1A 1A

Manitoba Health

APPLICATION/ASSESSMENT FOR LONG TERM CARE PLACEMENT

The Application/Assessment for Long Term Care is made up of four parts:

Part 1 – Application – consisting of Section A and B.
Part 2 – Application – consisting of Section C, D, and E.
Part 3 – Dependency Assessment Supplement
Part 4 – Behavioural Assessment Supplement

NOTE: Since this form contains carbonized paper, DO NOT WRITE on this instruction sheet.

General Instructions

This form is to be completed:
1) for long term care application/assessment
2) for application to transfer from one facility to another.

The form can be used for personal care home placement, chronic care placement, supportive housing placement and companion care placement.

Applicant or Applicant's Representative –

- Complete Section A in detail and refer form to your doctor. The parts "Preference of Applicant: and "Responsibility for Payment" should be completed in consultation with the nurse/social assessor.

Physician –

- Complete Section C of Part II.
- Submit form to patient's nearest Regional Health Authority Office.

Nurse Assessor –

- Complete Section D of Part II.
- Complete Dependency Assessment Supplement – Part III.
- Complete Behavioural Assessment Supplement – Part IV, if applicable.

Social Assessor –

- Complete Section E of Part II.
- Refer completed form to nurse assessor if Section D not completed.

Case Coordinator –

- Present completed Application/Assessment to the appropriate panel.

Panel –

- Complete Section B of Part I – Disposition of Application By Panel.
- If long term placement is approved:
  - remove page 1 of this form (Sections A & B) and direct to Manitoba Health.
  - retain remainder of form until page 1 (with eligibility information) is returned from Manitoba Health.
  - Transfer Manitoba Health Eligibility information from page 1 to page 2 and, when appropriate, direct page 2 of Part I, Part II, Part III and Part IV to the appropriate facility.
  - retain page 1 for your records.

SECTION A – PART 1

Preference of Applicant

"No Preference" – Applicant will accept placement in any appropriate facility.

ADDITIONAL INFORMATION RELATIVE TO ELIGIBILITY AND APPLICATION

Each application for long term care placement must be reviewed by the appropriate assessment panel. The panel determines if the person's care cannot be appropriately managed at home or in the community and if the person needs placement in a long term care facility and establishes the priority of need for placement.

DO NOT DETACH THIS INSTRUCTION SHEET UNTIL THE ENTIRE FORM IS COMPLETED

M.H. 241 MG-1682 (Rev 07/10)

MM# 20180156

SHT 1 FACE

Manitoba Santé

DEMANDE ET ÉVALUATION EN VUE DU PLACEMENT DANS UN ÉTABLISSEMENT DE SOINS PROLONGES

La formule de demande et d'évaluation en vue du placement dans un établissement de soins prolongés se compose de quatre parties :

Partie 1 – Demande – comprend les sections A et B.
Partie 2 – Demande – comprend les sections C, D et E.
Partie 3 – Supplément – Évaluation du niveau de dépendance
Partie 4 – Supplément – Évaluation du comportement

NOTE : N'ÉCRIVEZ PAS sur cette feuille d'instructions car la présente formule se compose de papier carbone.

B-1A B-1A

Directives générales

La présente formule doit être remplie :
1) dans le cas d'une demande et d'une évaluation en vue du placement dans un établissement de soins prolongés;
2) dans le cas d'une demande de transfert d'un établissement à un autre.

La formule peut être utilisée pour le placement chez un membre de la famille, dans un foyer de soins personnels, un établissement de traitement des maladies chroniques ou un logement avec services de soutien.

Requérant ou son représentant –

- Remplissez la section A et remettez-la à votre médecin. Veuillez remplir les parties «Préférence du requérant» et «Prise en charge du paiement» avec l'aide de l'infirmier ou du travailleur social chargé de l'évaluation.

Médecin –

- Remplissez la section C de la partie II.
- Faites parvenir la formule au bureau de l'office régional de la santé le plus près du domicile du client.

Infirmier chargé de l'évaluation –

- Remplissez la section D de la partie II.
- Remplissez la partie III «Supplément – Évaluation du niveau de dépendance».
- Remplissez la partie IV «Supplément – Évaluation du comportement», le cas échéant.

Travailleur social chargé de l'évaluation –

- Remplissez la section E de la partie II.
- Remettez la formule à l'infirmier chargé de l'évaluation si la section D n'a pas été remplie.

