BRITISH COLUMBIA | Ministry of Health

# APPLICATION AND ASSESSMENT FORM

UNDER REVIEW
1 ☐ NEW ASSESSMENT
2 ☐ REVIEW

RESPONSIBLE ASSESSOR | HEALTH DIST. | CLIENT NUMBER

1

DATE CASE OPENED/RE-OPENED (CC1) Y Y Y Y | M M | DD

## CLIENT'S PERSONAL DATA

CLIENT'S FAMILY NAME | FIRST NAME | INITIALS

PERSONAL HEALTH NUMBER 9 | BIRTHDATE Y Y Y Y M M DD | GENDER ☐M ☐F | VETERAN SERVICE CATEGORY ☐ YES ☐ NO ☐A ☐B ☐C ☐U (Unknown) | SERVICE NUMBER

MARITAL STATUS 1 ☐ SINGLE 2 ☐ MARRIED 3 ☐ WIDOWED 4 ☐ DIVORCED 5 ☐ SEPARATED 6 ☐ OTHER 7 ☐ AL-MARRIED BUT LIVING APART | SPOUSE'S CLIENT NUMBER | SPOUSE'S PERSONAL HEALTH NUMBER 9

CURRENT ADDRESS | FROM (DATE) | CITY | POSTAL CODE

PHONE (CURRENT) | CURRENT LOCATION OF CLIENT ☐ AS ABOVE ☐ OTHER: | LIVES WITH CARE GIVER? ☐ YES ☐ NO | MAIL TO CLIENT ☐ YES ☐ NO

CONTACT PERSON'S FAMILY NAME | NEXT OF KIN ☐ YES ☐ NO | RELATIONSHIP | CONTACT HOME PHONE

CONTACT STREET ADDRESS | CITY | POSTAL CODE | CONTACT BUSINESS PHONE

PHYSICIAN'S NAME | OFFICE ADDRESS | POSTAL CODE | PHYSICIAN'S OFFICE PHONE

**LOCATION OF ASSESSMENT**
1 ☐ HOME
2 ☐ FACILITY
3 ☐ HOSPITAL
4 ☐ OTHER

**ACTION REQUIRED**
1 ☐ TEAM REVIEW
2 ☐ FOLLOW-UP
3 ☐ N/A

**CLIENT GROUP**
1A ☐ HOME CARE ACUTE
1B ☐ HOME CARE END OF LIFE
1C ☐ HOME CARE LONG TERM SUPPORTIVE
1D ☐ HOME CARE MAINTENANCE
1E ☐ HOME CARE REHABILITATION
2A ☐ RESIDENTIAL CARE CLIENT

**REFERRAL SOURCE**
01 ☐ SELF
02 ☐ PHYSICIAN
03 ☐ FAMILY/NEIGHBOUR/FRIEND
04 ☐ HOSPITAL
05 ☐ OTHER HEALTH PROFESSIONAL
06 ☐ COMMUNITY AGENCY
97 ☐ OTHER
98 ☐ UNKNOWN

| APPROVED SERVICES | DATE ACCEPTED FOR SERVICE |
|---|---|
| 1 ☐ NOT ELIGIBLE | |
| 2 ☐ CARE DECLINED BY CLIENT | |
| 3 ☐ CARE AT HOME | Y Y Y Y M M DD |
| 4 ☐ CARE AT HOME WITH MH SUPPORT | Y Y Y Y M M DD |
| 5 ☐ FACILITY CARE | Y Y Y Y M M DD |
| 6 ☐ DAY CARE | Y Y Y Y M M DD |
| 7 ☐ ASSISTED LIVING | Y Y Y Y M M DD |
| 8 ☐ ASSISTED LIVING - SPOUSE | |

**ABORIGINAL ORIGIN (BB3)** ☐ YES ☐ NO 98 ☐ UNKOWN

**ACQUIRED BRAIN INJURY** ☐ YES ☐ NO

**DEVELOPMENTAL DISABILITY** ☐ YES ☐ NO

**RESEARCH CODES** ☐ ☐ ☐

**RUGS**

**OUTCOME** IADL DS: ☐ CPS: ☐ ADL LF: ☐ ADL SP: ☐ IADL INV: ☐

## APPLICATION

I hereby apply for benefits for which I / Client may be eligible under the Home and Community Care program and certify that the information I have provided is correct to the best of my knowledge and may be released to the Home and Community Care provider.

