	☐
(h) Able to bathe and shower self	☐	☐
(i) Able to use toilet facilities	☐	☐

5. Use of limbs — Lefthanded ☐ Righthanded ☐

Arms and hands	L	R	Lower limbs	L	R
(a) Normal use	☐	☐	(e) Normal use	☐	☐
(b) Impaired use	☐	☐	(f) Impaired use	☐	☐
(c) No use	☐	☐	(g) No use	☐	☐
(d) Amputation	☐	☐	(h) Amputation	☐	☐

6. Feeding — Check each question -

	Yes	No
(a) Feeds self	☐	☐
(b) Needs supervision	☐	☐
(c) Needs assistance	☐	☐
(d) Needs feeding	☐	☐

7. Dressing — Check each question -

	Yes	No
(a) Independent	☐	☐
(b) Needs supervision or assistance	☐	☐
(c) Needs to be dressed	☐	☐

8. Mobility — Check each question

	Yes	No
(a) Able to walk without help	☐	☐
(b) Requires walking aids	☐	☐
(c) Independent with wheelchair	☐	☐
(d) Requires assistance - to walk	☐	☐
- to lift in and out of a chair	☐	☐
- to move wheelchair	☐	☐
(e) Can get in or out of bed	☐	☐
(f) Needs some help to get in or out of bed	☐	☐
(g) Needs lifting in and out of bed	☐	☐
(h) Needs to be turned in bed	☐	☐
(i) Bedridden	☐	☐

Prepared by:

Signature | Date

Section B - Attending Physicians' Report

	Yes	No
1. Special diet	☐	☐
2. P. R. N. orders	☐	☐
3. Injections · Subcutaneous	☐	☐
· Intramuscular	☐	☐
4. Sterile dressings	☐	☐
5. Tube feeding or intubation	☐	☐
6. Irrigations	☐	☐
7. Indwelling catheter	☐	☐
8. Laboratory services: · Haematology	☐	☐
· Blood chemistry	☐	☐
9. X-ray	☐	☐

10. Rehabilitation services:

	Yes	No
· Physiotherapy	☐	☐
· Occupational therapy	☐	☐
· Speech therapy	☐	☐
· Vocational assessment	☐	☐
Other specify:	☐	☐

If "Yes" please specify:

Section C - Medical Assessment

1. Medical History: ____________________

2. Present Condition: ____________________

3. Present Medication with Dosage: ____________________

4. Allergies and Drug Sensitivity: ____________________

5. Diagnoses: List in spaces A, B, C, D, E, F in order of importance, the conditions that make care or treatment necessary.

For each condition indicate your assessment in each vertical line in the Prognosis:

	Duration Wks.	Mos.	Yrs.
A			
B			
C			
D			
E			
F			

	A	B	C	D	E	F
6. Prognosis:						
(a) Little effect on life span	☐	☐	☐	☐	☐	☐
(b) Improvement in 3 months	☐	☐	☐	☐	☐	☐
(c) Some deterioration in 3 months	☐	☐	☐	☐	☐	☐
(d) Probably fatal in 3 months	☐	☐	☐	☐	☐	☐
7. Rehabilitation Potential:						
(a) Independent living	☐	☐	☐	☐	☐	☐
(b) Moderate - to self-care level	☐	☐	☐	☐	☐	☐
(c) Limited	☐	☐	☐	☐	☐	☐
(d) None	☐	☐	☐	☐	☐	☐
8. Present state of Disease:						
(a) Stable	☐	☐	☐	☐	☐	☐
(b) Mildly active	☐	☐	☐	☐	☐	☐
(c) Active	☐	☐	☐	☐	☐	☐
9. Purpose of Medical Care:						
(a) Maintenance	☐	☐	☐	☐	☐	☐
(b) Evaluation and treatment	☐	☐	☐	☐	☐	☐
(c) Rehabilitation	☐	☐	☐	☐	☐	☐
(d) Palliative therapy	☐	☐	☐	☐	☐	☐

10. Estimated Duration of Stay:

Weeks ____________________

Months ____________________

Years ____________________

11. Comments: ____________________

12. Placement Certification:

The statements herein contained are correct to the best of my professional knowledge and in my opinion the care needs of the applicant indicate that he or she is eligible for admission to

Ivan Franko Home

Signature of Physician	Date

Schedule “A”

МІСЯЧНІ ОПЛАТИ ЗА УТРИМАННЯ В ПАНСІОНІ ім. ІВАНА ФРАНКА
PLEASE INITIAL CHOSEN PACKAGE OF MONTHLY COSTS OF ACCOMMODATION & CARE
ONLY AVAILABLE AS PACKAGE

3058 Winston Churchill Blvd., Mississauga, ON L5L 3J1
(effective January 1st, 2024)

PKG. #1: Assisted Living (Приміщення з харчуванням та опікою): includes heating, electricity and water, 4-pc bathroom, 3 meals per day and snacks, full weekly housekeeping services, bi-weekly laundry services, assistance with weekly bath or shower, health and medication monitoring and access to services of Medical Director/ Home Physician, 24-hour supervision and emergency response, social and recreational activity program, as needed assistance with personal hygiene, help with dressing;

PCK. # 1A: Accommodation in the **A/L suite** ……………………………………………………........$3,635/mo.