Coordonnateur du dossier –

- Faites parvenir la formule de demande et d'évaluation au comité approprié.

Comité –

- Remplissez la section B de la partie I – Décision du comité.
- Si la demande de placement dans un établissement de soins prolongés est approuvée :
  - détachez la page 1 de la formule (sections A et B) et expédiez-la à Santé Manitoba;
  - gardez le reste de la formule jusqu'à ce que Santé Manitoba vous renvoie la page 1 (qui comprendra alors les renseignements d'admissibilité);
  - transcrivez les renseignements d'admissibilité de Santé Manitoba de la page 1 à la page 2 et, au moment opportun, faites parvenir la page 2 de la partie I, et les parties II, III & IV à l'établissement concerné;
  - conservez la page 1 dans vos dossiers.

SECTION A – PARTIE 1

Préférence du requérant

«Pas de préférence» – Le requérant accepte d'être placé dans n'importe quel établissement convenable.

RENSEIGNEMENTS SUPPLÉMENTAIRES CONCERNANT L'ADMISSIBILITÉ ET LA DEMANDE

Chaque demande de placement dans un établissement de soins prolongés doit être examinée par le comité d'évaluation approprié. Le comité détermine si la personne ne pourrait pas recevoir des soins appropriés dans son domicile ou dans la communauté ou si, ou contraire, elle doit être placée dans un établissement de soins prolongés, et il fixe l'ordre de priorité de placement.

NE PAS DÉTACHER CETTE FEUILLE D'INSTRUCTIONS TANT QUE LA FORMULE N'EST PAS COMPLÈTEMENT REMPLIE

N.B. Le masculin s'applique, le cas échéant, aux personnes de l'un ou l'autre sexe.

MM# 20180156

M.H. 241 MG-1682 (Rev 07/10)

SHT 1 BACKER

2A 2A

Approved / Approuvé

Date _____ Initial / Initiale _____

MB Health / Santé MB

Manitoba Health/Santé Manitoba

2nd Floor
300 Carlton Street
Winnipeg, MB
R3B 3M9

2e étage
300, rue Carlton
Winnipeg MB
R3B 3M9

APPLICATION / ASSESSMENT FOR LONG TERM CARE/DEMANDE ET ÉVALUATION EN VUE DU PLACEMENT DANS UN ÉTABLISSEMENT DE SOINS PROLONGÉS

THIS FORM IS TO BE COMPLETED WITH THE CONSENT OF THE APPLICANT OR A RELATIVE OR KINDLY DISPOSED PERSON REPRESENTING THE APPLICANT'S INTERESTS/
LA PRÉSENTE FORMULE NE PEUT ÊTRE REMPLIE QU'AVEC LE CONSENTEMENT DU REQUÉRANT OU D'UN PARENT OU D'UN REPRÉSENTANT BIEN INTENTIONNÉ DU REQUÉRANT

(A) APPLICANT'S NAME/ NOM DU REQUÉRANT (SURNAME)/(NOM) (GIVEN NAMES)/(PRÉNOMS)

M.H. REGISTRATION NO./ N° D'INSCRIPTION À S.M.

PERSONAL HEALTH IDENTIFICATION NO. N° D'IDENTIFICATION PERSONNELLE

DATE OF BIRTH/DATE DE NAISSANCE DAY/JOUR MO./MOIS YR./ANNÉE

SEX/SEXE

MARITAL STATUS/ ÉTAT CIVIL ▶ Single/Célibataire ☐ Married/Marié ☐ Widowed/Veuf ☐ Divorced/Divorcé ☐ Separated/Séparé ☐

TEL. NO./ N° DE TÉL. _____

M.H./S.M.

PRESENT LOCATION/ ADRESSE ACTUELLE

POSTAL CODE/CODE POSTAL

RESIDENCE (Previous 5 years. Attach separate sheet if more space required)/**DOMICILE** (Pour les 5 dernières années. Joindre au besoin une feuille additionnelle.)

