

**Salvation Army Lawson Ministries**

**Residential Intake for Potential Residents Moving into Lawson Ministry accommodations**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Proposed Address of Residence:** | | | |
| Number | Street | | Apt. # |
| City: | | Province: | Postal Code |

**Table of Contents**

[ABOUT THIS DOCUMENT 3](#_Toc532314094)

[SECTION 1: GENERAL APPLICATION FORM - (Please Print) 3](#_Toc532314095)

[PEOPLE TO NOTIFY CHECKLIST: 3](#_Toc532314096)

[PERSONAL INFORMATION: 3](#_Toc532314097)

[HEALTH HISTORY: (Please circle answer) 3](#_Toc532314098)

[BEHAVIOUR BACKGROUND: 3](#_Toc532314099)

[COMMUNICATION: 3](#_Toc532314100)

[SAFETY CHECKLIST 3](#_Toc532314101)

[SOCIAL ASSESSMENT 3](#_Toc532314102)

[SELF-CARE SKILLS 3](#_Toc532314103)

[COMMUNITY & RECREATIONAL SKILLS 3](#_Toc532314104)

[BUDGETING SKILLS 3](#_Toc532314105)

[SECTION 2: RULES & REQUIREMENTS: 3](#_Toc532314106)

[ITEMS NEEDED FOR MOVING-IN CHECKLIST 3](#_Toc532314107)

[Review of mission statement, service principles, and service user rights 3](#_Toc532314108)

[ATTACHMENTS 3](#_Toc532314109)

# ABOUT THIS DOCUMENT

Salvation Army Lawson Ministries Hamilton is dedicated to helping individuals with a developmental disability to have enriched lives through promoting social inclusion.

The Residential Intake Package has two (2) major Parts:

1. Applicant information and assessment notes (F-037)
2. Individual Support Plan (F-038).

Promoting social inclusion means supporting people so that they can be a part of the community through activities such as volunteering, working, and participating in local sports and recreational activities. Lawson Ministries provides support to make sure people with developmental disabilities can be a part of our community. We make sure that all our tenants have the supports they need to live on their own or with others, and help people make informed choices.

The first part of this package helps us to understand the individual who will be living in our residences. It helps us understand the history of the individual, and their skills and ability.

The second part of this package is the Individual Support Plan (ISP) (F-038). The ISP puts all this information to use in helping to develop a plan and lifestyle that promotes individual independence based on abilities, and to provide needed supports. This is a dynamic plan that is reviewed frequently, at minimum once per year. It changes as the individual requires, ensuring that it is a vibrant and dynamic plan suited to the individual.

Individual support plans include information on:

* the person’s goals and expected results
* services and supports the person will get from the agency
* steps to make sure the person is healthy and safe
* whether the person needs help to manage their money
* other community resources that may be available (such as a sports team at the local gym, a program at the library, or a cultural activity).

All of the questions contained in these documents are of utmost importance. We ask that you complete as much as possible, particularly medical and other history. We will meet with every applicant and their support team to develop their Individual Support Plan. We’re looking forward to having a great relationship.

