



# Peel Senior Link

*helping seniors live independently*

We wish to introduce you to Peel Senior Link, a community health care service provider. Peel Senior Link has operated as a not-for-profit, charitable, community based agency since 1991 with the financial support of the Ministry of Health and Long-Term Care and United Way. Peel Senior Link operates 24 hour on-site **Supports for Daily Living** service for seniors in eight buildings located throughout Brampton and Mississauga as well as in surrounding neighbourhoods. In addition we provide **Day Service** to 1,000 seniors living independently in thirteen seniors apartment buildings, also located throughout Brampton and Mississauga.

Peel Senior Link clients are generally referred to our **Supports for Daily Living** program because of a decline in their ability to manage activities of daily living. Our clients require an environment where they can be **monitored intermittently** on a 24 hour, 7 day per week basis, often delaying the need for and preventing unnecessary hospitalization and institutionalization. Our program provides them with the opportunity to maximize their independence, foster stability, and allow aging in place – with dignity – in a safe environment.

Referrals are received through several sources in the community. Our client support needs generally exceed those provided by the CCAC (Community Care Access Center). As well, our clients usually have limited income, and require subsidized rent from one of our housing partners: Peel Living and Wavel Villa. If you would like more information regarding Peel Senior Link Services, you can visit our website: [www.peelseniorlink.com](http://www.peelseniorlink.com) or call us at 905-712-4413 and speak with our Intake Referral and Assessment Supervisor, Joeann Shorey at ext. 31.

Sincerely,

Joeann Shorey  
Intake, Referral and Assessment Supervisor  
Peel Senior Link

Email: [joeann@peelseniorlink.com](mailto:joeann@peelseniorlink.com)



# Peel Senior Link

helping seniors live independently

## ✓ Intake Package Check List

## Eligibility Criteria Check list

<input type="checkbox"/> Pages – to – completed and signed	<input type="checkbox"/> 65 years or older
<input type="checkbox"/> Include Power of Attorney or Substitute Decision Maker (SDM) document if applicable	<input type="checkbox"/> Valid Ontario Health Card
<input type="checkbox"/> Medical Consent form signed for medical release of information to Peel Senior Link by your Physician. Pg. –	<input type="checkbox"/> Willingness to move to a designated building to receive services (if applicable) and must NOT deny services after the move as agreed upon.
<input type="checkbox"/> Medical Information form to be completed and signed by your Physician and sent to Peel Senior Link either by fax or mail.	<input type="checkbox"/> Require personal care and home making services and be willing to accept multiple security checks throughout the day.
<input type="checkbox"/> Housing application to be filled (Peel Living-Market Rent / PATH-Subsidy or Social housing / Wavel Villa ) if applicable and sent to Peel Senior Link. Please refer to website for relevant application packages.	<input type="checkbox"/> Able to self direct care (irrespective of language) or have an SDM direct care.
<input type="checkbox"/> Mail or fax the completed Intake Package to Peel Senior Link Representative: <b>Joeann@ 905-712-3373 Ext. 31</b>	<input type="checkbox"/> Medically stable, can be left alone with no constant supervision required.
<input type="checkbox"/> Willing to accept <b>Life Line</b> personal response system for safety and liability issues (client responsible to absorb monthly cost)	<input type="checkbox"/> Agree that long-term care placement or an alternative housing arrangement may be required when care level increases to a level that is unsafe or not appropriate for Peel Senior Link.
<input type="checkbox"/> Approval will be based on meeting all eligibility criteria through an assessment tool mandated by the government.	<input type="checkbox"/> Alzheimer, Dementia, Depression or any on-going mental health concerns is maintained through professional help.

**Joeann Shorey**

Intake, Referral & Assessment Supervisor

Peel Senior Link

760-30 Eglinton Avenue West

Mississauga, ON

L5R 3E7

**Tel: 905 712 4413 Ext. 31**

**Fax: 905 712 3373**

Once the Peel Senior Link representative/s has received the all required documents, they will contact you within 2 weeks to further discuss the application process. **Please note that completing this package does not guarantee acceptance into the Peel Senior Link's Supports for Daily Living program.**

