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 Wawel Villa. If you would like more information regarding Peel Senior Link Services, you can visit our website: 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

Peel Senior Link
helping seniors live independently

✓ **Intake Package Check List**	**Eligibility Criteria Check list**
☐ Pages – to – completed and signed	☐ 65 years or older
☐ Include Power of Attorney or Substitute Decision Maker (SDM) document if applicable	☐ Valid Ontario Health Card
☐ Medical Consent form signed for medical release of information to Peel Senior Link by your Physician. Pg. –	☐ Willingness to move to a designated building to receive services (if applicable) and must NOT deny services after the move as agreed upon.
☐ Medical Information form to be completed and signed by your Physician and sent to Peel Senior Link either by fax or mail.	☐ Require personal care and home making services and be willing to accept multiple security checks throughout the day.
☐ Housing application to be filled (Peel Living-Market Rent / PATH-Subsidy or Social housing / Wawel Villa) if applicable and sent to Peel Senior Link. Please refer to website for relevant application packages.	☐ Able to self direct care (irrespective of language) or have an SDM direct care.
☐ Mail or fax the completed Intake Package to Peel Senior Link Representative: **Joeann@ 905-712-3373 Ext. 31**	☐ Medically stable, can be left alone with no constant supervision required.
☐ Willing to accept ***Life Line*** personal response system for safety and liability issues (client responsible to absorb monthly cost)	☐ 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.
☐ Approval will be based on meeting all eligibility criteria through an assessment tool mandated by the government.	☐ 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

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

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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:

☐ Cancer (p*lease explain*) _________________________ ☐ Diabetes *(Type)* __________________
☐ Coronary Artery Disease ☐ Hypertension ☐ Congestive Heart Failure
☐ Multiple Sclerosis ☐ Parkinson's disease ☐ Emphysema / COPD/ Asthma
☐ Arthritis (Type & location) _______________________ ☐ Depression (Circle One): Mild Moderate Severe
☐ Anxiety ☐ Falls in the last 6 months ☐ Use of Oxygen
☐ Disability: Physical / Developmental ☐ Dementia/Alzheimer: Mild Moderate Severe

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

____
____
____
____

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)*
☐ 1 Bedroom ☐ 2 Bedroom ☐ Modified/Handicapped Unit
☐ Subsidized/ Rent Geared To Income ☐ Market Rent

Preference of Location: 1:______________ 2:______________ 3:__________________

CURRENT SERVICES BEING RECEIVED:

☐ **Central West CCAC** ☐ **Mississauga Halton CCAC**
How many days/hours per week? Days: _________________ hours: ____________

How long have you been receiving these services? : ______________________________

Case worker name: ___________________________________ Ext. ___________________

Nursing: ☐ Personal Care: ☐ O.T: ☐ Physiotherapy: ☐ Other: ☐ __________________

☐ **PRIVATE CARE/VOLUNTEER** services being received: ____

☐ **Meals on Wheels** ☐ **FAMILY**: What does family assist with? __________________________________

PLEASE CHECK OFF THE FOLLOWING EQUIPMENT/ AIDS YOU CURRENTLY USE:

☐ Walker ☐ Wheelchair ☐ Cane ☐ Scooter ☐ Hospital Bed
☐ Bath Bench ☐ Hoyer ☐ Bedridden ☐ Commode ☐ Raised Toilet Seat
☐ Saska Pole ☐ Glucometer ☐ Catheter ☐ Colostomy ☐ Prosthesis
☐ Grab bars Other: *Please list:* ____

WHAT DO YOU FEEL YOU NEED HELP WITH? PLEASE CHECK OFF ALL THAT ARE APPLICABLE:

☐ Bathing ☐ Dressing ☐ Meal assistance/planning ☐ Essentials shopping
☐ Toileting ☐ Housekeeping ☐ Medication assistance/reminders
☐ Transfers ☐ Security Checks ☐ Other: ____

DO YOU CURRENTLY USE AN EMERGENCY RESPONSE SYSTEM SUCH AS:

☐ Lifeline ☐ Lifecall ☐ Other: ____________________________________

Why do you think you need our services? Is there any additional information you feel Peel Senior Link should be aware of regarding your current situation (medical, income, housing, personal etc…):

____

____

Name of individual who completed this form if *not* Self: ______________________________________

Relationship to client: _______________________________________ **Phone**: _____________________

I DECLARE THAT THE INFORMATION PROVIDED ABOVE IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.
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 above personal and medical information.

SIGNATURE OF APPLICANT: _______________________________________ **DATE:** ________________

SIGNATURE OF SUBSTITUTE DECISION MAKER (SDM) or POWER OF ATTORNEY for CARE (POA) ***(if applicable):***

_____________________________ ________________________________ ___________________
SIGNATURE **PRINT NAME** **DATE**

****Signed legal papers for POA/SDM to be mailed along with intake package forms****

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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

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MEDICAL CONSENT

Authorization and Direction to Release Medical Information
(to be completed by applicant)

Applicant *(first and last name): (please print)*	Date *(mm/dd/yy):*
Name of Physician: *(please print)*	Peel Senior Link Representative: *(please print)* 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: *(please print)*	Signature	Date: *(mm/dd/yy):*
Name of Witness *(If applicable)* *(please print)*	Signature	Date: *(mm/dd/yy):*
Name of PSL representative *(please print)*	Signature	Date*: (mm/dd/yy):*

Copy to Physician; Original to Peel Senior Link

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Medical Information

(to be completed by Physician)

Physician: (first and last name)	**Date *(mm/dd/yy):***

Physician Address:

Street::	City:	Province:
Phone (work):	Fax Number:	Postal Code:
e-mail address:		

Patient Information:

Name:	Street Address:		City:
Phone:	Postal Code	Province	Health Card number:

The above mentioned patient has applied to Peel Senior Link for supports for daily services. These services may include assistance with medications, personal bathing, grooming and hygiene, transferring, meal assistance, toileting, and home making.

The patient has authorized you to complete this form, which will be used by Peel Senior Link to determine the patient's eligibility for services. If the patient is accepted for services, this information will assist us in providing appropriate treatment and care.

When you have completed this Medical Information form, please fax a copy to the designated Peel Senior Link representative named on the Authorization and Direction to Release Medical Information form. Please print clearly. Thank you.

Medical History: *(Past 10 years) Please check all appropriate boxes for previous hospital admissions, surgeries and other prior illnesses:*

☐ CVA date: ______________________

☐ falls date: ______________________

☐ cancer date: ______________________

type: ______________________

☐ MI date: ____________________

☐ fractures date: _________________

location of fracture: ________________

☐ Other: (please explain)

____

____

____

List any patient allergies / sensitivities:

____

____

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):*

____

____

____

____

____

Medication Management:

In your opinion, is your patient able to manage their own medications? ☐ Y ☐ N
If NO, please explain:

____

Is your patient compliant and do they adhere to their prescribed medication regimes? ☐ Y ☐ N
If NO, please explain:

____

Does your patient have any history of abuse of prescribed medications? ☐ Y ☐ N
If YES, Please explain:

____

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.*