# SECTION 1: GENERAL APPLICATION FORM - (Please Print)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Application: | | | | | | | | | | | | | | | | | | |
| Applicant's Name: | | | | | | | | | | | | | | | | | | |
|  | | | | | Last | | | | | | First | | | Initial | | | | |
| Applicant's Preferred Name: | | | | | | | | | | | | | | | | | | |
| Male ( ) Female ( ) | | | | | | | | | | Telephone: | | | | | | | | |
| Person to contact: | | | | | | | | | | Relationship: | | | | | | | | |
| Date of Birth: / / / | | | | | | | | | | Place of Birth: | | | | | | | | |
| D | | | | M | | | | Y | | ODSP # : | | | | | | | | |
| Health Card Number | | | | | | | | | | S.I.N.: | | | | | | | | |
| Canadian Citizen: | | Y | | | | N | |  | | Landed Immigrant: | | | | Y | | N | | |
|  | | | | | | | | | | If yes record #:  Maintain a copy for file | | | | | | | | |
| Present Address: | | | | | | | | | | | | | | | | | | |
| Number | | | | | | | Street | | | | | | Apt. # | | | | | |
| City: | | | | | | | | | Province: | | | | Postal Code | | | | | |
| Address of all previous residence(s):  (List of reverse side if necessary) | | | | | | | | | | | | From | | | | | To | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Legal Guardian(s): | | | | | | | | | | Contact Phone Numbers: | | | | | | | | |
| Parents Living? | Father: | | Y | | | | | N | | Mother: | | | Y | | | | | N |
| Father's Name: | | | | | | | | | | | | | | | Age: | | | |
| Mother's Name: | | | | | | | | | | | | | | | Age: | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Present Address  (Primary Contact) (Relationship): | |  | | | | | | | | | | |
| Number | | | | | Street | | | | | | Apt. # | |
| City: | | | | | | Province: | | | | | Postal Code | |
| Phone: (Home) | | | | | | | (Work) | | | | | |
| Present Address: (alternate contact (relationship): same as above 🞏 or: | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Number | | Street | | | | | | | | Apt. # | | |
| City: | | | | Province: | | | | | | Postal Code | | |
| Phone: (Home) | | | | | | | (Work) | | | | | |
| **ALTERNATE EMERGENCY CONTACT INFORMATION:** | | | | | | | | | | | | |
| 1. Name: | | | | | | | | | Relation to Applicant: | | | | |
| Last | First | | Initial | | | | | |  | | | | |
| Phone: (Home) | | | | | | | | (Work) | | | | | |
| Present Address: | | | | | | | | | | | | | |
| Number | | | | Street | | | | | | | | Apt. # | |
| City | | | | Province | | | | | | | | Postal Code | |

|  |
| --- |
| Reason for Admission: |
| Is applicant aware of/does applicant understand referral? Y N |

**OTHER AGENCIES OR PROFESSIONALS INVOLVED:** (See ISP section for details)

|  |  |
| --- | --- |
| 🞏 Ministry of Community and Social Services | 🞏 Community Living |
| 🞏 Hamilton Health Sciences | 🞏BSP professional |
| 🞏 Chedoke | 🞏 |
| 🞏 APSW | 🞏 |
| 🞏 | 🞏 |

|  |  |
| --- | --- |
| PEOPLE TO NOTIFY CHECKLIST: | |
| * Each person, agency, business, or association that requires notification of the tenant’s move must receive the official Moving-In Notification Letter (F-066) * Customize each letter and if completing electronically, save in the tenant’s file * If completing manually, photocopy each letter for the tenant’s file. | |
| **Person, Agency, Business, Assoc. to be Notified** | **Check** |
| Family Practitioner or other Medical Specialists |  |
| Dentist |  |
| ODSP (if applicable) |  |
| Darts (if applicable) |  |
| Family Members/ other |  |
| Place of Employment |  |
| Day Program |  |
| Ministry of Health and Long Term Care |  |
| Taxi Scrip Program (if applicable) |  |
| Recreational Groups |  |
| Social Groups |  |
| Income Tax Centre |  |
| Trustee (if applicable) |  |
| Bank |  |

|  |  |  |
| --- | --- | --- |
| **Doctors (currently involved):** | | |
| **Name** | **Address** | **Phone Number** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| PERSONAL INFORMATION: | | | |
| Diagnosis: | | | |
| Physical Barriers: | | | |
| Allergies/Cautions: Any protocols around allergies (e.g. Epipen)? If yes – please explain: | | | |
| Seizures (frequency, type, severity, date of last seizure, any protocol in place and actions to be taken): | | | |
| Ongoing medical conditions: | | | |
| Precautions (e.g. monitor for choking/ dietary restrictions, etc.): | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| HEALTH HISTORY: (Please circle answer) | | | | | |
| Infections: | Y | N | Heart disease: | Y | N |
| Respiratory problems: | Y | N | Diabetes: | Y | N |
| Skin disorder: | Y | N | Asthma: | Y | N |
| Seizure: | Y | N | Allergies: | Y | N |
| Free of communicable disease: | | | | Y | N |
| Any other conditions not listed: | | | | Y | N |
| Does the applicant have difficulties sleeping? | | | | Y | N |
| Does the applicant have any dietary restrictions? | | | | Y | N |
| Does the applicant have any other health concerns; e.g.., constipation, ear infection? | | | | Y | N |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Please explain if you have answered yes to any of the above: | | | | | |
|  | | | | | |
|  | | | | | |
| Does the applicant smoke? | Y | N | Does the applicant drink alcohol? | Y | N |
| If yes for smoking or drinking, is it: Mild Moderate Extensive | | | | | |