**Supports for Daily Living 24 Hour Service Buildings**

<b>SITE</b>	<b>LOCATION</b>	<b>UNITS</b>	<b>1 BEDROOM REGULAR</b>	<b>2 BEDROOM REGULAR</b>	<b>1 BEDROOM MODIFIED</b>	<b>2 BEDROOM MODIFIED</b>
<b>HILLSIDE PLACE *</b> 107 –2440 Truscott Drive Mississauga, ON L5J 4N5	Erin Mills Parkway/Truscott Dr.	128	98	19	5	6
<b>KING STREET *</b> 202-66 King Street West Mississauga, ON L5B 2H7	Hurontario St./Dundas St.	121	121	0	0	0
<b>KNIGHTSBRIDGE *</b> 129-1 Knightsbridge Rd. Brampton, ON L6T 4B7	Dixie Rd./Queen St.E.	90	81	0	8	0
<b>MANORBRIDGE *</b> 111-160 Murray Street Brampton, ON L6X 3C8	Williams Pkwy. W/Main St. N.	98	75	17	4	2
<b>SOUTH COMMON *</b> 111-2250 South Millway Mississauga, ON L5L 3J6	Erin Mills Pkwy./Burnhamthorpe	140	107	21	11	1
<b>STAVEBANK *</b> 102-35 Stavebank Rd. N. Mississauga, ON L5G 2T7	Hurontario Street/Lakeshore Rd.	98	98	0	0	0
<b>TURTLE CREEK +</b> 1510 Lakeshore Rd. W. Mississauga, ON L5J 4T4	Lakeshore Road/Southdown Rd.	74	42	21	5	6
<b>SUMMERVILLE PINES</b> 1745 Dundas St. East Mississauga, ON L5J 3A4	Dixie / Dundas St. East	136	126	10	0	0

Peel Senior Link's **24 Hour Supports for Daily Living program** is offered in 8 buildings (listed above) in the Peel region, providing on-site and surrounding neighbourhood with personal care & homemaking services.

**Landlord - Peel Living + Landlord - Wavel Villa.**

**Peel Senior Link**  
*Helping seniors live independently*

**Intake Package**

**CLIENT INFORMATION:**

**NAME:** \_\_\_\_\_ **M / F** **DATE OF BIRTH:** (Y/M/D) \_\_\_\_/\_\_\_\_/\_\_\_\_

**STREET ADDRESS:** \_\_\_\_\_ **APT. / UNIT #** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **POSTAL CODE:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**Marital Status:**  Married  Single  Widowed  Divorced  Other \_\_\_\_\_

**Current living situation:**  Home  LTC  Hospital  Other \_\_\_\_\_

**Lives alone?** (Y/N) \_\_\_\_\_ *If no, with whom?* \_\_\_\_\_

**Citizenship:**  Canadian citizen  Immigrant  Refugee **Country of citizenship** \_\_\_\_\_

**Health Card #:** \_\_\_\_\_ **Version Code:** (if Applicable) \_\_\_\_\_ **D.V.A. #** (if applicable) \_\_\_\_\_

**EMERGENCY CONTACT(S):**

**(1) Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone (H):** \_\_\_\_\_ **(Bus):** \_\_\_\_\_ **Ext:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_

**E-MAIL address:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**(2) Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone (H):** \_\_\_\_\_ **(Bus):** \_\_\_\_\_ **Ext.:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_

**E-MAIL address:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Do you have a signed copy of Power of Attorney or Secondary Decision Maker?** (Y/N) \_\_\_\_\_

*If YES,* **Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone (H):** \_\_\_\_\_ **(Bus):** \_\_\_\_\_ **Ext:** \_\_\_\_\_

## MEDICAL INFORMATION:

Referred to Peel Senior Link by: \_\_\_\_\_ Phone: \_\_\_\_\_

### CURRENT HEALTH STATUS / DIAGNOSIS:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Cancer (please explain) _____        | <input type="checkbox"/> Diabetes (Type) _____      |   |
| <input type="checkbox"/> Coronary Artery Disease              | <input type="checkbox"/> Hypertension               | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Multiple Sclerosis                   | <input type="checkbox"/> Parkinson's disease        | <input type="checkbox"/> Emphysema / COPD/ Asthma |
| <input type="checkbox"/> Arthritis (Type & location) _____    | <input type="checkbox"/> Depression (Circle One):   | Mild Moderate Severe                              |
| <input type="checkbox"/> Anxiety                              | <input type="checkbox"/> Falls in the last 6 months | <input type="checkbox"/> Use of Oxygen            |
| <input type="checkbox"/> Disability: Physical / Developmental | <input type="checkbox"/> Dementia/Alzheimer:        | Mild Moderate Severe                              |

**BRIEF MEDICAL HISTORY:** list primary health concern, all recent hospitalizations, ER visits, surgeries, disabilities & prior illnesses if relevant.

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### PLEASE LIST ALL CURRENT MEDICATIONS (INCLUDING OTC / CREAMS & VITAMINS):

You can obtain a photocopied list from your pharmacist of all prescription medications and attach to form.

