

## ASSISTED LIVING ACCESS TOOL

<b>Name:</b>	<b>PARIS ID:</b>
<b>DOB:</b>	<b>Age:</b>
<b>Gender:</b>	<b>PHN:</b>
<b>Home Address:</b>	<b>Phone:</b>

**Assessment Start Date:**

**Assessment End Date:**

**Carried Out By:**

### Client Agreement

Client is aware of service and is in agreement to receive

Date of Agreement:

**OR**

Client is aware of service and is not in agreement to receive

Date of Discussion:

Comments:

### Assisted Living Admission Criteria

Assisted Living Admission Criteria from the MOH Assisted Living Eligibility Policy

**Client must meet ALL the following criteria**

1. Is eligible for continuing care services (meets criteria outlined in policy 2.A)

2. Requires BOTH personal care services and hospitality services

3. Is able to direct his or her own care

4. Is at significant risk in their current living environment

5. Client understands and has verbally agreed to the terms of a residency agreement

**Yes**

☐
☐
☐
☐
☐

### Current Service Utilization

Home support hours per month Total:

☐ ADL support

☐ IADL support

☐ Respite

Hrs of private pay services:

Respite used in the last year Facility days:

Adult Day Centre

Days per week:

Currently in ☐ Residential Care

☐ Group Home

☐ Other

### Cognitive Functioning

CPS Score:

CPS Score: Date Done:

MMSE Score: /

MMSE Score: Date Done:

MMSE Type:

MMSE Comments:

### Preferred Waitlist Location

**Date**

**Recorded**

**Program**

**Location**

**End Date**

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## Section A. Service needs meet tenant selection criteria in policy

### A.1 Requires Personal Care Services

Scoring:

Set-up, supervision or limited assistance = 1 Point

Extensive assistance = 2 Points

Maximal assistance or total dependence = 3 Points

Points

1.1 Toilet use	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
1.2 Personal hygiene	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
1.3 Bathing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
1.4 Dressing lower body	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
1.5 Locomotion outside of home	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
1.6 Transfer	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
1.7 Eating - (set-up only)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
Managing medications:	<input type="checkbox"/> 1		<input type="checkbox"/> 3
Some help = 1 Full help or by others = 3			

**TOTAL this sub-section - 2 points minimum needed:**

### A.2 Requires hospitality services

Difficulty Scale:

Some difficulty = 1 Point

Great difficulty = 2 Points

1.1 Meal Preparation	<input type="checkbox"/> 1	<input type="checkbox"/> 2
1.2 Ordinary Housework	<input type="checkbox"/> 1	<input type="checkbox"/> 2
1.3 Transportation	<input type="checkbox"/> 1	<input type="checkbox"/> 2

**TOTAL this sub-section - 3 points minimum needed:**

### A.3 Utilization of resources

1.1 Current overall combination of formal & informal services and resources available are not sufficient to meet client needs for health care and functional support	<input type="checkbox"/> 2
1.2 Needs unscheduled access to CHW care	<input type="checkbox"/> 1
1.3 Persistent expression of anxiety regarding health (E1e = 1 or 2)	<input type="checkbox"/> 1
In last 90 days, client had 1 or more admissions to hospital with overnight stay AND/OR 1 or more emergency visits without overnight stay	<input type="checkbox"/> 1

### A.4 Additional risks/needs not addressed in home setting that indicates need for assisted

Tick score based on severity 1, 2, or 3

1.1 Specify risk/need and why AL would address it:	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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**GRAND TOTAL in Section A: Service Needs:**

## Section B. Other Significant risks in current living environment

### B.1 Socialization

1.1 Isolation (F3a): alone long periods of time OR all the time	<input type="checkbox"/> 1
1.2 Client indicates feeling lonely (F3b)	<input type="checkbox"/> 1
1.3 Depression rating scale of 3+ or diagnosis of depression	<input type="checkbox"/> 1

### B.2 Nutrition

1.1 Pattern of eating one or fewer meals a day in last 30 days (L2a)	<input type="checkbox"/> 2
1.2 Unintended weight loss - due to physical, cognitive or social factors (L1a)	<input type="checkbox"/> 2

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## Section B. Other Significant risks in current living environment (continued)

