Saskatchewan Health

INSTITUTIONAL SUPPORTIVE CARE ADMISSION

Please Print

Type of Admission
- ☐ Long Term Care
- ☐ Adult Day Program
- ☐ Temporary Care
- ☐ Night Care

Health Services Number	Name (Surname, Given, Initial)	Date of Birth Year / Month / Day	☐ Male ☐ Female

Name of Facility	Location of Facility	Facility Number

Non-Saskatchewan Resident Name Province/State

Social Insurance (SIN) Number

Are you a Veteran? ☐ Yes

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Common-law
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

Admission Date or Hospital Paying Date — Year: 20 / Month / Day

Current Level of Care (Long Term Care and Temporary Care only):
- Level 1 ☐ Supervisory Care
- Level 2 ☐ Limited Personal Care
- Level 3 ☐ Intensive Personal/Nursing Care

Specify The Classification of Level 4 Care:
- Level 4a ☐ (Specialized Supervisory Care)
- Level 4b ☐ (Supportive Care)
- Level 4c ☐ (Restorative Care)
- Level 5 ☐ Rehabilitation

Purpose of Temporary Care Admission: (Choose One)
- ☐ Respite Care
- ☐ Convalescence
- ☐ Assessment
- ☐ Rehabilitation
- ☐ Palliative: Early/Intermediate
- ☐ Palliative: End Stage
- ☐ Palliative: Acute Care Management

If applicable:
☐ **Transfer from another facility** ☐ **Waiting LTC Placement**

Type of Residence Prior to Admission: (Place normally resided)
- ☐ House (single family detached)
- ☐ Apartment (Self-contained, including attached housing)
  - -Senior citizens' housing/Public Housing ☐ Yes ☐ **No**
  - -Assisted living/Enriched Housing ☐ Yes ☐ **No**
- ☐ Special-care home or Level 2, 3, or 4 care in hospital/health centre
- ☐ Personal care home
- ☐ Other care home (group, approved etc.)
- ☐ Boarding house/rooming house/hotel
- ☐ Rehab facility

Living Arrangements Prior to Admission: (Must correspond with Type of Residence above)
☐ Lived alone ☐ With spouse only ☐ With spouse and other(s) ☐ With other family member(s) ☐ With others

Services Received Prior to Admission: (Check only those services received within previous month)
- ☐ Home Care
- ☐ Hospital - Outpatient
- ☐ Hospital - Inpatient
- ☐ Hospital - Emergency
- ☐ Night care
- ☐ Adult Day Program
- ☐ Temporary care (respite, convalescence, etc.)
- ☐ Long Term care
- ☐ Mental health
- ☐ Addictions counselling
- ☐ Rehab/therapy

Main Factor Contributing to Admission: (Choose One)
- ☐ Accident or illness of resident
- ☐ Gradual loss of functional abilities
- ☐ Death or serious illness of resident's spouse/supporter
- ☐ Breakdown in support previously provided by another supporter
- ☐ Needs inappropriate for another facility
- ☐ Relief for supporter in community
- ☐ Lack of social contact

If Married or Common-law, please complete:

Spouse's Name _____

Health Services Number _____ Date of Birth — Year: 19 / Month / Day

Social Insurance (SIN) Number _____

Income Information Required (Long Term Care Only):

Submit a completed CRA Consent Form (Side A) **or** Annual Consent Form (Side B) and a photocopy of the most recent year's Notice of Assessment(s) from Canada Revenue Agency (CRA) for **you and your spouse** (if applicable).

Answer the following questions only if applicable:

1. Are you financially responsible for dependants under age 18; or 18 years of age or older and in full time attendance at an educational institution; or a dependent adult as defined in The Dependent Adults Act? ☐ Yes Number of dependants _____
2. Is the full cost of your care paid for by a Third Party Agency? ☐ Yes Specify Agency _____

I declare that all the information I have provided is complete and correct in all respects and fully discloses my total income from all sources. I further consent to the use of this information by Saskatchewan Health for the purpose of determining my entitlement for other Health Care benefits or programs but will not be disclosed to any other person or organization without my approval.

_____ _____
RESIDENT'S SIGNATURE OR SPOUSE'S/SUPPORTER'S SIGNATURE **DATE**

_____ **RES:** **BUS:**
NAME OF SPOUSE/SUPPORTER (Please Print) **TELEPHONE # OF SPOUSE/SUPPORTER**

_____
ADDRESS OF SPOUSE/SUPPORTER (Please Print)

_____
AUTHORIZED OFFICIAL

Saskatchewan Health

INSTITUTIONAL SUPPORTIVE CARE DISCHARGE

Please Print

Type of Admission
- ☐ Long Term Care
- ☐ Adult Day Program
- ☐ Temporary Care
- ☐ Night Care

Health Services Number	Name (Surname, Given, Initial)	Date of Birth Year / Month / Day	☐ Male ☐ Female

Name of Facility	Location of Facility	Facility Number

Purpose of Temporary Care Admission: (Choose One)
- ☐ Respite Care
- ☐ Convalescence
- ☐ Assessment
- ☐ Rehabilitation
- ☐ Palliative: Early/Intermediate
- ☐ Palliative: End Stage
- ☐ Palliative: Acute Care Management

Admission Date or Hospital Paying Date	**Year**	**Month**	**Day**
	20		

Reason for Discharge (select one only)
- ☐ Functional improvement or recovery
- ☐ Care provider in community able and willing to support resident/client
- ☐ Resident request for transfer
- ☐ Transfer for other reasons
- ☐ Moved out of area/province
- ☐ Permanent Placement
- ☐ Care needs changed
- ☐ Deceased

Date of Discharge 20 ____ ____ (YY/MM/DD)

Alternative Arrangements (leave blank if person deceased)
- ☐ Level 5 or Level 6 stay in hospital
- ☐ Level 2, 3, or 4 in Special-care home/hospital/health centre
- ☐ Other care home (personal care, group, approved, etc.)
- ☐ Communitycare (Home care, Adult Day Program, etc.)
- ☐ Self/family care