



Bruce House 251 Bank Street Suite #402, Ottawa ON K2P 1X3 (613)729-0911 Fax (613)729-0959

Application Form

Name: _____		
Date of Birth: _____	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Language: _____	English <input type="checkbox"/>	French <input type="checkbox"/>
Address: _____		
May we send confidential mail to this address:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Phone: _____		
May we leave confidential messages at this number?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Referral Information

Referral Date: _____		
Source of Referral: _____		
Contact Person: _____	Phone: _____	Fax: _____
May we leave a message with this contact?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Service Requested

Bachelor Apartment <input type="checkbox"/>	Two-Bedroom Apartment <input type="checkbox"/>
One Bedroom Apartment <input type="checkbox"/>	Transition House <input type="checkbox"/>

Emergency Contact(s)

Name: _____	Relationship: _____
Address: _____	
Phone: _____	Home: _____
Work: _____	

Name: _____	Relationship: _____
Address: _____	
Phone: _____	Home: _____
Work: _____	

Physician(s)

Name: _____	Phone: _____
Address: _____	

Name: _____	Phone: _____
Address: _____	

Social Worker or other Professional(s)

Name: _____
Agency: _____ Phone: _____
Address: _____

Name: _____
Agency: _____ Phone: _____
Address: _____

Source of Income

Ontario Works ODSP Private Insurance Other _____
Contact Name: _____ Phone: _____

Special Placement Criteria

In order to assist us in allocating our accommodation appropriately, we ask that you complete the following form. Failure to do so will not result in our refusal of your application

Please check all appropriate boxes:

Health Status:

HIV+ Asymptomatic

The person being referred is HIV positive but has no physical symptoms of HIV.

HIV+ Early Symptomatic

The person being referred is experiencing HIV related illness and is receiving active treatment.

HIV+ Late Symptomatic

The person being referred requires palliative care.

HIV+ HIV Encephalopathy

The person being referred is HIV positive and suffers from AIDS related dementia.

HIV+ Stage Unknown

Abusive Living Situation:

In the person's current living situation, the person being referred is exposed to or at risk for sexual, physical or psychological abuse.

Age:

The person being referred has or is likely to experience difficulty obtaining accommodation or service by virtue of his or her age.

Culture:

The person being referred is unaccustomed to mainstream Canadian culture.

Disability:

In addition to any disability related to HIV, the person being referred has one or more disabilities.

Gender:

The person being referred is female or has or is likely to experience gender-based discrimination.

Homeless or Risk of Losing Home:

The person being referred presently has no home, resides in an emergency shelter or is a custodial parent of children and resides with one or more of his or her parents.

Housing Inappropriate to Healthy Living:

The person being referred lives in a marginal living situation that has or is likely to compromise his/her health.

Lack of Skills to Promote Personal Health:

The person's health and well-being are jeopardized by a lack of the skills for daily living.

Lack of Social Supports:

The person being referred has little or no support of friends, family or caregivers.

Parent with Children:

The person being referred is the custodial parent of a child or children under 18.

Poverty:

The income of the person being referred falls below the poverty line for the region.

Race:

The person being referred is Black, Asian (including South, Southeast and West Asian) or Aboriginal.

Sexual Orientation:

The person being referred is Lesbian, Gay or Bisexual.

Substance Abuse:

The person being referred has identified the abuse of alcohol or drugs as an issue in his or her life.

Transgendered, Cross-dresser, Pre- or Post-Operative Transsexual or Transvestite.

Applicants Emotional State and Degree of Urgency of Placement:

Current Housing Situation:

Factors Precipitating Present Need for Housing:

Significant Health Issues:

Health Knowledge and Knowledge of HIV:

Supportive Relationships/Social Network:

Use or Abuse of Alcohol or Drugs (e.g. Levels of Usage, Programs Involved):

Financial Situation:

Relevant Background Information (e.g. Family of Origin, Significant Attachments/Losses):

Additional Comments or Information from Interview:

OHIP Number: _____ Quebec Health Plan Number: _____
Social Insurance Number: _____ Para Transpo Account Number: _____
Extended Health Care Yes No
If yes, Carrier: _____
Group Number: _____