### ALLERGIES: Please list all (medications, food, environmental or other)

VISION:  Glasses  Cataracts  Glaucoma  Macular Degeneration  Blind  
HEARING:  Impaired  Use of Aids  Deaf

Do you have a special diet? (Y/N) \_\_\_\_\_ if YES, please explain: \_\_\_\_\_

Are you incontinent of the bladder? (Y/N) \_\_\_\_\_ Are you incontinent of the bowel? (Y/N) \_\_\_\_\_

## INCOME INFORMATION:

Complete all that are applicable: (monthly)

O.A.S amount: \$ \_\_\_\_\_ G.I.S \$ \_\_\_\_\_ C.P.P. \$ \_\_\_\_\_

Disability: \$ \_\_\_\_\_ Supplement: \$ \_\_\_\_\_ Other: \$ \_\_\_\_\_

Total monthly income: \$ \_\_\_\_\_

## HOUSING INFORMATION:

Designated Buildings  Surrounding Neighbourhoods

Peel social housing application completed (Available from Peel Living 905 453-1300).  
(Y/N)? \_\_\_\_\_ Date mailed: \_\_\_\_\_

Type of accommodation you require if applicable: (check all that apply)

- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="checkbox"/> 1 Bedroom                         | <input type="checkbox"/> 2 Bedroom   | <input type="checkbox"/> Modified/Handicapped Unit |
| <input type="checkbox"/> Subsidized/ Rent Geared To Income | <input type="checkbox"/> Market Rent |  |

Preference of Location: 1: \_\_\_\_\_ 2: \_\_\_\_\_ 3: \_\_\_\_\_





# Peel Senior Link

*helping seniors live independently*

Dear Dr. \_\_\_\_\_

Re: \_\_\_\_\_

We wish to introduce you to Peel Senior Link, a community health care service provider. Peel Senior Link has operated as a not-for-profit, charitable, community based agency since 1991 with the financial support of the Ministry of Health and Long-Term Care. We are also a United Way member agency. Peel Senior Link operates 24 hour on-site supports for daily living for seniors in seven buildings throughout Brampton and Mississauga.

Peel Senior Link clients are generally referred to our **Supports for Daily Living** program because of a decline in their ability to manage activities of daily living. Our clients require an environment where they can be **monitored intermittently** on a 24 hour, 7 day per week basis, often delaying the need for and preventing unnecessary hospitalization and institutionalization. Our program provides them with the opportunity to maximize their independence, foster stability, and allow aging in place – with dignity – in a safe environment. Our client support needs generally exceed those provided by the CCAC. We utilize an on-site apartment staffed by a supervisor, personal support workers, and home helpers providing personal care, homemaking and medication assistance. We are branching out now into surrounding neighbourhoods from our designated buildings so our services can reach all those who can't reach us.

In order for us to determine client eligibility for **Supports for Daily Living**, we request that you complete the enclosed/attached medical form. If accepted to the program, we will involve you as a health care partner by requesting that you complete a "Doctors Order Form" at each visit for the purpose of monitoring/reviewing client service plans. We have obtained written authorization from the client allowing us to gather/share this information.

If you require additional information, please contact, Joeann Shorey at (905) 712-4413 Ext. 31. We are grateful for your support and assistance in this matter.

Sincerely,

Joeann Shorey  
Intake Referral and Assessment Supervisor  
Peel Senior Link

**Authorization and Direction to Release Medical Information**

*(to be completed by applicant)*

Applicant <i>(first and last name): (please print)</i>	Date <i>(mm/dd/yy):</i>
Name of Physician: <i>(please print)</i>	Peel Senior Link Representative: <i>(please print)</i>
	Fax:

Peel Senior Link requires an applicant to have current (within six months) medical information completed by a physician for the purpose of assessing my eligibility for service and as a condition of service.

I, the above mentioned applicant, do hereby authorize and direct the above named Physician to complete the attached Medical Information form and to forward to the above named Peel Senior Link representative as part of an application for supports for daily living services.

I am aware that this information will be used for the purposes of assessing my eligibility for Peel Senior Link services and for the purposes of Peel Senior Link providing services to me, and I hereby authorize Peel Senior Link representatives involved in assessing my eligibility or involved in providing services to me, to obtain and review the attached medical information.

*In the event that the applicant is only able to provide verbal consent, the signature of the Substitute Decision Maker along with a witness is required. The witness, when required, acknowledges that the applicant fully understands the information in this document and has provided full consent to release the above mentioned medical information to Peel Senior Link.*

Please return this information to the Peel Senior Link representative with the completed Intake Package.