ADDRESS/ADRESSE _____ FROM/DU _____ 20___ TO/AU _____ 20___

ADDRESS/ADRESSE _____ FROM/DU _____ 20___ TO/AU _____ 20___

NEXT OF KIN OR PERSON(S) RESPONSIBLE (Please state two)/**PLUS PROCHE PARENT OU PERSONNE(S) RESPONSABLE(S)** (Veuillez en nommer deux)

1) NAME/NOM _____ 2) NAME/NOM _____

ADDRESS/ADRESSE _____ ADDRESS/ADRESSE _____

POSTAL CODE/CODE POSTAL POSTAL CODE/CODE POSTAL

RELATIONSHIP/ LIEN DE PARENTÉ _____ TEL. NO./ N° DE TÉL. _____ RELATIONSHIP/ LIEN DE PARENTÉ _____ TEL. NO./ N° DE TÉL. _____

PREFERENCES OF APPLICANT (This portion of Section "A" to be completed by applicant or family in consultation with nurse/social assessor prior to assessment by panel.)/
PRÉFÉRENCES DU REQUÉRANT (Le requérant ou sa famille doit remplir cette partie de la section A avec l'aide de l'infirmier ou du travailleur social chargé de l'évaluation avant que le comité n'évalue la demande.)

NAME OF FACILITY REQUESTED:/NOM DE L'ÉTABLISSEMENT OÙ LE REQUÉRANT DEMANDE À ÊTRE PLACÉ :

▶ 1ST CHOICE/PREMIER CHOIX _____

2ND CHOICE/DEUXIÈME CHOIX _____

3RD CHOICE/TROISIÈME CHOIX _____

(✓ IF APPLICABLE/COCHER S'IL Y A LIEU)
☐ NO PREFERENCE/AUCUNE PRÉFÉRENCE

I hereby authorize the sharing of the information contained in this application with those persons involved in determining the applicant's need for care and those other persons who may become involved in the provision of care./Je permets que les renseignements contenus dans la présente demande soient communiqués aux personnes chargées de déterminer si le requérant a besoin des soins demandés, ainsi qu'aux personnes qui lui prodigueront ces soins.

Date DAY/JOUR MO./MOIS YR./ANNÉE

Applicant or Representative/Requérant ou son représentant

Relationship to Applicant/Lien de parenté

RESPONSIBLE FOR PAYMENT/PRISE EN CHARGE DU PAIEMENT

COMPLETE AT TIME OF ASSESSMENT/ REMPLIR AU MOMENT DE L'ÉVALUATION	AUTHORIZED CHARGE/ FRAIS AUTORISÉS	PROV OF MAN./ PROV. DU MAN. 1.	GOVT. OF CAN./ GOUV DU CAN. 2.	W.C.B./ C.A.T. 3.	SELF/ REQU. 4.	OTHER e.g. Relative or Trustee (SPECIFY NAME)/AUTRE (parent ou fiduciaire) (DONNER LE NOM) 5.
M.H. TO COMPLETE/ RÉSERVÉ À S.M.	PER DIEM CHARGE/ FRAIS QUOTIDIENS	M.H./ S.M. 1.	GOVT. OF CAN./ GOUV DU CAN. 2.	W.C.B./ C.A.T. 3.	SELF/ REQU. 4.	OTHER e.g. Relative or Trustee (SPECIFY NAME)/AUTRE (parent ou fiduciaire) (DONNER LE NOM) 5.

(B) **DISPOSITION OF APPLICATION BY PANEL/DÉCISION DU COMITÉ**

RECOMMENDATION/RECOMMANDATION

☐ NO FORMAL SERVICES/AUCUN SERVICE
☐ HOME CARE/SOINS À DOMICILE

PERSONAL CARE/SOINS PERSONNELS
☐ PLACEMENT/ADMISSION
☐ RESPITE/RELÈVE

CHRONIC CARE/TRAITEMENT DE MALADIES CHRONIQUES
☐ PLACEMENT/ADMISSION
☐ RESPITE/RELÈVE

☐ SUPPORTIVE HOUSING/ LOGEMENT AVEC SERVICES DE SOUTIEN
☐ COMPANION CARE/PLACEMENT CHEZ UN MEMBRE DE LA FAMILLE
☐ IF BEHAVIOR MANAGEMENT/SUPERVISION ASSESSED AT C OR D ENTER Y OR N/ SI LA GESTION OU LA SURVEILLANCE DU COMPORTEMENT EST ÉVALUÉE À C OU D, INSCRIRE O OU N
☐ IF PERSONAL CARE ENTER LEVEL 1, 2, 3 OR 4/ S'IL S'AGIT DE SOINS PERSONNELS INSCRIRE NIVEAU 1, 2, 3 OU 4
☐ IF THERE IS ONE OR MORE CHRONIC CARE INDICATOR, CHECK THIS BOX

RESIDENCE B.P./ RÉSIDENCE – EXCEPTION ☐

M.H. USE/RÉSERVÉ À S.M.