|  |  |  |
| --- | --- | --- |
| Does the applicant’s consumption of alcohol or cigarette smoking place self or others at risk of harm? If yes – please explain: | | |
|  | | |
| BEHAVIOUR BACKGROUND: | | |
| **Psychological/Psychiatric Assessments:** | | |
| **Date** | **Purpose** | **Dr. OR Agency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| Is there a Behaviour Support Plan in place? | Y | N |

|  |
| --- |
| If so, what is the date of the last review? |

|  |
| --- |
| Please explain: |

|  |  |  |
| --- | --- | --- |
| Others involved with this applicant (i.e. friends, volunteers, friends, etc.) | | |
|  | | |
| Does the applicant have any behavior concerns? Y N If yes, please explain: | | |
|  | | |
| Are there any behavioral approaches or means of motivation that would be helpful to know? | Y N |
|  | |
| Please comment on any special concerns: | |
|  | |

Please provide information on the following:

|  |
| --- |
| Stressors: |
|  |
| Indicators of stress which may lead to aggression: |
|  |

|  |
| --- |
| Interventions: |
|  |
| Coping Skills: |
|  |
| Reinforcers: |
|  |
| Aggression: |
|  |
| Others: |
|  |
| Fears/Phobias: |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **POLICE INVOLVEMENT:** | | | |
| Approximate Date: | Were there charges? | Y | N |
| Is the applicant on probation? | | Y | N |

|  |
| --- |
| If yes to any of the above, please explain: |
|  |
| Others involved with this applicant (i.e. friends, volunteers, family member, etc.): |
|  |
|  |

**Has a SIS assessment been completed? Y N (**if yes, please attach)

|  |  |  |
| --- | --- | --- |
| COMMUNICATION: | | |
| Does the applicant understand what is being said to them? | Y | N |
| Does the applicant make their needs known? | Y | N |
| Does the applicant communicate verbally? | Y | N |
| Can the applicant answer questions? | Y | N |
| Does the applicant understand and follow instructions? | Y | N |
| Does the applicant use the telephone independently? | Y | N |
| If the applicant cannot communicate verbally, is an alternate means of communication used? | Y | N |
| Does the applicant read? | Y | N |
| Does the applicant write or print their own name? | Y | N |

|  |
| --- |
| Method of Communication: |
|  |
| What social activities does this applicant enjoy? |
|  |
| What does the applicant not enjoy? |
|  |

|  |  |  |
| --- | --- | --- |
| SAFETY CHECKLIST | | |
| Can the applicant access help? | Y | N |
| * Phone | Y | N |
| * From staff | Y | N |
| * From community official | Y | N |
| Can the applicant be alone? | Y | N |
| * Over night | Y | N |
| * Short periods of time; i.e., 30 minutes - 1 hour | Y | N |
| * Other: (give details) | Y | N |
| Does the applicant respond to safety systems? | Y | N |
| * Leaves building when alarm goes off | Y | N |
| * Stays out of building until it is safe to return | Y | N |
| Does applicant take medication? | Y | N |
| * Independently | Y | N |
| * With support | Y | N |
| Does the individual engage in behaviour that is potentially harmful? | Y | N |
| * To self | Y | N |
| * To others | Y | N |
| Can the applicant travel in community? | Y | N |
| * Independently | Y | N |
| * Safely | Y | N |
| Can the applicant seek assistance appropriately when out in community? | Y | N |
| Is the applicant likely to get targeted by peers? | Y | N |
| Does the community location of the residence being applied for pose any safety risk? | Y | N |

