TSI ION KWA NONH SO: TE
"OUR HOME"

APPLICATION FOR ADMISSION

MOHAWK COUNCIL OF AKWESASNE

70 KAWEHNOKE APARTMENTS RD.
AKWESASNE, ONTARIO K6H 5R7
TEL: 613-932-1409 FAX: 613-932-8845
WEBSITE: www.akwesasne.ca

TSI ION KWA NONH SO:TE

The attached application for admission to TSI ION KWA NONH SO:TE , Akwesasne was completed with assistance from:

□ SOCIAL WORKER NAME: _____

□ CLIENT ADVOCATE: NAME: _____

□ CLIENT REPRESENTATIVE NAME: _____

□ AGENCY, OTHER FACILITY NAME: _____

ADDRESS: _____
_____
_____

CONTACT # Home: _____Work:_____
Cell: _____Other:_____

REASON(S) WHY ASSISTANCE WAS NECESSARY:

Immediate family n/a	_____	Limited reading skills	_____
Family requested assistance	_____	Client does not have family	_____
Language barrier	_____	Limited writing skills	_____
Speech deficit	_____	Physical limitations	_____
Client requested assistance	_____	No other representative	_____

APPLICANT'S COMPREHENSION LEVEL TO APPLICATION PROCESS.

Fully aware: _____ Partial comprehension: _____

Unable to comprehend application requirements: _____

I have assisted the client: _____, and/or family thereof in the completion of the attached application to TSIIONKWANONHSO: TE. I have answered/assisted in answering the application to the best of my knowledge.

Social Worker/Client Advocate: Signature: _____

Date: _____

PERSONAL DATA

THIS INFORMATION IS STRICTLY CONFIDENTIAL.

Applicant Name: (Mr., Mrs., Ms.) _____

Current Residence: _____

Mailing Address if different from above: _____

_____

Marital Status: ☐Married ☐Widow(er) ☐Divorced ☐Single ☐Separated ☐Common-law

Band Name & Membership #:_____ D.O.B.:_____
M/D/Y

Social Insurance #: _____-_____-_____
Social Security #: _____-_____-_____

HEALTH COVERAGE & ID NUMBERS: _____
OHIP/QHIP/ OTHER

_____
ADDITIONAL HEALTH INSURANCE POLICY AND/OR ID#

REASON FOR APPLICATION:

_____

_____

_____

APPLICANT'S CHILDREN:

	NAME	ADDRESS	PHONE (HOME & WORK)	LIVING/DECEASED
1.				
2.				
3.				
4.				

PEERSONAL DATA CONT'D:

- **Please note: If any needed information is currently being processed, please enter "PENDING" and the date applied.**

Does applicant have a guardian? ☐ YES ☐ NO
If yes, please state name, address and telephone number:

_____
_____
_____

Is there a Power of Attorney established? ☐ YES ☐ NO
If yes, please state name, relationship, address and telephone number:

_____
_____
_____

Please provide a copy of the Power of Attorney for applicants' property/finances and/or care.
Please state who will be directly responsible for care decisions while resident of TSI ION KWA NONH SO:TE, if other than applicant. **Please note that this is the person who will be contacted by the home for any care matters.**

Please state who will be directly responsible for maintenance bill and/or other financial obligations for residency at TSI ION KWA NONH SO: TE, if other than applicant**. Please note that this is the person who will be contacted by the home for financial matters.**

Name: _____ Telephone # _____

Mailing Address: _____

_____

_____

E-mail: _____

Telephone: _____

MEDICAL RECORDS RELEASE

I, _____, hereby consent to the release of all my
Applicant Name

medical records from: _____

_____

_____
(Name/Address/of Physician/Clinic/Hospital /Other Facility)

From the period of: _____ to _____

Records to be sent to: ☐ DR. OJISTOH HORN ☐ DR. HANNA COOKSON

TSI ION KWA NONH SO: TE
70 KAWEHNOKE APARTMENT'S RD.
AKWESASNE, ONTARIO
K6H 5R7

Applicant Signature: _____ Date: _____

Signature: _____ Date: _____
Guardian/Trustee/ Power of Attorney (if indicated)

Administrative Witness: _____ Date: _____

This form is to be completed by applicant, and/or applicant's Guardian, Trustee, or Power of Attorney.

FINANCIAL DISCLOSURE STATEMENT

Please list **ALL** sources of income. Verification is required. Failure to fully describe income may delay processing of this application.