PANEL DATE/ DATE DU COMITÉ DAY/JOUR MO./MOIS YR./ANNÉE

COMMENTS/OBSERVATIONS

APPLICATION/PANEL ASSESSMENT/ DEMANDE ET ÉVALUATION DU COMITÉ

Tel. No. of Panel/N° de tél. du comité _____

Address of Panel/Adresse du comité _____

NAME OF PANEL CHAIRMAN OR DESIGNATE/NOM DU PRÉSIDENT DU COMITÉ OU DE SON DÉLÉGUÉ

Signature of Panel Chairman or Designate/Signature du président du comité ou de son délégué

MM# 20180156

SHT 2 FACE

3A 3A

Approved / Approuvé

Date / Initial / Initiale

MB Health / Santé MB

Manitoba Health/Santé Manitoba

2nd Floor
300 Carlton Street
Winnipeg, MB
R3B 3M9

2e étage
300, rue Carlton
Winnipeg MB
R3B 3M9

APPLICATION / ASSESSMENT FOR LONG TERM CARE/DEMANDE ET ÉVALUATION EN VUE DU PLACEMENT DANS UN ÉTABLISSEMENT DE SOINS PROLONGÉS

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PERSONAL HEALTH IDENTIFICATION NO. N° D'IDENTIFICATION PERSONNELLE

DATE OF BIRTH/DATE DE NAISSANCE DAY/JOUR MO./MOIS YR./ANNÉE SEX/SEXE

MARITAL STATUS/ ÉTAT CIVIL ▶ Single/Célibataire ☐ Married/Marié ☐ Widowed/Veuf ☐ Divorced/Divorcé ☐ Separated/Séparé ☐

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CHRONIC CARE/TRAITEMENT DE MALADIES CHRONIQUES
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M.H. USE/RÉSERVÉ À S.M.

PANEL DATE/ DATE DU COMITÉ DAY/JOUR MO./MOIS YR./ANNÉE

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Signature of Panel Chairman or Designate/Signature du président du comité ou de son délégué

MM# 20180156

SHT 3 FACE

4A 4A

APPLICATION / ASSESSMENT FOR LONG TERM CARE

MEDICAL DATA – TO BE COMPLETED BY PHYSICIAN

© APPLICANT'S NAME _____ (SURNAME) _____ (GIVEN NAMES) M.H. REGISTRATION NO. _____

PLACE OF EXAMINATION _____ DATE OF EXAMINATION _____

PERTINENT HISTORY (Including recent hospital admissions) _____

PHYSICAL FINDINGS

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____

IS THERE EVIDENCE OF PAST OR PRESENT ABNORMALITY OF:	NO	YES	IF "YES", GIVE FULL PARTICULARS
HEAD & NECK - INCLUDING FUNDI VISION, HEARING, SPEECH ETC.			
CARDIOVASCULAR SYSTEM INCL. HEART SOUNDS, MURMURS, HEART SIZE, BLOOD VESSELS, ETC.			
LUNGS			
ABDOMEN AND GENITALIA			
SKIN, LYMPH NODES, BREASTS INCLUDING BED SORES ETC.			
MUSCLES, BONES AND JOINTS INCLUDING SPINE, ETC.			
NERVOUS SYSTEM			

MENTAL STATUS INCLUDING ALCOHOLISM		
IS FURTHER INVESTIGATION OF THE PATIENT'S COMPETENCE TO HANDLE OWN AFFAIRS INDICATED?	NO	YES

INVESTIGATIVE FINDINGS

	RESULTS	DATE	PLACE RESULTS AVAILABLE
1) CHEST X-RAY ◀ Must be done within 1 year prior to placement			
2) Hgb			
3) FBS			
4) BUN			
5) ELECTROLYTES			
6) URINALYSIS			
7) ECG			
8)			

PRESENT THERAPY: (Include List of Medications, Occupational Therapy, Physiotherapy, Etc.)