|  |  |  |
| --- | --- | --- |
| SOCIAL ASSESSMENT | | |
| **Social Skills:** |  | |
| Are small groups a good environment for the applicant? | Y | N |
| Are large groups a good environment for the applicant? | Y | N |
| Is the applicant comfortable in new situations or with unfamiliar people? | Y | N |
| Does the applicant engage in behaviour that is aggressive? | Y | N |
| Does the applicant have an unusually high level of energy/activity? | Y | N |
| Is the applicant friendly? | Y | N |
| Is the applicant outgoing? | Y | N |
| Is the applicant easily agitated or alarmed? | Y | N |
| Does the applicant act out? | Y | N |
| * Physically, toward others? | Y | N |
| * Physically, toward property? | Y | N |
| * Verbally? | Y | N |
| * By withdrawing socially? | Y | N |
| * In other ways? | Y | N |
| Is the applicant sexually appropriate with peers? | Y | N |
| Does the applicant have any difficulty during sleeping hours? | Y | N |
| Does the applicant make friends easily? | Y | N |
| Please explain: | | |
|  | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| SELF-CARE SKILLS | | | | | |
|  | **No Opportunity Given** | **Not at All** | **With Assistance** | **With Reminders** | **Independently** |
| Does the applicant dress independently? |  |  |  |  |  |
| Does the applicant dress appropriately? |  |  |  |  |  |
| Does the applicant change clothing as needed? |  |  |  |  |  |
| Does the applicant wash independently? |  |  |  |  |  |
| Does the applicant brush teeth independently? |  |  |  |  |  |
| Does the applicant bathe independently? |  |  |  |  |  |
| Does the applicant wash their hair? |  |  |  |  |  |
| Does the applicant care for their hair? (Hair appointments, combing regularly, etc.)? |  |  |  |  |  |
| Does the applicant shave as needed? |  |  |  |  |  |
| Does the applicant apply deodorant as needed? |  |  |  |  |  |
| Does the applicant care for self during menstruation? |  |  |  |  |  |
| Does the applicant eat with correct utensils? |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Does the applicant select and control their own diet? |  |  |  |  |  |
| Does applicant require assistance toileting? |  |  |  |  |  |
| Does applicant require assistance to manage continence? |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DOMESTIC SKILLS** | | | | | |
|  | **No opportunity Given** | **Not at All** | **With Assistance** | **With Reminders** | **Independently** |
| Does the applicant dust furniture? |  |  |  |  |  |
| Does the applicant use a sponge mop? |  |  |  |  |  |
| Does the applicant use broom and dustpan? |  |  |  |  |  |
| Does the applicant use a vacuum cleaner? |  |  |  |  |  |
| Does the applicant make their own bed? |  |  |  |  |  |
| Does the applicant keep room (drawers and closets) tidy? |  |  |  |  |  |
| Does the applicant set and clear a table? |  |  |  |  |  |
| Does the applicant wash and dry dishes? |  |  |  |  |  |
| Does applicant recognize when laundering is required? |  |  |  |  |  |
| Does the applicant use laundry facilities? |  |  |  |  |  |
| Does the applicant prepare their own packed lunch? |  |  |  |  |  |
| Does the applicant make coffee or tea? |  |  |  |  |  |
| Does the applicant prepare a simple meal? |  |  |  |  |  |
| Does applicant know proper use of stove? |  |  |  |  |  |
| Does the applicant tell time to regulate activities? |  |  |  |  |  |
| Does the applicant tell time to an accuracy of 5 min.? |  |  |  |  |  |
| Does the applicant use a calendar to plan activities? |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| COMMUNITY & RECREATIONAL SKILLS | | | | | |
|  | **No opportunity Given** | **Not at All** | **With Assistance** | **With Reminders** | **Independently** |
| Are there any games or hobbies that the applicant likes to participate in during leisure hours? |  |  |  |  |  |
| List leisure activities: |  | | | | |
| Does the applicant participate in sports activities? |  |  |  |  |  |
| Does the applicant know how to use community facilities (e.g. YMCA)? |  |  |  |  |  |
| Does the applicant know role of community officials  (police, doctor)? |  |  |  |  |  |
| Does the applicant use crosswalk? |  |  |  |  |  |
| Does the applicant cross streets with lights? |  |  |  |  |  |
| Does the applicant read street signs? |  |  |  |  |  |
| Does applicant walk independently to neighborhood facilities (plazas, parks)? |  |  |  |  |  |
| Does the applicant travel on HSR? |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| BUDGETING SKILLS | | | | | |
|  | **No opportunity Given** | **Not at All** | **With Assistance** | **With Reminders** | **Independently** |
| Can the applicant make purchases using the correct amount of money? |  |  |  |  |  |
| Can the applicant plan for purchases over one week, budgeting according to money on hand? |  |  |  |  |  |
| Can the applicant make change for $1.00? |  |  |  |  |  |
| Does the applicant shop for personal items  (e.g., shampoo, magazines)? |  |  |  |  |  |
| Does the applicant use the bank? |  |  |  |  |  |