X _____
*Client or authorized signature*

CANADIAN CITIZEN ☐ YES ☐ NO | BC RESIDENT DATE Y Y Y Y M M DD | ASSESSMENT DATE Y Y Y Y M M DD

SPONSORED IMMMIGRANT ☐ YES ☐ NO | SPONSORSHIP EXPIRY DATE Y Y Y Y M M DD | CASE MANAGER'S SIGNATURE

### 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.

## SERVICE AUTHORIZATION

PROVIDER ID | ASSESSOR | SA - ID

AUTHORIZATION DATE Y Y Y Y M M DD | 1 ☐ PAID 2 ☐ UNPAID | ORG. | SERVICE | TYPE

☐ START | CARE LEVEL EC | CLIENT CONTRIBUTION $ . | APPROVED HRS./DAYS

☐ CHANGE | 1 ☐ BEGIN PAID ABSENCE A ☐ VACATION B ☐ ILLNESS 2 ☐ RETURN

☐ END | 1 ☐ DEATH A ☐ UNPAID TEMP ABSENCE

☐ CORRECT ☐ DELETE | SA - ID

AUTHORIZING SIGNATURE | DATE Y Y Y Y M M DD

# INSTRUCTIONS and GUIDE

**TYPE OF ASSESSMENT**
- Type of assessment is now either NEW ASSESSMENT (first time assessment) or SUBSEQUENT. Please note: assessment refers to the interRAI Home Care assessment, Canadian Version, 2nd edition, October 2002.

**CLIENT'S PERSONAL DATA**
- Most fields are in this section are self explanatory. The following are areas that may need some clarification.
- Current address: This is the client's home address even if the client has been admitted to a hospital or facility.
- Veteran: If the client is a veteran, tick the YES box, and tick the appropriate A. B. or C box and fill the service number (regimental number). This information can be obtained from Veteran Affairs Canada Offices in Vancouver, Victoria, Prince George or Penticton. Otherwise tick the NO box if the client is not a veteran.
- **Marital Status:** Tick the appropriate MARITAL STATUS box. #7 AL-Married but living apart: Married but Living Apart is when a couple is married, but only the client moves into AL. The spouse may live anywhere, and may or may not be receiving HCC services. If the couple is a same sex couple then tick box #2 MARRIED.
- **Mail to Client:** Tick the NO box if the client is not to receive rate change letters directly. This indicates the Health Authority will manage distribution to the appropriate client contact.
- **Assisted Living – Spouse:** This type of approved service is to be used when a Spouse, who has not been an HCC Client to date, remains in an Assisted Living setting after the husband or wife has permanently left the Assisted Living residence.
- **Client Group:** A high-level description of home care clients, based on their health status (health and living conditions, and personal resources) and assessed needs.
  *Acute:* The client who needs immediate or urgent time limited (within 3 months) interventions to improve or stabilize a medical or post-surgical condition.
  *End of Life:* The client for whom death is anticipated within six months.
  *Long Term Supportive:* The client who is at significant risk of institutionalization due to unstable, chronic health conditions, and/or living condition(s) and/or personal resources.
  *Maintenance:* The client with stable, chronic health conditions, stable living conditions and personal resources, who needs support in order to remain living at home.
  *Rehab:* The client with a stable health condition that is expected to improve with a time-limited focus on functional rehabilitation.
  *Residential Care:* Client permanently resides in a residential care facility, family care home or group home. Do not include Assisted Living. (This value is for MoH specifically and is not included in the current RAI client group categories. Should be used if a residential care client is reassessed).
- **Aboriginal Origin (InterRAI-HC BB3):** If the question is asked and the client identifies himself or herself as being of aboriginal origin, then check "Yes". If the question is asked and the client does not identify himself or herself as being of aboriginal origin then check "No". Unknown is used when the question is not asked or, if the client is unwilling to answer the question.
- **Acquired Brain Injury:** (ABI) Possible causes of acquired brain injury include, but are not limited to, the following: trauma to the brain, cerebral vascular accidents, tumour, infections of the brain, toxic exposure and lack of oxygen to the brain due to a variety of causes. Guidelines for Planning Brain Injury Services and Supports in BC 2002 (available on the Ministry of Health's website, under Mental Health and Addictions, Publications).
- **Date Case Opened/Re-opened (InterRAI-HC CC1):** The date of the very first contact with Home & Community Care in the Health Authority. The Referral Source (e.g. client's relative, neighbour, friend, physician, etc.) will be linked to this date. This date will be used to match with InterRAI records submitted to CIHI. 1) Must be in a valid date format; 2) cannot be before the birth date; 3) cannot be after service date for the record submitted. Will be mandatory October 1, 2006 for all clients.
- **Date Accepted for Service:** The date the HA determined that the client meets all eligibility criteria including being ready and willing to accept the service.
- **Research Codes:** up to 3 codes can be used to classify a client for research purposes as determined by the Health Authority.
- **Resource Utilization Groups (RUGS):** RUG III/HC categories reflect a client's level of functioning, care needs and intensity of resource use. Values are: RA1 RA2 RB SE1 SE2 SE3 SSA SSB CA1 CA2 CC IA1 IA2 IB BA1 BA2 BB PA1 PA2 PB PC PD.
- **Outcome:** The outcome scores for Instrumental Activity of Daily Living-Difficulty Scale, Cognitive Performance Scale, Activities of Daily Living-Long Form, Activities of Daily Living-Self Performance and Instrumental Activities of Daily Living-Involvement Scale.