DRUG SENSITIVITIES:

DIAGNOSES: (In order of Significance including any psychiatric diagnoses)

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

ARE DIAGNOSES KNOWN BY PATIENT? ☐ YES ☐ NO FAMILY? ☐ YES ☐ NO

STATE REASONS FOR RECOMMENDING ASSESSMENT FOR LONG TERM PLACEMENT

✔ TYPE OF CARE RECOMMENDED ☐ PERSONAL CARE ☐ CHRONIC CARE

WOULD YOU ACCEPT A GERIATRIC ASSESSMENT FOR PATIENT? ☐ YES ☐ NO

NAME & ADDRESS OF PHYSICIAN (PLEASE PRINT)

_____ Tel. No. _____

Will you continue to attend this person? YES ☐ NO ☐

Physician's Signature _____

Date _____

MM# 20180156

SHT 4 FACE

APPLICATION / ASSESSMENT FOR LONG TERM CARE
CARE PLAN

Ⓓ

APPLICANT'S NAME _____ (SURNAME) _____ (GIVEN NAMES) M.H. REGISTRATION NO. _____

DATE ASSESSED _____ LOCATION WHEN ASSESSED _____

FUNCTIONAL ASSESSMENT

SIGHT _____ GLASSES _____ DATE TESTED _____ BY WHOM _____

HEARING _____ AID _____ DATE TESTED _____ BY WHOM _____

SPEECH _____

TEETH – DENTURES: UPPER ☐ LOWER ☐ ARE THEY WORN? ☐ YES ☐ NO

DENTIST _____ DATE EXAMINED _____

MOBILITY AIDS: _____

ALLERGIES/SENSITIVITIES: _____

DIET CONTROLLED FOR: WEIGHT REDUCTION ☐ FAT INTOLERANCE ☐ FOR DIABETES ☐ FOR SODIUM ☐

GIVE DETAILS: _____

CARE PLAN (Including Medications and Treatments)

FACTORS AFFECTING SAFE CARE (e.g. Attitude, Behaviours, Use of Alcohol, Drugs, Wandering)

B-4A B-4A

MM# 20180156

SHT 4 BACKER

5A 5A

APPLICATION/ASSESSMENT FOR LONG TERM CARE

DEPENDENCY ASSESSMENT SUPPLEMENT

Manitoba Health

APPLICANT'S NAME _____ (Surname) _____ (Given names) _____ MH Registration No.

(check and underline appropriate descriptors and circle level of dependency in each category)

I: BATHING & DRESSING

X: Independent
- — Requires no assistance/supervision

A: Minimum Dependence
- — Requires minimal assistance with dressing e.g. buttons, zippers
- — Requires change of clothing to be laid out, soiled ones removed
- — Requires assistance in and out of tub

B: Partial Dependence
- — Requires partial assistance and/or supervision on a daily basis
- — Requires intermittent supervision, assistance and/or coaching with personal care e.g. peri-care in a.m. and h.s.
- — Requires assistance with more than one item of clothing on a daily basis

C: Maximum Dependence
- — Completely dependent
- — Requires constant coaching, supervision or assistance with personal care and dressing on a daily basis
- — Requires more than one person for assistance with bathing and some personal care
- — Requires daily re-dressing because of inappropriate dressing

D: CHRONIC CARE INDICATOR: Maximum dependency above and consistently requires three or more persons to carry out daily tasks related to bathing and dressing.

II: ASSISTANCE WITH MEALS (FEEDING)

X: Independent
- — Requires no assistance once food is served and uncovered

A: Minimum Dependence
- — Can feed self once meat is cut, bread buttered, beverage poured
- — Requires encouragement to stay at table

B: Partial Dependence
- — Requires partial assistance with eating and/or some encouragement to consume food
- — Food must be served one item at a time
- — Requires intermittent attention throughout meal

C: Maximum Dependence
- — Requires complete assistance with eating
- — Requires continual coaching or supervision because of confusion, dysphagia or other condition

D: CHRONIC CARE INDICATOR: Maximum dependency above and requires professional expertise to carry out feeding procedure e.g. syringe, nasogastric tube, gastrostomy, parenteral – I.V. or hypodermocylsis.