INCOME TYPE	MONTHLY CHEQUE AMOUNT	JOINT/ SINGLE	ADMINISTRATION VERIFICATION (FOR OFFICE USE)	ACCOMODATION	
				ROOM RATE	PREFERENCE B/SP/P
OLD AGE SECURITY	$				
PROVINCIAL SUPPLEMENT	$			**NOTES:**	
VETERAN'S	$				
RETIREMENT	$				
OTHER: Specify	$				
OTHER: Specify	$				
TOTAL	$				

All the above information is true to the best of my knowledge. I understand that any change to any income source at any time must be reported and may affect the amount of monthly co-payment at Tsiionkwanonhso:te. **I UNDERSTAND AND AGREE TO AN ANNUAL INCOME VERIFICATION AND WILL PROVIDE ALL DOCUMENTATION AS REQUIRED.**

_____ _____

Applicant Signature Date: (dd/mm/yyyy)

_____ _____

Power of Attorney – Holder Signature Date: (dd/mm/yyyy)

_____ _____

Guardian Signature – If Different Date: (dd/mm/yyyy)

CONSENT TO VERIFY INCOME OF APPLICANT/RESIDENT

I, _____
(Signature of applicant or person holding Power of Attorney)

Authorize the Administrator of TSI ION KWA NONH SO: TE and/or authorized representative

_____ to inspect all income pertaining to the applicant
(Specify}

_____, in order to determine on-going co-payment rate for
(Signature of Applicant)

continued occupancy at TSI ION KWA NONH SO: TE. For the purposes of this document, income shall mean:

a) Any or all Canadian Governmental Benefit(s) including Old Age Security Pension, Veteran's Pension, Blind Person's Allowance, Disabled Person's Allowance, Social Aid Benefit, Social Assistance Income and/or all other income.

b) Any or all U.S. Government Governmental Benefit(s) including U.S. Social Security,Veteran Pension and/or private pensions.

c) Any or all other income from private company pension(s)/disability plan(s).

Where, in the opinion of the Administrator, the applicant has insufficient funds to meet the financial obligation for residency at TSI ION KWA NONH SO: TE, the Administrator shall:

1) Request that the applicant or person holding Power of Attorney pursue all avenues to upgrade/increase the financial means of the applicant through investigating and making application to government and non-government agencies for the purpose of increasing/supplementing income benefit amounts.

2) The applicant or person holding Power of Attorney shall consent to the investigation by the Administrator as to amounts of income and may make inquiries to such agencies on the applicant/resident(s) behalf.

3) The Administrator will delay processing an application for admission on the basis of "incomplete information."

I, _____, agree to give consent as outlined in this consent form.
(Applicant of person holding Power of Attorney)

_____ DATE: _____
(Signature of Applicant or person holding Power of Attorney) (dd/mm/yyyy)

_____ DATE: _____
WITNESS: (TSI ION KWA NONH SO: TE) (dd/mm/yyyy)

CONSENT FOR TSI ION KWA NONH SO:TE TO COLLECT, KEEP ON FILE, AND RELEASE INFORMATION

I, _____, on behalf of _____, am
(Given Name Surname) (applicant name)
applying for eligibility determination for admission to **TSI ION KWA NONH SO:TE** and request that **TSI ION KWA NONH SO:TE** and its authorized agents to collect all personal and medical information necessary to determine eligibility for admission to the facility, arrange for assessment, maintain this information on file and subsequently release information to affiliated programs/services and government agencies for which services are accessed by the resident. In the event a physical transfer occurs between the facilities of Tsiionkwanonhso:te and Iak hih soh tha, I hereby give consent to gather, collect, and/or exchange information from one entity to the other as necessary for admission. I acknowledge that I have been informed regarding the reasons why this information is needed and I understand them. In the event I choose to seek admission to facilities or services other than **TSI ION KWA NONH SO:TE**, I give consent to release information on file those facilities/services which I identify. This consent is valid while a resident of **TSI ION KWA NONH SO:TE**, and may be withdrawn at any time by giving the facility a written notice of withdrawal.

_____ _____
(Signature) (Date: dd/mm/yyyy)

Relationship to Applicant: _____

Indicate whether or not information may be shared with family members: ☐ YES ☐ NO

Is the person signing this consent the applicant? ☐ YES ☐ NO

OR

Is the person signing this consent the lawfully authorized substitute? ☐ YES ☐ NO