



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 ПРИЗВИЩЕ / 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:

ADDRESS:

ГРОМАДЯНСТВО / CITIZENSHIP

РЕЛІГІЯ / RELIGION

КОНТАКТНА ІНФОРМАЦІЯ ОПІКУНА / POA 2

NAME:

TEL:

EMAIL:

ADDRESS:

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: _____

1. Skin		Check each question -		Yes	No
(a) Ulcers				<input type="checkbox"/>	<input type="checkbox"/>
(b) Rash				<input type="checkbox"/>	<input type="checkbox"/>
(c) Bruises				<input type="checkbox"/>	<input type="checkbox"/>
(d) Abrasions				<input type="checkbox"/>	<input type="checkbox"/>
(e) Other abnormalities				<input type="checkbox"/>	<input type="checkbox"/>
explain:					
2. Mental State		Check each question -		Yes	No
(a) Occasional brief periods of recent memory loss and confusion				<input type="checkbox"/>	<input type="checkbox"/>
(b) Marked confusion and disorientation with brief periods of being alert				<input type="checkbox"/>	<input type="checkbox"/>
(c) persistent confusion and disorientation				<input type="checkbox"/>	<input type="checkbox"/>
(d) Organic brain syndrome and/or senile dementia				<input type="checkbox"/>	<input type="checkbox"/>
(e) Mental Retardation				<input type="checkbox"/>	<input type="checkbox"/>
3. Behaviour		Check each question		Yes	No
(a) Quiet and co-operative				<input type="checkbox"/>	<input type="checkbox"/>
(b) Unco-operative				<input type="checkbox"/>	<input type="checkbox"/>
(c) Abnormally talkative				<input type="checkbox"/>	<input type="checkbox"/>
(d) Emotional lability				<input type="checkbox"/>	<input type="checkbox"/>
(e) Suspicious				<input type="checkbox"/>	<input type="checkbox"/>
(f) Noisy				<input type="checkbox"/>	<input type="checkbox"/>
(g) Quarrelsome				<input type="checkbox"/>	<input type="checkbox"/>
(h) Requires restraint				<input type="checkbox"/>	<input type="checkbox"/>
4. Functional Activity		Check each question		Yes	No
(a) Bladder control normal				<input type="checkbox"/>	<input type="checkbox"/>
(b) Bowel control normal				<input type="checkbox"/>	<input type="checkbox"/>
(c) Able to speak normally				<input type="checkbox"/>	<input type="checkbox"/>
(d) Registered Blind person				<input type="checkbox"/>	<input type="checkbox"/>
(e) Able to read				<input type="checkbox"/>	<input type="checkbox"/>
(f) Able to hear speech at normal level				<input type="checkbox"/>	<input type="checkbox"/>
(g) Able to wash face and hands				<input type="checkbox"/>	<input type="checkbox"/>
(h) Able to bathe and shower self				<input type="checkbox"/>	<input type="checkbox"/>
(i) Able to use toilet facilities				<input type="checkbox"/>	<input type="checkbox"/>
5. Use of limbs		Lefthanded <input type="checkbox"/> Righthanded <input type="checkbox"/>		L - R	Lower limbs
(a) Normal use				<input type="checkbox"/>	<input type="checkbox"/>
(b) Impaired use				<input type="checkbox"/>	<input type="checkbox"/>
(c) No use				<input type="checkbox"/>	<input type="checkbox"/>
(d) Amputation				<input type="checkbox"/>	<input type="checkbox"/>
6. Feeding		Check each question -		Yes	No
(a) Feeds self				<input type="checkbox"/>	<input type="checkbox"/>
(b) Needs supervision				<input type="checkbox"/>	<input type="checkbox"/>
(c) Needs assistance				<input type="checkbox"/>	<input type="checkbox"/>
(d) Needs feeding				<input type="checkbox"/>	<input type="checkbox"/>
7. Dressing		Check each question -		Yes	No
(a) Independent				<input type="checkbox"/>	<input type="checkbox"/>
(b) Needs supervision or assistance				<input type="checkbox"/>	<input type="checkbox"/>
(c) Needs to be dressed				<input type="checkbox"/>	<input type="checkbox"/>
8. Mobility		Check each question		Yes	No
(a) Able to walk without help				<input type="checkbox"/>	<input type="checkbox"/>
(b) Requires walking aids				<input type="checkbox"/>	<input type="checkbox"/>
(c) Independent with wheelchair				<input type="checkbox"/>	<input type="checkbox"/>
(d) Requires assistance		- to walk		<input type="checkbox"/>	<input type="checkbox"/>
		- to lift in and out of a chair		<input type="checkbox"/>	<input type="checkbox"/>
		- to move wheelchair		<input type="checkbox"/>	<input type="checkbox"/>
(e) Can get in or out of bed				<input type="checkbox"/>	<input type="checkbox"/>
(f) Needs some help to get in or out of bed				<input type="checkbox"/>	<input type="checkbox"/>
(g) Needs lifting in and out of bed				<input type="checkbox"/>	<input type="checkbox"/>
(h) Needs to be turned in bed				<input type="checkbox"/>	<input type="checkbox"/>
(i) Bedridden				<input type="checkbox"/>	<input type="checkbox"/>
Prepared by:					
Signature				Date	