# SECTION 2: RULES & REQUIREMENTS:

This section includes information on:

1. General Courtesies, Rules, and Expectations for 1590 Main St
2. Items Needed for Move Checklist

**General Courtesies, Rules, and Expectations for 1590 Main St**

* All residents will treat each other and Lawson staff members with respect at all times.
* No smoking will be permitted inside the building; smoking areas are outside and clearly marked.
* If residents are scheduled to complete their hygiene routine at a certain time, it should not be prolonged or delayed if such a delay will interfere with their roommates’ hygiene routine.
* All residents (with staff guidance) are to consider their roommates when doing activities or making plans which might affect them.
* All residents are to respect their roommates’ right to peace and quiet, especially at night.
* No family members, friends, or members of the public will be given keys to 1590 or the apartment their family member, friend, or associate will be living in.
* All residents will take an active interest in their care and will try to make personal progress to the best of their abilities with staff support.
* All residents and staff must knock and wait to be invited in when wishing to enter an apartment/ bedroom. Staff is exempt from this of course if an emergency situation is taking place.
* No resident may enter another resident’s apartment/ bedroom without being invited to do so.
* No residents shall loiter or hang around the hallways.
* All resident must lock their apartment and bedroom doors when they leave the building.
* All resident must evacuate the building if they hear the fire alarm.
* All residents will promptly pay rent on the first of each month.
* The underground parking lot of 1590 is reserved for Lawson vehicles and staff vehicles exclusively.
* Friends or visitors must leave by 10 p.m. unless special arrangements have been made

## ITEMS NEEDED FOR MOVING-IN CHECKLIST

**Note:** For the living room furniture, please check off one item that you will agree to purchase solely for all to share. This will be expected of all families so there is even distribution of purchases made for common room furniture and equipment.

|  |  |
| --- | --- |
| **Item** | **Check** |
| **Bedroom:** |  |
| Bed (includes frame and mattress) |  |
| Bedding (blankets, sheets, pillow) |  |
| Bedroom reading lamp |  |
| End table or other table for beside bed. |  |
| Dresser |  |
| Curtains (measurements need to be taken) |  |
| Posters or pictures? |  |
| Appropriate clothing for all four seasons (socks, underwear, t shirts, sweaters, pants, winter/spring jackets, shoes, boots, etc.) |  |
|  |  |
| **Bathroom:** |  |
| Hygiene stuff (soap, deodorant, tooth brush, tooth paste, razor, shaving cream, nail clipper, shampoo, conditioner, mouth wash, hair brush, etc.) |  |
| Bathrobe |  |
| Slippers |  |
|  |  |
| **Kitchen:** |  |
| Cutlery  i.e., serving/eating utensils, pots/pans, frying pans, baking pans, cups, mugs, juice pitchers, etc. |  |
| Dishes  i.e., salad/mixing bowls, Tupperware, plates, mugs, lunch bag, etc. |  |
| Cleaning supplies  i.e., mop & bucket, broom, duster, tea towels, dish cloths, bath towels, face cloths, bathmat, shower curtain, toilet bowl brush, etc. |  |
|  |  |
| **Living Room:** |  |
| Couch or Loveseat |  |
| Armchair |  |
| TV/DVD |  |
| TV Stand |  |
|  |  |
|  |  |
| **Other:** |  |
| Radio |  |
| Medications |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

## Review of mission statement, service principles, and service user rights

The Salvation Army Lawson Ministries Service Principles and Mission Statement (OP 1.01)

Our programs and service are based upon our Statement of Beliefs. We believe in:

###### providing enriching environments in the community that promote social inclusion

###### developing support to assist each individual to attain their fullest potential

###### providing individual services, developed by the person and their family or support person, in conjunction with support staff

###### assisting people in developing support networks within their social and spiritual community

###### providing services in an equitable and flexible manner.

T**HE SALVATION ARMY LAWSON MINISTRIES HAMILTON MISSION STATEMENT:**

The Salvation Army Lawson Ministries Hamilton is committed to establishing a network of people who strive to provide support and social inclusion to individuals with developmental disabilities and their families through residential and day Program services by establishing and maintaining a supportive, caring environment that addresses the individual’s needs.