### B.3 Physical Frailty

- |   |                          |   |
|---|--------------------------|---|
| 1.1 Stamina: client went out of the house in last 30 days - 1 day a week or no days | <input type="checkbox"/> | 1 |
| 1.2 Stair climbing: last 3 days client could not go up & down stairs                | <input type="checkbox"/> | 1 |
| 1.3 Has conditions or diseases that are unstable (K8b) (mental or physical)         | <input type="checkbox"/> | 1 |
| 1.4 Danger of fall: Unsteady gait (K6a)   | <input type="checkbox"/> | 1 |
| Client limits going outdoors due to fear of falling score 1                         | <input type="checkbox"/> | 1 |

### B.4 Limited Ability to Pay

Before Taxes: 1 person \$19,795; 2 persons: \$24,745

After Taxes: 1 person: \$16,348; 2 persons: \$19,948

- |                                    |                          |   |
|------------------------------------|--------------------------|---|
| 1.1 At or below low income cut-off | <input type="checkbox"/> | 1 |
|------------------------------------|--------------------------|---|

### B.5 Living Situation and Informal Support

- |   |                          |   |
|---|--------------------------|---|
| 1.1 Lives alone now   | <input type="checkbox"/> | 1 |
| 1.2 No primary or secondary caregiver                                     | <input type="checkbox"/> | 3 |
| 1.3 Caregiver is unable to continue in activities                         | <input type="checkbox"/> | 2 |
| 1.4 Primary caregiver expresses feelings of distress, anger or depression | <input type="checkbox"/> | 1 |

### B.6 Hazards in Living Environment

**Maximum score** in this section is 2 points

Tick any of the following that make the home environment hazardous or uninhabitable

- |   |                          |   |
|---|--------------------------|---|
| Bathroom and toilet room (e.g. non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet) | <input type="checkbox"/> | 1 |
| Kitchen (e.g. dangerous stove, inoperative refrigerator, infestation by rats or bugs)   | <input type="checkbox"/> | 1 |
| Heating and cooking (e.g. too hot in summer, too cold in winter)  | <input type="checkbox"/> | 1 |
| Personal safety (e.g. fear of violence, safety problem in going to mailbox or visiting neighbors)                             | <input type="checkbox"/> | 1 |
| Access to home (e.g. difficulty entering/leaving home)  | <input type="checkbox"/> | 1 |

**TOTAL** this sub-section - **Maximum 2 points:**

**GRAND TOTAL** Section B1 to B6: Other risks:

**TOTAL Client Score from Sections A and B:**

## Section C. Review appropriateness based on MOHS criteria for tenant selection

**Instructions:** If client score falls in the right-hand column on any question (from C1 1.1-1.2 to C2 1.1-1.8), this service is **NOT** appropriate. Consider other options.

### C.1 Client is able to communicate effectively to direct own care

- |   |                              |                              |
|---|------------------------------|------------------------------|
| 1.1 Making self-understood (expressing of information content however able) |                              |                              |
| Understood OR usually understood OR often understood                        | <input type="checkbox"/> Yes |                              |
| Sometimes understood OR rarely, never understood                            |                              | <input type="checkbox"/> Yes |
| 1.2 Ability to understand others  |                              |                              |
| Understands OR usually understands OR often understands                     | <input type="checkbox"/> Yes |                              |
| Sometimes understands OR rarely, never understands                          |                              | <input type="checkbox"/> Yes |

### C.2 Client exhibits behaviour that jeopardize own or other tenant's safety

In the last 90 days

- |   |                             |                              |
|---|-----------------------------|------------------------------|
| 1.1 Verbally abusive (threatened, screamed at, cursed at others):<br>not easily altered   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 1.2 Physically abusive (hit, shoved, scratched, sexually abused others):<br>easily or not easily altered                                      | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 1.3 Socially inappropriate (noisiness, screaming, sexual behaviour or<br>disrobing in public, causes disruption) easily or not easily altered | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 1.4 Expression of what appears to be unrealistic fears & constant calls<br>for help? Not easily altered                                       | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

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## Section C. Review appropriateness based on MOHS criteria for tenant selection (continued)