	Yes	No		Yes	No	10. Rehabilitation services:	Yes	No
1. Special diet	<input type="checkbox"/>	<input type="checkbox"/>	6. Irrigations	<input type="checkbox"/>	<input type="checkbox"/>	- Physiotherapy	<input type="checkbox"/>	<input type="checkbox"/>
2. P. R. N. orders	<input type="checkbox"/>	<input type="checkbox"/>	7. Indwelling catheter	<input type="checkbox"/>	<input type="checkbox"/>	- Occupational therapy	<input type="checkbox"/>	<input type="checkbox"/>
3. Injections • Subcutaneous	<input type="checkbox"/>	<input type="checkbox"/>	8. Laboratory services: • Haematology	<input type="checkbox"/>	<input type="checkbox"/>	- Speech therapy	<input type="checkbox"/>	<input type="checkbox"/>
• Intramuscular	<input type="checkbox"/>	<input type="checkbox"/>	• Blood chemistry	<input type="checkbox"/>	<input type="checkbox"/>	- Vocational assessment	<input type="checkbox"/>	<input type="checkbox"/>
4. Sterile dressings	<input type="checkbox"/>	<input type="checkbox"/>	9. X-ray	<input type="checkbox"/>	<input type="checkbox"/>	Other specify:	<input type="checkbox"/>	<input type="checkbox"/>
5. Tube feeding or intubation	<input type="checkbox"/>	<input type="checkbox"/>						
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:

6. Prognosis:

- Little effect on life span
- Improvement in 3 months
- Some deterioration in 3 months
- 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;

PKG. # 1A: Accommodation in the A/L suite\$3,635/mo.

PKG. # 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

<u>Tray service</u> (delivery of meals to apartment)	\$ 4.00 per meal
<u>Extra laundry</u>	\$ 10.00 per laundry
<u>Use of a resident's personal air conditioner</u> (extra cost of hydro)	\$ 100.00 per season
<u>Installation and removal of a resident's personal air conditioner</u>	\$ 50.00 per season
<u>Security bracelet (rent)</u>	\$ 60.00 per month
<u>Medical bed (rent)</u>	\$ 60.00 per month
<u>Foot Care</u> <u>Care</u> (by Registered Chiropodist, available onsite, bi-monthly).....	\$ 40.00 per service
<u>Laboratory services</u> (by LifeLab technician every Wednesday).....	\$ 30.00 per service
<u>Medical Services</u> (by Home Attending Physician, onsite every Tuesday)	\$ paid by OHIP
<u>Physiotherapy Services</u> (onsite, by referral from doctor)	\$ paid by OHIP
<u>Hairdressing (bi-weekly)</u>	\$ 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 recent income statement (Notice of Assessment – NOA or other IFH Approved Proof of Income). 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.

Financial Information: Income and Assets

Alimony or Support		
Annuities		
Bank/Other Account		
Bonds		
Canada Pension		
Cash		
Certificates		
D.V.A. Allowance		
Debentures		
Family Benefits		
GAINS		
Gross Salary		
Life Interest in Estate		
Life Interest in Trust		
Old Age Security		
Other Country O.A.S.		
Private Pension		
U.S. Social Security		
Unemployment Insurance		
Values of Security, Shares, Stocks		
Veteran's Pension		
Welfare Benefits		
Workman's Compensation		
Other Assets		
Total Value of Assets		

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

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
----------------------	----------------------	---	----------------------	----------------------	---	----------------------	----------------------

PERSONAL INFORMATION / ПЕРСОНАЛЬНА ІНФОРМАЦІЯ

Full Name Ім'я	<input type="text"/>		
Address Адреса	<input type="text"/>	City Місто	<input type="text"/>
Date of Birth : Дата народження	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email Імейл	<input type="text"/>	Nationality Національність	<input type="text"/>
OHIP #	<input type="text"/>	Home Phone Число Телефону	<input type="text"/>
Allergies Алергії	<input type="text"/>	Cell Phone Мобільний	<input type="text"/>
		Medical Info Медична інформація	<input type="text"/>

POA / КОНТАКТНА ІНФОРМАЦІЯ ОПІКУНА

Name	<input type="text"/>		
Telephone	<input type="text"/>	Email	<input type="text"/>
Address	<input type="text"/>	City	<input type="text"/>
Name	<input type="text"/>		
Telephone	<input type="text"/>	Email	<input type="text"/>
Address	<input type="text"/>	City	<input type="text"/>

Kindly mail/email your application to:

Ivan Franko Homes
3058 Winston Churchill Blvd.
Mississauga ON L5L 3J1
E: info@ivanfrankohomes.com
Tel: 905-820-0573