PCK. # 1B: Accommodation in the **Enlarge A/L 1-bedroom suite** ....$3,845/mo.

PKG. # 1C: Accommodation in the **Bachelor apartment** ……………………………………………….$3,795/mo.

PKG. # 1D: Accommodation in the **1-bedroom apartment** …………………………………………….... $4,055/mo.

PKG. # 1E: Accommodation in the **1.5-bedroom apartment** …………………………………………….... $4,170/mo.

PKG. # 1F: Accommodation in **2-bedroom apartment**…………………………………………………...... $4,285/mo.

*For second occupant with same services add $1,765/mo.

PKG. #2: Independent Living with 1 meal daily (Приміщення з харчуванням один раз денно): includes heating, electricity and water, kitchenette, 4-pc bathroom, patio/balcony, 1 meal daily, weekly access to services of Medical Director/Home Physician, social and recreational program, 24-hour emergency response;

PKG. # 2A: Accommodation in the **Bachelor apartment**.. $2,385/mo.

PKG. # 2B: Accommodation in the **1-bedroom apartment**……………………………………………….$2,650/mo.

PKG. # 2C: Accommodation in the **1.5-bedroom apartment** ……………………………………………..$2,775/mo.

PKG. # 2D: Accommodation in the **2-bedroom apartment**………………………………………………. $2,890/mo.

*For second occupant add $755 per month

PKG. #3: Partially Assisted with 2 meals daily (Приміщення з харчуванням 2 рази денно і частинною допомогою): includes heating, electricity and water, kitchenette, 4-pc bathroom, patio/balcony, 2 meals daily, bi-weekly housekeeping service, bi-weekly laundry services, weekly access to services of Medical Director/Home Physician, social and recreational program, 24-hour emergency response;

PKG. # 3A: Accommodation in the **Bachelor apartment** ……………………………………………........$3,185/mo.

PKG. # 3B: Accommodations in a **1-bedroom apartment**……………………………………............. $3,495/mo.

PKG. # 3C: Accommodation in the **1.5-bedroom apartment** ……………………………………………..$3,625/mo.

PKG. # 3D: Accommodations in **2-bedroom apartment**…………………………………………......... $3,740/mo.

* For second occupant add $1,260 per month

PKG. #4: Short Term Stay: (Короткотривалий догляд): Accommodations and care – see PKG. #1
Minimum of 14 days. After 60 days of stay terms and conditions will be revised……………….......$130/day

Note: For a newly renovated suite or apartment additional charge of $0.625 per sq. ft. per month (A/L suite - 400 sq. ft., Bachelor - 400 sq. ft., 1-Bedroom – 600 sq. ft., 1.5/2 – Bedrooms - 800 sq. ft.)

Additional Services

Tray service (delivery of meals to apartment) ………………………………………………………… $ 4.00 per meal

Extra laundry…………………………………………………………………………………………… $ 10.00 per laundry

Use of a resident's personal air conditioner (extra cost of hydro) …………………………………… $ 100.00 per season

Installation and removal of a resident's personal air conditioner…………………………………….. $ 50.00 per season

Security bracelet (rent)…………………………………………………………………………………$ 60.00 per month

Medical bed (rent)………………………………………………………………………………………$ 60.00 per month

Foot Care Care (by Registered Chiropodist, available onsite, bi-monthly)…………………………...$ 40.00 per service

Laboratory services (by LifeLab technician every Wednesday)……………………………………...$ 30.00 per service

Medical Services (by Home Attending Physician, onsite every Tuesday) ………………………… $ paid by OHIP

Physiotherapy Services (onsite, by referral from doctor) …………………………………………...$ paid by OHIP

Hairdressing (bi-weekly)…………………………………………$ onsite, in accordance with fees set by hairdresser

Note: The above-noted price(s) are subject to increase from time to time, as permitted by applicable legislation. If a resident is absent from the Home for any reason (eg. hospitalized or on vacation or family visit), there will be no refunds for missed meals or care.

Note: The applicant or his/her guardian must fully complete the application form and provide most resent income statement. The applicant must submit a **medical assessment** completed by an accredited physician. The physician filling out the pre-admission medical form must certify in writing that the applicant is free from active tuberculosis or from other communicable diseases. Results of a **chest X-ray and Mantoux test** (done within the last 6 months) should be attached to the pre-admission medical form. Under no circumstances will persons be admitted to the Home with infectious diseases, open sores and unhealed wounds, indwelling catheters, or requiring the use of oxygen tanks.

Senior's Day Program Registration Form

Monday and Friday
9:00 am to 3:00 pm
$30 per day includes lunch
$16 stay for dinner

DATE OF REGISTRATION

__ __ / __ __ / __ __

PERSONAL INFORMATION / ПЕРСОНАЛЬНА ІНФОРМАЦІЯ

Full Name
Ім'я

Address
Адреса

City
Місто

Date of Birth :
Дата народження

__ __ / __ __ / __ __

Nationality
Національність

Email
Імейл

Home Phone
Число Телефону

OHIP #

Cell Phone
Мобільний

Allergies
Алергії

Medical Info
Медична інформація

POA / КОНТАКТНА ІНФОРМАЦІЯ ОПІКУНА

Name

Telephone

Email

Address

City

Name

Telephone

Email

Address

City

Kindly mail/email your application to:

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E: info@ivanfrankohomes.com
Tel: 905-820-0573