**APPLICATION**
- When assessment is complete, have client sign application. If a client cannot sign but can make his or her mark then, the Case Manager enters the name and the words "His/Her Mark", and countersigns. If the client cannot sign or mark, the contact person may sign on behalf of the client.
- Case Manager must ensure that the client is aware that the signature certifies that answers 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.
- Case Manager signs in the space provided and dates the signature.

**SERVICE AUTHORISATION**
- Please note: Care level is no longer assigned. Therefore, EC has been entered as the default care level.
- 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.
- Service authorisations will print on the Health Unit printer. Use the 5OH screen to designate printer, number of copies and when service authorisations will print.

**Start of Service**
- Authorisation 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. Also indicate client's contribution.

**IMPORTANT, PLEASE NOTE:**
- For assisted living clients, .enter the monthly personal care hours and ensure these hours are entered in the personal care hours field on the CC-IMS transaction. Enter the assisted living monthly charge in the client contribution field for this form and then ensure it is entered in the monthly charge field on the CC-IMS transaction.

**Change of Service**
- Authorisation Date indicates when a change of service is to begin.
- For Home Support Service or Day Program, indicate the approved hours or days. Indicate client's contribution, if changed.

**IMPORTANT, PLEASE NOTE:**
- If there is a change in the assisted living service (e.g. a change in the monthly charge or a change to the personal care hours per month) then a change authorisation needs to be completed. For assisted living clients, enter the monthly personal care hours and ensure these hours are entered in the personal care hours field on the CC-IMS transaction. Enter the assisted living monthly charge in the client contribution field for this form and then ensure it is entered in the monthly charge field on the CC-IMS transaction.

**Temporary Absence (Facility Clients Only)**

**Paid** If the client has departed the facility on an approved paid temporary absence, indicate the Authorisation 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 a 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 a SA Action Memo.

**End to Service**
- Authorisation 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 Authorisation being corrected or deleted.

**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:

| | | |
|---|---|---|
| A=Referral | D=Hospital to Community | G=Other |
| B=Provider Request | E=Awaiting Client Info | |
| C=Review Plan or Hours | F=Start Facility Service | |

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