FORM: I-101

Niagara Supportive Living

"Where Support and Independence go hand-in-hand"

Residential Application

Home for which application is being made:

Date Of Application:

Section 1- Applicant

Resident Name: _____ **Smoker/Non-Smoker:**

Date of Birth: _____ **OHIP #** _____ **Exp.** _____

Identification: _____

SIN#:

Marital Status:

Section 2- Family Contacts

Primary Contact

Name: _____ **Relationship:** _____

(person to contact in case of emergency)

Address: _____ **Tel:** _____

(street address, city, province, postal code)

Secondary Contact:

Name: _____ **Relationship:** _____

(Alternate person to contact in case of emergency)

Address: _____ **Tel:** _____

(street address, city, province, postal code)

Other Contacts: *(Next of Kin)*

Name: _____ **Tel:** _____

Name: _____ **Tel:** _____

Section 3- Income

Primary Source of Income:

Source: _____ **Amount:** _____ **How Often:** _____

Case Manager: ***(of primary income source, if government agency)***

Name: _____ **Tel:** _____ **ext.** _____ **Fax:** _____

Other Sources of Income: _____ **Amount:** _____

Do you have an Income Trustee? _____ **Since when?** _____

Name _____ **Tel:** _____ **ext.** _____ **Fax:** _____

Do you require the services of an income trustee: _____

If so, you must fill out the form: Voluntary request for Trusteeship

Other Notes: _____

Section 4- Agency Information *(Government or social agencies you are a client of)*

Primary Agency or Organization:

Agency: _____ **Address:** _____

Contact: _____ **Tel:** _____ **Ext.** _____ **Fax:** _____

Secondary Agency or Organization:

Agency: _____ **Address:** _____

Contact: _____ **Tel:** _____ **Ext.** _____ **Fax:** _____

Other Agencies or Organizations:

Agency: _____ **Address:** _____

Contact: _____ **Tel:** _____ **Ext.** _____ **Fax:** _____

Section 5- Medical

Primary Medical Practitioner

Do you have a family Doctor? ☐ **Name:** _____ **since:** _____

Address: _____ **Tel:** _____ **Fax:** _____
(street address, city, province, postal code)

Secondary Medical Practitioner:

Name: _____ **Address:** _____
(street address, city, province, postal code)

Specialty: _____ **Tel:** _____ **Fax:** _____

Other Medical Practitioner:

Name: _____ **Address:** _____
(street address, city, province, postal code)

Specialty: _____ **Tel:** _____ **Fax:** _____

Pharmacy:

Existing Pharmacy: _____ **Address:** _____
(street address, city, province, postal code)

Pharmacy Tel: _____ **Pharmacy Fax:** _____

Medical Conditions:

Allergies to medicine: _____

Allergies to food: _____

Medical Conditions: _____

_____

Section 5- Medical conditions *(continued)*

Mental Health Diagnosis: _____

Specific behaviours/diagnosis: _____

When were you diagnosed? _____ **Doctor:** _____

Other Notes: _____

_____

_____

Section 6- Consents

I have provided the above information to the best of my ability and know it to be true and correct.
If any of the above information changes, I agree to notify the administration staff at
Niagara Supportive Living so that this information can be updated.

I hereby give permission to any of the Agencies or persons named herein for the release of any pertinent information to Niagara Supportive Living.

The belowsigned understands that this application is for the sole use of
Niagara Supportive Living and will be used in accordance with the Privacy act.

Any sharing of this information will be limited to the ongoing care of the resident and in
case of emergencies.

I hereby consent to the monitoring of my medication on a need-be basis and understand
that medication compliance (if I am on any presciption medication) is manditory to maintain resident
status in any of Niagara Supportive Living's Independent Supportive Living homes.

I understand that for purposes of medication monitoring, my prescriptions will be transferred
to the Pharmacy which Niagara Supportive Living uses on a regular basis and hereby give
my consent to Niagara Supportive Living to requisition the transfer upon acceptance of my
application.

I have read and understand all of the above consents OR all of the above consents have been
explained to me.

Signature _____ **Date:** _____
(applicant OR trustee/guardian)

Name: _____
(type / print name here)