

Joint Resident Admission and Transfer Application Form



TSIIIONKWANONHSO:TE
“OUR HOME”
and
IAKHIHSONHTHA LODGE
“OUR GRANDPARENTS”

APPLICATION FOR ADMISSION

MOHAWK COUNCIL
OF AKWESASNE

Iakhihsohtha Lodge
95 Snye School Road
Akwesasne, Quebec
H0M 1A1

Tsiionkwanonhso:te
70 Kawehnoke Apartment Road
Akwesasne, Ontario
K6H 5R7

TEL: 613-575-2507
FAX: 613-575-1267

TEL: 613-932-1409
FAX: 613-932-8845

WEBSITE: www.akwesasne.ca

TSIIION KWA NONH SO:TE

IAKHIHSONHTHA LODGE

TRANSFER

The attached application for admission and or transfer to TSI ION KWA NONH SO:TE and or IAKHIHSOHTHA LODGE, 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 AND OR IAKHIHSOHTHA LODGE. I have answered/assisted in answering the application truthfully to the best of my knowledge.

Social Worker/Client Advocate:

Signature: _____

Date: _____

PERSONAL DATA

THIS INFORMATION IS STRICTLY CONFIDENTIAL
(Provide copies of Status Card, SS or SIN, Birth Certificate if applicable)

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.	_____	_____	_____	_____

Please provide the Residents Parents Names and DOB:
Mother (Maiden Name): _____ Fathers Name: _____

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 residing at

TSI ION KWA NONH SO:TE and or IAKHIHSOHTHA LODGE, 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 and or IAKHIHSOHTHA LODGE, 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: _____

Bank Name: _____

Bank Address: _____

The resident and/or representative is responsible for timely and complete payments for all expenses incurred at the Home. A 1.2% interest rate per month will be applied on unpaid accounts. Please be advised that all rate subsidy applications are the responsibility of the resident and or of his/her representative.

MEDICAL RECORDS RELEASE

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

medical records from: _____

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

From the period of: _____ to _____

Records to be sent to:

For applicants of TSI ION KWA NONH SO: TE

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

and/or

For applicants of IAKHIHSOHTHA LODGE

DR. EVE MAILHOT-DAYE
IAKHIHSOHTHA LODGE
95 SNYE SCHOOL ROAD
AKWESASNE, QUEBEC
H0M 1A1

Signature of applicant: _____

Date: _____

Signature: _____

Guardian/Trustee/ Power of Attorney (if indicated)

Date: _____

Administrative Witness: _____

Date: _____

This section is to be completed by applicant, and/or applicant’s Guardian, Trustee, Power of Attorney, Family Member or Recognized Resident Representative.

FINANCIAL DISCLOSURE STATEMENT

Please list **ALL** sources of income including US Income(s). Verification is required. Failure to fully describe income will render this application incomplete.

INCOME TYPE	MONTHLY CHEQUE AMOUNT	JOINT/ SINGLE	ADMINISTRATION VERIFICATION (FOR OFFICE USE)	ACCOMODATION	
				ROOM RATE	PREFERENCE B/SP/P
OLD AGE SECURITY Canadian / American	\$				
PROVINCIAL SUPPLEMENT	\$			NOTES:	
VETERAN’S Canadian / American	\$				
RETIREMENT PENSIONS	\$				
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 immediately and may affect the amount of monthly co-payment at Tsiionkwanonhso:te and or Iakhihsohtha Lodge. **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 IAKHIHSOHTHA LODGE and/or authorized representative

_____ to inspect all income pertaining to the applicant
(Specify)
_____, in order to determine ongoing co-payment rate for
(Signature of Applicant)

continued occupancy at TSIIONKWANONH SO:TE and or IAKHIHSOHTHA LODGE.

For the purposes of this document, income shall mean: 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.

1. Any or all U.S. Government Governmental Benefit(s) including U.S. Social Security, Veteran Pension and/or private pensions.
2. 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 _____, 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) Processing an application for admission based on “incomplete information.”, may be delayed or refused.

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

(Signature of Applicant or person holding Power of Attorney)

DATE: _____
(dd/mm/yyyy)

WITNESS: (TSI ION KWA NONH SO:TE/IAKHIHSOHTHA LODGE)

DATE: _____
(dd/mm/yyyy)

CONSENT FOR TSI ION KWA NONH SO:TE AND OR IAKHIHSOHTHA LODGE 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 OR IAKHIHSOHTHA LODGE** request that **TSI ION KWA NONH SO:TE AND OR IAKHIHSOHTHA LODGE** 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 or **IAKHIHSOHTHA LODGE**, 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 **TSIIONKWANONHSO:TE AND OR IAKHIHSOHTHA LODGE**, I give consent to release information on file those facilities/services which I identify. This consent is valid while a resident of **TSIIONKWANONHSO:TE AND OR IAKHIHSOHTHA LODGE**, 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