MM# 20180156

III: AMBULATION/MOBILITY/TRANSFERS

X: Independent
- — Requires no assistive devices

A: Minimum Dependence
- — Independently mobile with aid e.g. wheelchair, walker, cane
- — Ambulates independently within own room or for short distances

B: Partial Dependence
- — Requires assistance of one person to get in/out of bed and/or on/off toilet but is otherwise purposely mobile with wheelchair or other aid.
- — Requires assistance with walking or wheelchair movement but can transfer independently

C: Maximum Dependence
- — Requires mechanical lift for all transfers
- — Confined to bed or chair and requires positioning every two hours (includes skin care at this time)
- — Requires assistance for all transferring, transporting and walking
- — Uses electric wheelchair and otherwise requires assistance for all mobility
- — Propels wheelchair without purposeful direction

D: CHRONIC CARE INDICATOR: Maximum dependency above and consistently requires two or more persons to carry out all tasks related to ambulation, positioning and transferring. Intense intervention required totalling 2 hours or more over a 24 hour period.

IV: ELIMINATION

X: Independent
- — Independent in toiletting including management of occasional incontinence, ostomy or catheter

A: Minimal Dependence
- — Requires reminding to go to bathroom
- — Requires assistance for incontinence/dribbling less than daily but more than once a week

B: Partial Dependence

Requires one or more of the following:
- — Condom application at h.s.
- — Assistance with urinal/bedpan at night
- — Change once or twice in 24 hours for incontinence

C: Maximum Dependence

Requires one or more of the following:
- — Toiletting routine every two hours
- — Change more than four times in 24 hours
- — Bowel routine/disimpaction, minimum of every 2 days
- — Ostomy care (simple)
- — Catheter care (simple)
- — Peri-care more than a.m. and h.s.

D: CHRONIC CARE INDICATOR: Maximum dependency above and professional nurse is required to carry out related procedures: e.g. intermittent catheterizations, continuous bladder irrigations, specialized ostomy care.

DEPENDENCY ASSESSMENT – SUPPLEMENT

APPLICANT'S NAME: (Surname) (Given Name) MH Registration No.

V: PROFESSIONAL INTERVENTION (Treatment/Medication)

Interventions must be based on written orders. Some may be performed by nonprofessional caregivers under professional direction or supervision but in the institutional setting, unless otherwise specified, these tasks are carried out by a professional.

Examples: medication distribution and recording, vital signs, special skin care, application of ointments, instillation of eye drops, suctioning, oxygen therapy, range of motion exercises, walking as an exercise, behaviour modification interventions or retraining.

X: Independent
- — May be on a self-administered medication program

A: Minimal Dependence
- — Requires intervention every four hours or less i.e. up to six interventions in a 24 hour period

B: Partial Dependence
- — Requires intervention more often than every four hours but less often than hourly i.e. every two to three hours or more than six interventions in 24 hours

C: Maximum Dependence
- — Requires intervention constantly to hourly
- — May require terminal care
- — May require oxygen which can be delivered by a concentrator

D: CHRONIC CARE INDICATOR: Professional intervention is also required for one or more of the following procedures/treatments:
- — suctioning more than once daily
- — tracheotomy care on a daily basis
- — medications by I.V or infusion pump
- — complicated skin or ulcer care
- — dialysis
- — respiratory/treatments in addition to continuous oxygen (at least 18 hr/day)
- — Frequent lab testing and treatment due to a severe chronic medical condition e.g. blood gases or blood sugars one or more times a day; anticoagulent monitoring
- — Access to medical supervision and treatment for advanced progressive disease or multiple pathologies e.g. ALS, seizure disorder, MS, brittle diabetic, severe respiratory disease
- — other (specify)

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DEPENDENCY ASSESSMENT — SUPPLEMENT

VI: BEHAVIOUR MANAGEMENT/SUPPORT SUPERVISION

These interventions are in addition to those required to meet physical care needs and are usually in response to frequent or continual behaviours. There must be documentation describing the behaviour, the intervention that is required and the frequency required.