Name of Applicant/ Substitute Decision Maker: <i>(please print)</i>	Signature	Date: <i>(mm/dd/yy):</i>
Name of Witness <i>(If applicable)</i> <i>(please print)</i>	Signature	Date: <i>(mm/dd/yy):</i>
Name of PSL representative <i>(please print)</i>	Signature	Date: <i>(mm/dd/yy):</i>

Copy to Physician; Original to Peel Senior Link



**Present Medical Diagnosis:** *(please include prognosis)*

- CAD       Hypertension       CHF       Peripheral Vascular Disease
- Cancer      Type: \_\_\_\_\_      Onset: \_\_\_\_\_
- Diabetes       Emphysema/ COPD/ Asthma       Renal Failure       Osteoporosis
- Thyroid disease (*Hyper / Hypo*)
- Neurological disorders (*please explain*): \_\_\_\_\_
- Communicable diseases (*please explain*): \_\_\_\_\_
- Gastrointestinal disorder (*please explain*): \_\_\_\_\_
- Other (*please explain*): \_\_\_\_\_

**Prognosis:**  Improvement     Remain stable     Deteriorate     Unknown     Palliative

Comments: \_\_\_\_\_

**Cognitive:**  No problem       Confused       Depressed       Anxious

Alzheimer's       Dementia (other than Alzheimer's): \_\_\_\_\_

Memory Loss: Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_

Oriented to:  Person  Place  Time (*please explain*) \_\_\_\_\_

Other: (*please explain; include treatment and prognosis*):

Is your patient able to self-direct his/her services?  Y       N

If no, *please explain*: \_\_\_\_\_

Is your patient capable of managing, determining, and communicating when such assistance is required, and cooperating with its provision?  Y       N

If no, *please explain*: \_\_\_\_\_

**Vision:**  No problems     glasses     Cataracts     Glaucoma     AMD     Blind

**Hearing:**  No problems     Impaired RT \_\_\_\_\_ LT \_\_\_\_\_     Use of aids     Deaf

**Sensory:**  No problems     Numbness     Tingling     Decreased Sensation

**Pain:**  Acute     Chronic

Please comment: \_\_\_\_\_

Last BP reading \_\_\_\_\_ Pulse \_\_\_\_\_ Resps \_\_\_\_\_

Is this usual for this patient?  Y  N (please explain): \_\_\_\_\_

**Medications:** (please list all current medications to include OTC / PRN's /Eye drops/ Creams & Vitamins):

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**Medication Management:**

In your opinion, is your patient able to manage their own medications?  Y  N

If NO, please explain:

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Is your patient compliant and do they adhere to their prescribed medication regimes?  Y  N

If NO, please explain:

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Does your patient have any history of abuse of prescribed medications?  Y  N

If YES, Please explain:

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**What Equipment / Aids does your patient require?**

Walker  Wheelchair  Cane  Scooter  Hospital bed  Bath bench

Hoyer  Bedridden  Commode  Raised toilet seat  Saska pole

Catheter  Colostomy  Glucometer  Prosthesis (type): \_\_\_\_\_

Oxygen  Other (please explain): \_\_\_\_\_

**Continence:**

Is your patient continent of the bladder?  Y  N

Do they require assistive services such as ongoing bladder pericare?  Y  N

If yes, please explain: \_\_\_\_\_

Is your patient continent of the bowel?  Y  N

Do they require assistive services such as ongoing bowel Pericare?  Y  N

If yes, please explain: \_\_\_\_\_

**Lifestyle:**

Does your patient smoke?  Y  N

Does your patient consume alcohol?  Y  N If yes, how often? \_\_\_\_\_

**Diet:**

Does your patient require a special diet?  Y  N

If yes, please explain: \_\_\_\_\_

**Moving:**

Will moving your patient to a supportive housing building negatively affect his/her health?  Y  N

If yes, please explain: \_\_\_\_\_

**Safety:**

Is your patient safe to be left alone for long periods of time?  Y  N

If no, please explain: \_\_\_\_\_

**How long have you treated this patient?**

\_\_\_\_\_

**How often do you see this patient?**

\_\_\_\_\_

**Additional Information:** (please provide any other information or advice that would be useful to Peel Senior Link in determining your patient's eligibility for supportive housing services):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Physician:

\_\_\_\_\_  
Date:

Please fax/mail the completed form to the Peel Senior Link representative named on the attached Authorization and Direction to Release Medical Information form. The information will remain confidential. Thank you.

