

**CHESHIRE HOMES OF SASKATOON  
RESIDENCY APPLICATION FORM**

This form is to be completed by the applicant and submitted to  
The Residency Task Group  
2901 Louise Street  
Saskatoon, SK, Canada  
S7J 3L1

GENERAL INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Alternate Number: \_\_\_\_\_

Next of Kin: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Significant Other (Relative or Friend): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_

Date of Injury or Accident: \_\_\_\_\_

Personal Physician: \_\_\_\_\_

Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

## PERSONAL INFORMATION

Date of Birth: \_\_\_\_\_

Current Living Arrangement: \_\_\_\_\_

In the space provided, please answer yes or no to the following questions. If you answer is no, please identify who manages these matters. Do you manage to following personal matters?

Financial Matters: \_\_\_\_\_

Medical Matters: \_\_\_\_\_

Personal Matters: \_\_\_\_\_

Please list your Educational Background: \_\_\_\_\_

Are you involved in work or an activity program outside of the home? \_\_\_\_\_

Please list your leisure interests and volunteer activities: \_\_\_\_\_

## IMPACT OF DISABILITY ON DAILY LIVING

Does your disability affect you're:

- |                     |                |                       |
|---------------------|----------------|-----------------------|
| 1. Mobility         | Yes ___ No ___ | Please Explain: _____ |
| 2. Vision           | Yes ___ No ___ | Please Explain: _____ |
| 3. Hearing          | Yes ___ No ___ | Please Explain: _____ |
| 4. Allergies        | Yes ___ No ___ | Please Explain: _____ |
| 5. Skin             | Yes ___ No ___ | Please Explain: _____ |
| 6. Behaviour        | Yes ___ No ___ | Please Explain: _____ |
| 7. Diet             | Yes ___ No ___ | Please Explain: _____ |
| 8. Communication    | Yes ___ No ___ | Please Explain: _____ |
| 9. Outdoor Mobility | Yes ___ No ___ | Please Explain: _____ |

Please specify any special needs: \_\_\_\_\_

DAILY LIVING SKILLS

Please place a mark where applicable:

	Full Assistance	Partial Assistance	Supervision	No Assistance
Eating				
Washing Face and Hands				
Brushing/Flossing Teeth				
Bathing				
Toileting				
Hair/Nail Care				
Bladder Care				
Specify Bladder Care				
Bowel Care				
Specify Bowel Care				
Dressing				
Indoor Mobility				
Specify Indoor Mobility				
Outdoor Mobility				
Specify Outdoor Mobility				
In Bed Mobility				
Specify In Bed Mobility				
Laundry				
Room Care (Beds, Floors, Dusting, etc.)				
Booking Appointments/Transportation				
Medication Management				
Shopping				

Other Assistance Requested: \_\_\_\_\_

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GOVERNING POLICIES

Please be advised that there is a three month probationary period with a possible extension of one month. During the probationary period, one month's notice is required for either part to terminate occupancy.

Management has the right to dismiss any resident in crises situations such as the endangerment of others, illegal activities, and the disrespect for property.

There is a review process for residents who are experiencing difficulty in meeting medical, cognitive, and/or social expectations.

GOVERNING DOCUMENTS

I have reviewed the following governing documents and I am prepared to adhere to the expectations:

Mission Statement: Yes \_\_\_ No \_\_\_ Comments: \_\_\_\_\_

Residency Expectations: Yes \_\_\_ No \_\_\_ Comments: \_\_\_\_\_

PERSONAL EXPECTATIONS

What do I expect of Cheshire Homes? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I expect Cheshire Homes will provide me with Residency (with attendant services): \_\_\_\_\_

What can you offer Cheshire Homes? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I have completed this application to the best of my knowledge.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

## SOCIAL HISTORY FORM

This form is to be completed by an allied professional who knows the applicant personally (for example a social worker, counsellor, doctor, elder, etc.). Upon completion, please forward to The Residency Task Group, 2901 Louise Street, Saskatoon, SK, Canada S7J 3L1.

Applicant \_\_\_\_\_

Date Completed \_\_\_\_\_

Person Completing this Form \_\_\_\_\_

Name \_\_\_\_\_

Telephone Number \_\_\_\_\_

I have known \_\_\_\_\_ for \_\_\_\_\_ years in the capacity of \_\_\_\_\_  
(indicate professional or personal association.)

1. Please explain the nature and extent of the applicant's relationships (for example family situations, social networks, etc.)

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2. How has the applicant adjusted to having a disability?

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3. Are there any mental health or behavioural issues? If so, please explain.

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4. Briefly highlight past interests, activities, programs, living arrangements, and any other pertinent information.

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5. Briefly highlight current interests, activities, programs, living arrangements, and any other pertinent information.

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6. How do you think the applicant will adjust to living in a cooperative living environment? Have they ever lived in a group setting? Do you perceive any issues arising? If so, what could they be?

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7. In your opinion, does the applicant have the skills required to meet the residency expectations?

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## MEDICAL REPORT FORM

This form is to be completed by the examining physician. On completion, please forward to The Residency Task Group, 2901 Louise Street, Saskatoon, SK, Canada S7J 3L1 or fax to (306) 374-6191.

Please Print

Name of Applicant \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

Date of Birth \_\_\_\_\_

Sex \_\_\_\_\_

Height and Weight \_\_\_\_\_

Blood Pressure \_\_\_\_\_

Date Last Examined \_\_\_\_\_

How long has this Person been Under Your Care? \_\_\_\_\_

Examining Physician Name \_\_\_\_\_

Medical Address \_\_\_\_\_

Telephone \_\_\_\_\_

Facsimile \_\_\_\_\_

Medical Diagnosis \_\_\_\_\_

\_\_\_\_\_

Medical History (Nature of Disability or, if applicable, details of accident) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physical Status \_\_\_\_\_

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Psychological History \_\_\_\_\_

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Surgical Procedures \_\_\_\_\_

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Mental Status/Behavioural Issues \_\_\_\_\_

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Medications with Presenting Problems \_\_\_\_\_

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Special Challenges/Needs (Allergies, Drug intolerance, Dietary, etc.) \_\_\_\_\_

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Any History of Addiction Issues \_\_\_\_\_

Any Communicable Diseases \_\_\_\_\_

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Any Vision Problems \_\_\_\_\_

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Any Hearing Problems \_\_\_\_\_

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Any Seizure Activity \_\_\_\_\_

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Any Skin Integrity \_\_\_\_\_

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Allergies \_\_\_\_\_

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Heart Conditions \_\_\_\_\_

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Diabetes \_\_\_\_\_

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Signature

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Date

## CONSENT FOR RELEASE OF INFORMATION

I, \_\_\_\_\_ of \_\_\_\_\_  
authorize Cheshire Homes of Saskatoon to release relevant information from my personal file to  
its governance committee, staff, and to external professionals including Community Resources  
and Employment, Community Living Division Social Worker, if applicable, involved in  
assessing, planning, and/or service provision.

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## WAIVER OF RESPONSIBILITY

The information disclosed in the application and interview process for residency at Cheshire Homes of Saskatoon is current and accurate. I understand that this information is the basis for deciding what supports and services are to be provided by Cheshire Homes at the time of occupancy. I understand that it is my ongoing responsibility to inform Cheshire Homes of any changes in supports and services that are required.

I will not hold Cheshire Homes of Saskatoon responsible for any event or circumstance which arises from lack of disclosure of relevant information deemed essential to meeting my personal care needs.

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Applicant

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Witness

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Date