

# **APPLICATION AND ASSESSMENT FORM**

								_
1	NEW ASSESSMENT	RESPON	SIBLE A	ASSESS	SOR			11
2								Jl
3	REASSESSMENT	HEALTH	DIST	CLIEN	T NI IN	ADED		
4	APPEAL	IILALIII	DIOI.	CLILIN	II INOIN	IDLI		
		1 1	1		1		- 1	1

SE	CTION 1 - ADMINISTRATIVE AND SUMMARY		5 CORRECTION				
Α	CLIENT'S PERSONAL DATA						
1	CLIENT'S FAMILY NAME	FIRST NAME		INITIALS PHONE (CURRENT)			
	CURRENT ADDRESS	FROM (DATE)	3 MARITAL STATUS 1 SINGLE	VETERAN SERVICE CATEGORY  ☐ YES ☐ NO			
2	CITY	POSTAL CODE	2 MARRIED 3 WIDOWED 4 DIVORCED	IIIA I B I C I U (Unknown)			
	CURRENT LOCATION OF CLIENT	MAIL TO CLIEN	J SEPARATE				
	AS ABOVE OTHER:	∐Y ∐N					
	GENDER BIRTHDATE (YYYY / MM / DD) PERSONAL HEALTH NUMBER	SPOUSE'S	CLIENT NUMBER	SPOUSE'S PERSONAL HEALTH NUMBER			
	$\square$ M $\square$ F $						
В	CONTACT PERSON'S FAMILY NAME	NEXT OF KIN RELAT	IONSHIP	LOCATION OF ACTION REQUIRED			
		Y N		1   TEAM REVIEW			
	STREET ADDRESS			2 FOLLOW-UP			
				3 □ N/A			
	CITY POSTAL CODE HOME PHONE	BUSI	NESS PHONE	3   HOSPITAL			
				4 OTHER			
C	NAME NEXT OF KIN	RELATIONSHIP	RESEARCH CODES	APPROVED SERVICES			
	$\square_{Y} \square_{N}$			1 NOT ELIGIBLE			
	ADDRESS POSTAL 0	CODE PHOI	NE	2 CARE DECLINED BY CLIENT			
				3 CARE AT HOME			
D	PHYSICIAN'S NAME	OFFI	CE PHONE	4 CARE AT HOME WITH MH SUPPORT			
				5 FACILITY CARE			
	OFFICE ADDRESS	F	POSTAL CODE	6 Day Care			
				7 ASSISTED LIVING			
Ε	APPLICATION			8 ASSISTED LIVING - SPOUSE			
1.6	avalar, annih, far hanafita far rikiala I / Oliant mari ha alimikla	alau Haallana	and Canana initia	AGGIGTED EIVING - GI GGGE			
	nereby apply for benefits for which I / Client may be eligible are program and certify that the information I have provided i			APPROVED CARE LEVEL			
	dge and may be released to the Home and Commun <u>ity Care</u>		est of fifty knowl-	1 PC 4 IC3			
ec	CANADIAN	N CITIZEN BC RESIDE	NT (YYYY / MM / DD)	2			
		Пио		3			
			HIP EXPIRY (YYYY / MM / DD)	LIVES WITH CARE GIVER?			
X.				YES NO			
	SUMMARY			NO			
	JOINIMANT			YYYY/MM/DD			
				7			
			CASE MANAGER'S SIGNATURE				
G	SERVICE AUTHORIZATION	H CLIENT	'S PREFERENCE (	see reverse)			
	OVIDER ID ASSESSOR SA - ID		PREFERRED FAC	•			
AU <sup>*</sup>	THORIZATION DATE (YYYY/MM/DD) ORG. SERVICE TYPE						
	1 PAID 2 UNPAID	1 ☐ AT HO	ME				
	CARE LEVEL CLIENT CONTRIBUTION APPROVED H	IRS./DAYS 2 FACILI	FACILITY CODE	DATE ON LIST (YYYY / MM / DD)			
	START     \$		BDEEEDBED EAG	CILITY			
	CHANGE 1 BEGIN PAID A VACATION B ILLNESS 2 ABSENCE	RETURN 21 STAND	DARD	<del></del>			
	☐ END 1 ☐ DEATH A ☐ UNPAID TEMP ABSENCE						
	SA - ID	23 PRIVA	FACILITY CODE	DATE ON LIST (YYYY / MM / DD)			
	CORRECT DELETE						
AU'	THORIZING SIGNATURE DATE (YYYY/MM/DD)	. [	BF CODE	BF DATE (YYYY / MM / DD)			
1		1 I					

#### **DOCUMENTATION**

- If New Assessment or Appeal: complete pages 1 to 5; tick NEW ASSESSMENT box or APPEAL box.
- If Review: tick Review box; complete HEALTH DISTRICT, ASSESSOR, CLIENT NUMBER, CLIENT NAME, REVIEW DATE, ASSESSMENT LOCATION, and APPROVED CARE LEVEL AND SERVICES. Submit only page 1.
- If Reassessment: tick REASSESSMENT box; complete HEALTH DISTRICT, ASSESSOR, CLIENT NUMBER, CLIENT NAME, REVIEW DATE, REASSESSMENT DATE, ASSESSMENT LOCATION and APPROVED CARE LEVEL AND SERVICES. Submit only page 1.
- If Correction: tick CORRECTION box; enter detail in shaded sections only as it should read. Submit only pages to be corrected; date stamp form.

