Better at Home Participant Intake

PART I

**denotes required fields per UWLM reporting requirements*

Participant Information

***First name**: _____ **Middle name:** _____ ***Last name:** _____

Personal Health Number (PHN)**:** _____

***Date of birth**: _____ **Age:** _____
(yyyy/mm/dd)

Phone (primary): _____ **Phone (Secondary):** _____

Email: _____

Street address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Country: _____

Access Instructions (ex. Buzzer #):

***Living Arrangement:**
☐ Living alone
☐ Do not live alone
☐ Unknown

Marital status:
☐ Married
☐ Common law
☐ Single
☐ Divorced
☐ Widowed

***Gender:**
☐ Female
☐ Male
☐ Other _____

☐ Prefer Not to Disclose
☐ Unknown

***Ethnic origin:**

☐ Anglo-Canadian
☐ French-Canadian (Quebecois, Acadian)
☐ European
☐ African
☐ North American Indigenous (First Nations, Indigenous, Metis, Inuit)
☐ Oceania
☐ East/South East Asian (Chinese, Vietnamese, Japanese)
☐ South Asian (Indian, Pakistani)
☐ West Asian/Middle Eastern (Persian)
☐ Caribbean
☐ Latin or Central or South American
☐ Other _____
☐ Prefer not to disclose

***Primary language:**

☐ English
☐ French
☐ Indigenous Language
☐ German
☐ Korean
☐ Mandarin
☐ Cantonese
☐ Punjabi
☐ Tagalog
☐ Farsi
☐ Spanish
☐ Other _____

Emergency Contact

First name: _____ **Last name:** _____

Relationship: _____ **Email:** _____

Phone (primary): _____ **Phone (secondary):** _____

Lifeline / Lock Box / PIN: _____

Participant – Other

UWLM Photo Consent Form Signed:
☐ Yes
☐ No

Date Signed: _____
(yyyy/mm/dd):

Staff Notes:

PART II

Staff

***Intake date**: _____ (yyyy/mm/dd):

***Intake Staff:** _____

Region: _____

***Referral source:**

☐ bc211
☐ Host organization
☐ Other community-based agency
☐ Advertisement
☐ Allied health professional
☐ Physician
☐ Nurse
☐ Friend/family
☐ Self-referral
☐ Unknown
☐ Other

Services

Services requested and relevant details (check all that apply):

☐ Friendly Visits
☐ Light Housekeeping
☐ Light Yard Work
☐ Minor Home Repairs
☐ Snow Removal
☐ Grocery Shopping
☐ Prepared Meal Services
☐ Prescription Pickup/Delivery

☐ Transportation
☐ Group Activities
☐ Other _____

Transportation methods:

☐ Own vehicle
☐ HandyDart
☐ Friends/Family/Neighbour
☐ Public transit
☐ Volunteer driver program
☐ Taxi
☐ Walk
☐ Other _____

Preferred Days:

☐ Monday
☐ Tuesday
☐ Wednesday
☐ Thursday
☐ Friday
☐ Saturday
☐ Sunday

Preferred Times:

_____
_____
_____
_____
_____
_____
_____

Home

Accommodation Type:

☐ House
☐ Suite in house
☐ Townhouse
☐ Apartment/condo
☐ Assisted living
☐ Mobile
☐ Subsidized
☐ Other _____

Access Instructions (ex. buzzer #)**:**

Potential hazards:

☐ Hoarding/excessive clutter
☐ Biohazards (e.g. improperly stored insulin syringes)
☐ Aggressive pets
☐ Aggressive residents/visitors
☐ Substance misuse
☐ Cigarette or other smoke
☐ Structural issues (e.g. unsafe stairs)
☐ Other _____

Past pest infestations:

☐ Yes

☐ No

If yes, what type of infestation, date of extermination and if home was inspected post-extermination for re-infestation:

Smoke Alarm:

☐ Yes

☐ No

CO2 Monitor:

☐ Yes

☐ No

Any pets:

☐ Yes

☐ No

If yes, please describe:

Other Safety Concerns: _____

Health

Physical health conditions:

☐ Balance issues

☐ Stroke

☐ Arthritis/pain

☐ Heart condition

☐ Diabetic

☐ Multiple medications

☐ Other _____

Allergies:

☐ Smoke

☐ Pets

☐ Dust

☐ Food

☐ Chemicals

☐ Perfume/scents

☐ Other _____

Please describe the nature and severity of the allergies (if applicable):

Mobility Aids:
☐ Cane
☐ Walker
☐ Wheelchair
☐ Other _____

Able to get in and out of vehicle without assistance?
☐ Yes
☐ No

If no, please describe:

Mental health conditions or cognitive impairments:
☐ Yes
☐ No

If yes, please describe:

Name of physician, health practitioner and/or local clinic:

Phone: _____ **Fax:** _____

Email: _____ **Permission to contact:**
☐ Yes
☐ No

Other Health Concerns:

Financial

Annual income (line 150 from CRA tax forms):

***Receiving other publicly funded home supports:**

☐ Yes
☐ No
☐ Unknown

If yes, please indicate:

☐ Veteran's Affair Canada
☐ Health Authority/ Home Support Services
☐ Other

***Applied Subsidy**

☐ 100% (full subsidy)
☐ 95%
☐ 90%
☐ 85%
☐ 80%
☐ 75%
☐ 70%
☐ 65%
☐ 60%
☐ 55%
☐ 50%
☐ 45%
☐ 40%
☐ 35%
☐ 30%
☐ 25%
☐ 20%
☐ 15%
☐ 10%
☐ 5%
☐ 0% (no subsidy)

Reason for any subsidy adjustment (if applied subsidy is different from eligible subsidy):

Service fees and subsidy confirmed:

☐ Yes
☐ No

Date of agreement: _____
(yyyy/mm/dd)

Client signature: _____

Staff Notes (text box):