- |   |                             |                              |
|---|-----------------------------|------------------------------|
| 1.5 Wandering: Easily or not easily altered   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 1.6 Resists care: Not easily altered  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 1.7 Substance use: Client was told by others to cut down or others were concerned with client's use (issue is also whether use causes any of the above) (K7a) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 1.8 Other behaviour of concern, specify:  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Also review full history prior to 90 days and specify below where to find notes/comments on frequency and circumstances of any relevant events to support placement in an appropriate building:

### C.3) Client needs 24 hour professional care OR CHW service needs are beyond what can be provided in assisted living

**Instructions:** If client score falls in the right-hand column on any question (from C3 1.1-1.3 to C4 1.1-1.3), this service **MAY NOT** be appropriate - review AL policies and regulations to determine if some sites could accommodate the client. Flag issues for access team in comment section and/or on application form.

- |   |                             |                              |
|---|-----------------------------|------------------------------|
| 1.1 Ongoing professional procedures done in home (P2 j, m, o, p, v, w), e.g., Medication or other regime is unable to be safely/accurately administered or monitored under the Personal Assistance Guidelines (PAG) for transfer of function. Yes, if daily for recurring periods, check history. | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 1.2 Two person transfer required (must review lift accessibility)   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 1.3 Eating assistance required at maximal assistance or higher level  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
- \* Yes, if daily for recurring periods, check history
- Comment on specific AL site characteristics needed for this client:

### C.4 Client is capable of directing own care & will be safe in this setting in an emergency

- |  |  |  |
|--|--|--|
| 1.1 Procedural memory OK (can perform all or almost all steps in a multitask sequence without cues for initiation, e.g., respond to fire bell) | <input type="checkbox"/> Yes                               | <input type="checkbox"/> No                                    |
| 1.2 How well client made decisions about organizing the day - tick answer for one of the four choices at client's level of impairment          |  |  |
| Independent (decisions consistent reasonable and safe)   | <input type="checkbox"/> Yes                               |  |
| Modified independence (some difficulty in new situations only)   | <input type="checkbox"/> Yes                               |  |
| Minimally impaired (In specific situations, decisions become poor or unsafe and cues/supervision necessary)                                    | <input type="checkbox"/> Yes<br>(Yes, and will live alone) | <input type="checkbox"/> Yes<br>(Yes, but will not live alone) |
| Moderately or severely impaired  |  | <input type="checkbox"/> Yes                                   |
| 1.3 CPS scale of 0, 1 or 2; OR MMSE of 19 or above   | <input type="checkbox"/> Yes                               | <input type="checkbox"/> No                                    |
- Comment on any specific AL site characteristics required for this client:

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### Primary Caregiver Burden

*Please note: the Zarit Caregiver-Zarit Burden assessment must be done before this section can be completed.*  
*Extent of informal help by primary caregiver (related to G3 a, b)*

**Score**

If sum of hours across last 7 days is over 55 hours = 2 points

If sum of hours across last 7 nights is over 4 hours = 2 points

Needs frequent unscheduled access to caregiver = 3 points

ZARIT Screener Score. Total score is between 2 and 7 = 1 point or

Total score is 8 or higher = 2 points

Total

### Additional Information for PAT Consideration

*The following information may be utilized by the Priority Access Team when considering applications for assisted living. Please note that the wait times for Assisted Living units may be long. Alternate interim strategies for supporting the client in the community should be developed.*

*Instructions: Please put a check mark beside any of the factors that are of special consideration for this client*

☐ Currently living in unsafe housing environment

☐ Currently living in temporary housing (hotel/motel/emergency shelter/other not including family member)

☐ Currently living with family/friends but needing to move

☐ Need to relocate due to abuse or neglect by other(s) in current environment

☐ Health affected by current housing (documented by medical practitioner, must be a valid medical condition that will be improved by adequate housing)

☐ Need to relocate due to persistent self neglect (that could be addressed in AL setting)

☐ Other (please specify)

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### Additional Information for PAT Consideration (continued)

Interim plan: Since client is affected by the above factor(s) describe below the interim plan for maintaining client at home or in the community.

### Casenotes

Note: Once downtime information from this form has been entered in PARIS, shred this working sheet.

----- End of Report -----