Examples: counselling of individual and/or family, listening to individual and/or family, redirection of behaviour, personal guidance and orientation

X: Independent

A: Minimum Support/Supervision
- — Can be supported with brief instruction or informational conversation. Family is not demanding of time. Examples: providing information about time and location, reminders about meals, routines

B: Partial Support/Supervision

Requires one or more of the following interventions as a result of depression, lack of motivation, confusion or anxiety:
- — Requires coaxing to get up and to leave room
- — Requires to be pointed in right direction for any movement within the unit
- — Requires intervention for a specific routine e.g. smoking
- — Family places demands on staff time on a daily basis
- — Requires pass-by supervision throughout day to ensure safety
- — Requires frequent reassurance e.g. related to anxiety

C: Maximum Support/Supervision

Requires a high degree of staff supervision or guidance for disorientation and confusion or uncontrolled behaviours*. One or more of the following may apply:
- — Behaviour is disruptive
- — Behaviour affects safety of self or others
- — Would wander out of building
- — Lack of ability to deal with people or routine living situations and requires constant guidance for any activity
- — Requires supervision for restraints (Documentation must indicate reason, specific time intervals, specific intervention)

D: CHRONIC CARE INDICATOR: Partial or maximum dependency above and professional intervention is required in one or more of the following situations:
- — Receives at least 30 minutes of therapy per day e.g. sensory stimulation due to comatose or semicomatose condition
- — Direct interventions to manage behaviour totalling more than two hours per 24 hour day
- — Professional supervision for dangerous or erratic behaviour
- — Requires psychiatric intervention

* Indicate if Behaviour Assessment Supplement has been completed — Yes ☐ No ☐ — If yes, date completed _____

Dependency Level:

The number of categories assessed at each of the three levels are totalled i.e. number of A's, B's, C's and D's. (Disregard any X's when adding). The dependency level is arrived at using the following criteria:
- At least one A and no B's, C's or D's..... Level 1
- Four or more C's..... Level 4
- Two or three C's and the rest A's and B's, or one C under "Support or Supervision" and at least two B's..... Level 3
- Any other combination of A, B and C..... Level 2

If applicable check Chronic Care.

Enter Total Number Circled

A_____ B_____ C_____ D_____

Personal Care Level _____ (Enter dependency level, if applicable)

and ☐ check if Chronic Care Indicator
or ☐ check if Chronic Care Placement at Deer Lodge Centre or Riverview Health Centre

COMPLETED BY _____ (PRINT NAME IN FULL AND POSITION) AGENCY _____

DATE _____ SIGNATURE _____

7A 7A

APPLICATION/ASSESSMENT FOR LONG TERM CARE

BEHAVIOURAL ASSESSMENT SUPPLEMENT

Manitoba Health

APPLICANT'S NAME _____ (Surname) _____ (Given Name) _____ MH Registration Number

Does the person:

1. Become confused about familiar places? (e.g. lose way, aimless wandering, forgetting location of toilets)	☐ No ☐ Occasionally ☐ Frequently	Approximate Date of Onset _____
Provide examples; indicate if the behaviour developed recently and describe the situation in which it occurs.	How is this behaviour currently Managed?	
2. Periodically fail to recognize familiar persons or mistake familiar persons for others?	☐ No ☐ Occasionally ☐ Frequently	Approximate Date of Onset _____
Examples	Current Management	
3. Experience significant confusion about time, day of the week, night versus day; time of year.	☐ No ☐ Occasionally ☐ Frequently	Approximate Date of Onset _____
Examples	Current Management	

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SHT 7 FACE

Does the person:

4. Demonstrate confusion about time of life? (e.g. lapsing into behaviour and speech/language associated with past)	☐ No ☐ Occasionally ☐ Frequently	Approximate Date of Onset _____
Examples	Current Management	

5. Become upset in stressful situations? (noise, crowds, visitors, public places, etc.)	☐ No ☐ Occasionally ☐ Frequently	Approximate Date of Onset _____
Examples	Current Management	

6. Lapse into confused and disoriented speech? (e.g. rambling, forgetting ordinary words)	☐ No ☐ Occasionally ☐ Frequently	Approximate Date of Onset _____
Examples	Current Management	

B-7A B-7A

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SHT 7 BACKER

APPLICANT'S NAME: (Surname) (Given Name) MH Registration No.