#### THE ABOVE ACTIONS ARE THE MINIMUM DATA ENTRY REQUIREMENTS.

## A. CLIENT'S PERSONAL DATA

- Most fields are self explanatory.
- A2: Enter current address and applicable dates. Even if the client has been admitted to hospital or facility, use client's home address.
- Tick the NO box if client is not a veteran. For veterans, tick the appropriate
  A, B, or C box and the service number (*regimental number*). This
  information can be obtained from Veteran Affairs Canada Offices in
  Vancouver, Victoria, Prince George or Penticton.
- Tick the NO box if client is not to receive rate change letters directly.
   This indicates the letter will be sent to the Health Authority for distribution to the appropriate client contact.
- A3: Check appropriate Marital status. If situation is unusual, tick 6 (other) and describe circumstances in Section IF.

## C. EMERGENCY CONTACT PERSON and RESEARCH CODES

- Give details of person or next-of-kin to contact in an emergency. Enter Contact Person if they are also the Emergency Contact.
- Up to 3 Research Codes, determined by the Health Unit, can be used to classify a client for future research.

#### D. RESPONSIBLE PHYSICIAN

- Give details of the physician responsible for client care.
- Specialists or other physicians involved, enter in F.

#### **E. APPLICATION**

- When assessment is complete, have client sign application. If clients
  cannot sign name but can make their mark, Case Manager enters their
  names, the words "His/Her Mark", and countersigns. If clients cannot
  sign or mark, the contact person may sign on behalf of the client.
- Case Manager is to ensure that clients are aware they are specifically certifying that their answers to Section IV A1, IV A2, IV A3 are correct.
- Indicate Canadian Citizenship. Enter the date the client became a BC resident.
- Tick the YES box if client is a sponsored immigrant. Enter the date the sponsorship expires.

# Freedom of Information and Protection of Privacy

All personal information is collected under the *Continuing Care Act*, and will be used to determine the applicant's functional and self care capabilities. Personal information will be used and disclosed in accordance with the privacy protection provisions of the *Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection, use and disclosure of this information, you should contact your case manager at your local health unit, which is listed in the blue pages of the telephone book under Health Authorities.

# F. ASSESSMENT SUMMARY

- Case Manager signs in the space provided and dates the signature.
- If the client lives with a caregiver in client's own home (not Family Care or Group Home) tick YES. Caregiver means a family member or other person providing client ongoing care and/or supervision.

# G. SERVICE AUTHORIZATION (SA)

- One service can be started/changed/ended in this section. Use the SA Action Memo to authorize additional starts/changes/ends to service.
- Home and Community Care Manager or delegated person(s) signs in the Authorizing Signature space to authorize service.
- Once the SA information is entered into the computer, write the SA-ID in the SA-ID box.
- SA's will print on the Health Unit printer. Use the 5OH screen to designate printer, number of copies and when SA's will print.

#### START OF SERVICE

- Authorization Date indicates when service can begin or the admission date.
- Paid or Unpaid indicates whether service is paid for by the Health Authority.
- Organization/Service/Type codes relate to the service provider's category. Use the 6P7 screen to see available provider choices.
- For Home Support Service or Day Program, indicate the approved hours or days and attach an authorized memo if in excess of normal limits. Also indicate client's contribution.

#### CHANGE OF SERVICE

- Authorization Date indicates when a change of service is to begin.
- For Home Support Service or Day Program, indicate the approved hours or days and attach an authorized memo if in excess of normal limits. Indicate client's contribution, if changed.

# **TEMPORARY ABSENCE (FACILITY CLIENTS ONLY)**

Paid If the client has departed the facility on an approved paid temporary absence, indicate the Authorization Date in the Change Service section and tick a Vacation or Illness box. When the client returns, enter the date care resumes in a Change Service on an SA Action Memo and tick Return box.

**Unpaid** If the client has left on an unpaid temporary absence, service must be terminated in the End Service section by ticking the Unpaid Temp Absence box. When the client returns from the unpaid absence, use the Start Service of an SA Action Memo.

# **END TO SERVICE**

- Authorization date indicates when the service terminates.
- Tick Death box or Unpaid Temp Absence box only if applicable. Blank indicates a normal end to service.

# **ERROR CORRECTIONS OR DELETIONS**

 Tick Correct or Delete box and indicate the Service Authorization being corrected or deleted.

# H. CLIENT'S PREFERENCE

- The Client's Preference (bottom of form 1) should be completed after the assessment to ensure an informed choice. Client condition and financial circumstances should be considered to avoid inappropriate choices when premium payments are involved.
- Enter BF (bring forward) reason code and date, if applicable. BF codes:

G=Other

A=Referral D=Hospital to Community

B=Provider Request E=Awaiting Client Info C=Review Plan or Hours F=Start Facility Services