Religious Affiliation: _____
Name of Clergy: _____
Phone: _____

Lawyer: Yes No
Name: _____
Address: _____
Phone: _____

Power of Attorney: Yes No
Name: _____
Address: _____
Phone: _____

Living Will: Yes No **Do Not Resuscitate Order:** Yes No
Name: _____
Address: _____
Phone: _____

Last Will and Testament: Yes No

Held By: _____

Address: _____

Phone: _____

Funeral Arrangements:

 Yes No**Functional Assessment****Ambulation**

History of Falls	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fear of Falling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Walks Independently	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Uses a Cane or Walker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unsteady	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Able to Climb Stairs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Able to Descend Stairs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Uses a Wheelchair	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Non-Ambulatory/Bedridden	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Notes: _____

Hygiene

Independent Use of Shower	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Independent Use of Bath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shaves Independently	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bathes with Bath Chair	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Independent Nail Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Requires Assistance with Personal Hygiene (please describe): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Notes: _____

Sleep Patterns

Sleeps Soundly	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Daytime Naps/Rest	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Night Sweats	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Requires Nighttime Sedation (please describe): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Sleeps Intermittently Yes No

Notes: _____

Elimination

Day Continence of Stool Yes No

Night Continence of Stool Yes No

Day Continence of Urine Yes No

Night Continence of Urine Yes No

Urinary Retention Yes No

Chronic Constipation Yes No

Chronic Diarrhea Yes No

Requires Incontinence Pads Yes No

Requires Catheter Yes No

Requires Urinal Yes No

Requires Ostomy Yes No

(please describe): _____

Requires Commode Yes No

Requires Bedpan Yes No

Notes: _____

Nutrition/Diet

Appetite Good Fair Poor

Special Diet Yes No

(please describe): _____

Food Allergies Yes No

(please describe): _____

Requires Assistance to Eat Yes No

Notes: _____

Oral Care

Brushes Teeth/Dentures Independently Yes No

Natural Teeth Yes No

Dentures Upper Lower Yes No

Partial Bridge Yes No

(please describe): _____

Notes: _____

Skin

Normal Yes No
Dry Yes No
Scaly Yes No
Oily Yes No
Rashes Yes No
(please describe and locate): _____
Sores/Lesions Yes No
(please describe and locate): _____

Notes: _____

Hearing and Vision

Within Normal Range for Vision Yes No
Uses Glasses/Contacts Always Sometimes
(please describe): _____
Can Care for Glasses Independently Yes No
Within Normal Range for Hearing Yes No
Uses Hearing Aids Yes No
Can Care for Hearing Aids Independently Yes No

Notes: _____

Behaviour and Cognition

Cooperative/Receptive Yes No
Motivated/Alert Yes No
Depressed/Withdrawn/Sad Yes No
Aggressive/Hostile Yes No
Oriented To Time Place Person Yes No
Memory Impairment Short Term Long Term Yes No
Impaired Decision-making/Problem-solving Yes No
History of Mental Illness Yes No
Suicidal Behaviour, Ideation or History Yes No
Fearful Yes No
Knowledgeable about Safe Sex Yes No
Tobacco Use Active Use Historical Use Yes No
(date of last use): _____

Alcohol Use Active Use Historical Use Yes No
 (date of last use): _____

Drug Use Active Use Historical Use Yes No
 (please specify drug/s of choice): _____
 (date of last use): _____

Notes: _____

Activities of Daily Living

Can Clean Room Independently Yes No
 Can Prepare Meals Independently Yes No
 Can Do Laundry Independently Yes No

Notes: _____

Medical

Relevant Diagnosis	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Notes: _____

Episodes of Opportunistic Infection	Treatment	Effectiveness
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Notes: _____

Notes: _____

Special Needs

- | | | |
|--------------------------------------|------------------------------|-----------------------------|
| Oxygen | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Catheterization | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Incontinence Pads | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nutritional Supplements | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cane/Walker | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Physiotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Occupational Therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Psychiatric/Psychological Counseling | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Grief Counseling | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Other: _____

Notes: _____

Completed By: _____

Title: _____

Agency: _____

Address: _____

Phone: _____ Date: _____