**I (print name), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have reviewed the above service principles and mission statement**

Date (M/D/Y) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date (M/D/Y) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Know Your Rights:**

|  |  |  |  |
| --- | --- | --- | --- |
| Description: speaking and being heard  I have the Right to speak and be heard. | Description: freedom  I have the Right to freedom. | Description: right to live on own.jpg  I have the Right to choose with whom and where I live. | Description: respect  I have the Right to be treated equally. |
| Description: saying no  I have the Right to say “No” about things  affecting my life. | Description: respect2  I have the Right to be respected in the community. | Description: cowering  I have the Right to be safe and free from abuse and neglect. | Description: money  I have the Right to decide how to spend my money. |
| Description: relationships  I have the Right to have relationships, to love, be loved and be respected. | Description: stand out from crowd  I have the Right to be treated as a unique individual. | Description: do not enter  I have the Right to privacy. | Description: clubs  I have the Right to join groups and clubs and be around the people I choose. |
| Description: community  I have the Right to go places in the community. | Description: isp  I have the Right to participate in my plan of care. | Description: prescription drugs  I have the Right to be free of unnecessary drugs. | Description: clothes  I have the Right to choose my own clothes. |

**I (print name), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have had my rights reviewed**

Date (M/D/Y) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date (M/D/Y) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## ATTACHMENTS

The following forms must be completed and submitted with this Application Form prior to the Intake Meeting.

1. **Release of Information - Form 14:**

Attached are blank copies of the Ministry of Community and Social Services Form 14:

* 1. This form allows agencies and individuals involved in a person’s care to share information about that individual
  2. Each professional or social service agency that has or is involved with the prospective resident’s care must sign a Form 14 so all parties can share all pertinent information

Form 14 must printed separately; it cannot be cut and pasted into this document.

1. **Emergency Information (F- 010)**

Primary staff completes this form once the tenant moves in. The purpose of this form is

* 1. to provide emergency medical information
  2. to describe behaviour and medical protocols should the individual go missing.

1. **Lease Agreement**
2. Attached is a blank copy of the lease which potential 1590 residents must sign prior to moving in.
3. It is attached so that family members can read it over and take their time to digest what's included in the lease.
4. The attached lease does not have to be signed or returned until the day the potential resident moves in.
5. **Residential Content Insurance** (F-057)**:**
   1. All tenants must maintain adequate content insurance for replacement costs of personal belongings (contents) in case of fire, flood, or robbery.
   2. Lawson Ministries has arranged a group policy that assists in lowering the cost of the premium for the tenant.
6. **Tenant Key Policy/Agreement** (F-067)**:**
   1. All tenants must agree and sign the Key Policy Agreement (F-067).
7. **Medical Information** (F-011):

All prospective tenants must provide completed medical information as follows:

1. Admissions Physical Exam (F-011).
2. **Moving in:**
3. Upon moving in the assigned staff will:
   * Review the moving-in list requirements from the Moving-In Checklist in this section.
   * Complete the Personal Property Inventory (PPI) (F- 049).
4. Send a copy of the PPI to the Office Administrator (OP 7.08).The Program Manager will send the Moving in Notification Letter (F-066) to the required individuals and agencies.
5. The Program Manager will review all tenant documents for accuracy and completion.
6. **Individual Support Plan** (F-038)
7. This critical plan must be developed and implemented within three (3) months or less of the tenant moving in (OP 5.23 – Individual Support Plan).

**NOTE: All required forms are located on the Company Drive in the Forms directory. If completing form electronically ensure to save the template into the client’s directory before completing.**