HOME CARE CASE ACTION FORM

Manitoba Health

1. CLIENT NAME: Birth Date

M.H.S.C.# PHIN #:

ADDRESS: Phone:

☐ New Opening
☐ Re-opening
☐ Transfer in from V.O.N. or Coordinating Hospital

OPEN FOR:
☐ Home Care Assessment and/or
☐ Personal Care Home Assessment
☐ Other (specify)

Age of Opening

Transfer Date D/M/Y

Opening Date

Case Assessors: Nurse: Social Worker:

Case Coordinator:

2. **NON-ADMISSION** TO HOME CARE:

Non-Admission Date D/M/Y

30 ☐ Chronic Care Placement
31 ☐ Inter-Regional Transfer
32 ☐ Home Care Services Not Required
33 ☐ Home Not Suitable For Home Care
34 ☐ Person Deceased
35 ☐ Admitted To a Care Facility Or Hospital
36 ☐ Person Or Family Refused Service
37 ☐ Other (Specify)

3. **ADMISSION** TO THE HOME CARE PROGRAM: ☐ Admission ☐ Re-Admission Admission Date D/M/Y

4. **SOURCE OF REFERRAL** FOR ADMISSIONS: (Check One)
A ☐ Self B ☐ Doctor C ☐ Hospital D ☐ Family/Friend E ☐ Other Agency F ☐ Own Agency

5. **CARE LEVEL EQUIVALENT** AT POINT OF ADMISSION/RE-ADMISSION: (If Home Care were not available, what equivalent level of facility care would be required for the individual? (Check One)

1 ☐ Personal Care Home Level I
2 ☐ Personal Care Home Level II
3 ☐ Personal Care Home Level III
4 ☐ Personal Care Home Level IV
5 ☐ Post Acute Care
6 ☐ Hospital – Extended Care/Long Term
7 ☐ Other Facility
8 ☐ No Facility Care Level Equivalent

6. **DISCHARGE** FROM THE HOME CARE PROGRAM: (Check One) Discharge Date D/M/Y

☐ Person Deceased
☐ Personal Care Home Placement
☐ Other (Specify)
☐ Hospital Admission including Extended Care Hospital
☐ Home Care No Longer Required/Service Provided By Other
☐ Home Care No Longer Required/Person Improved/Recovered

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