8A 8A

Does the person:

7. Exhibit undue fear or suspicion of others?	☐ No ☐ Occasionally ☐ Frequently	Approximate Date of Onset _____

Examples	Current Management

8. Accuse others of stealing or hiding property and/or money or of being threatening or causing bodily harm?	☐ No ☐ Occasionally ☐ Frequently	Approximate Date of Onset _____

Examples	Current Management

9. Withdraw or have periods of despair? (e.g. crying, expressing hopelessness through speech, behaviour or facial expressions)	☐ No ☐ Occasionally ☐ Frequently	Approximate Date of Onset _____

Examples	Current Management

Does the person:

10. Have difficulty getting along with others? (e.g. quarrelsome, uncooperative, irritable, loud or constantly talking, interfering)	☐ No ☐ Occasionally ☐ Frequently	Approximate Date of Onset _____
Examples	Current Management	

11. Have episodes of self-destructive or self-abusive behaviour?	☐ No ☐ Occasionally ☐ Frequently	Approximate Date of Onset _____
Examples	Current Management	

12. Have periods of intensive and apparently unprovoked aggressive acts against others? (e.g. verbal or physical)	☐ No ☐ Occasionally ☐ Frequently	Approximate Date of Onset _____
Examples	Current Management	

B-8A B-8A

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SHT 8 BACKER

9A 9A

APPLICANT'S NAME: _____ (Surname) _____ (Given Name) _____ MH Registration No.

Does the person:

13. Hoard and hid things inappropriately? (e.g. food, cutlery, linen)

☐ No
☐ Occasionally
☐ Frequently

Approximate Date of Onset _____

Examples	Current Management

14. Have difficulty adhering to normal hygiene practices and dressing appropriately?

☐ No
☐ Occasionally
☐ Frequently

Approximate Date of Onset _____

Examples	Current Management

15. Exhibit inappropriate sexual behaviour? (e.g. exhibitionism, public masturbation, inappropriate physical aggressive advances)

☐ No
☐ Occasionally
☐ Frequently

Approximate Date of Onset _____

Examples	Current Management

BEHAVIOURAL ASSESSMENT SUPPLEMENT - Part IV

Does the person:

16. Smoke carelessly?	☐ No ☐ Occasionally ☐ Frequently	Approximate Date of Onset _____
Examples	Current Management	

17. Have any history of substance abuse?	☐ No ☐ Occasionally ☐ Frequently	Approximate Date of Onset _____
Examples	Current Management	

18. Exhibit disruptive or unusual sleep patterns? (e.g. nighttime wandering)	☐ No ☐ Occasionally ☐ Frequently	Approximate Date of Onset _____
Examples	Current Management	

Completed by: _____ Agency _____
Print name in full and position

Date: _____ Signature _____

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10A 10A

APPLICATION / ASSESSMENT FOR LONG TERM CARE
CARE PLAN

Ⓔ APPLICANT'S NAME _____ (SURNAME) _____ (GIVEN NAMES) _____ M.H. REGISTRATION NO.

REASON FOR APPLICATION AND PRESENT LIVING ARRANGEMENT:

_____

_____

_____

_____

_____

INFORMATION SUPPLIED BY: _____ RELATIONSHIP _____ TEL. NO. _____

NAME OF ADVOCATE: _____ RELATIONSHIP _____ TEL. NO. _____

ADDITIONAL INFORMATION: Relevant To Placement (Include Attitude Toward Placement, Coping Mechanisms, Social Networks, Family Dynamics)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

RELIGION: _____

LANGUAGE OF CHOICE: _____

OTHERS SPOKEN AND/OR UNDERSTOOD: _____

DEPENDENCY ASSESSMENT: X, A, B, C OR D IN EACH SECTION BELOW – TRANSFERRED FROM DEPENDENCY ASSESSMENT SUPPLEMENT

I BATHING & DRESSING	
II ASSISTANCE WITH MEALS/FEEDING	
III AMBULATION/MOBILITY/TRANSFERS	

IV ELIMINATION	
V PROFESSIONAL INTERVENTION	
VI BEHAVIOUR MANAGEMENT/SUPERVISION	

ENTER TOTAL NUMBER OF EACH

A	B	C	D

DEPENDENCY LEVEL

PERSONAL CARE _____ OR CHRONIC CARE _____
1, 2, 3 or 4

RECOMMENDATION TO PANEL

- ☐ NO FORMAL SERVICES
- ☐ HOME CARE
- ☐ PERSONAL CARE HOME PLACEMENT
- ☐ CHRONIC CARE PLACEMENT
- ☐ REQUEST FOR PANEL CONSULT

ASSESSED BY:

NURSE _____

SOCIAL WORKER _____

OTHER _____

COMPLETED BY _____ DATE _____