CADENCE
RESIDENCE

APPLICATION

500-12th Ave. N. | 500-12e ave. N.
Cochrane, On, P0L 1C0
T: (705) 272-2720

CADENCE
RESIDENCE

If you wish to become a resident, complete the following:

1. Fill out the 2-page application form

Your completed application form can be brought to or mailed to:

Cadence Residence
P.O. Box 135
500-12th Avenue North
Cochrane, On, P0L 1C0

CADENCE
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APPLICANT:

LAST NAME:		FIRST NAME:
DOB:		
STREET ADDRESS:	APT:	TOWN:
MAILING ADDRESS (IF DIFFERENT FROM ABOVE):		
PROVINCE:	POSTAL CODE:	HOME PHONE:
CELL PHONE:		EMAIL:
ARE YOU A: CANADIAN CITIZEN ☐ LANDED IMMIGRANT ☐ REFUGEE/APPLICANT ☐ STATUS INDIAN/METIS ☐		PRESENT MARITAL STATUS: MARRIED ☐ SINGLE ☐ WIDOWED ☐

CO-APPLICANT:

LAST NAME:		FIRST NAME:
DOB:		
STREET ADDRESS:	APT:	TOWN:
MAILING ADDRESS (IF DIFFERENT FROM ABOVE):		
PROVINCE:	POSTAL CODE:	HOME PHONE:
CELL PHONE:		EMAIL:
		PRESENT MARITAL STATUS: MARRIED ☐ SINGLE ☐ WIDOWED ☐

ALTERNATE CONTACT NAME: _____ PHONE: _____

DO YOU WISH US TO CONTACT THIS PERSON SHOULD A SUITE BECOME AVAILABLE? YES ☐ NO ☐

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SUITE SELECTION:

Mini Suite 335 sq.ft. Single Occupancy $1,480/mth	☐		
Bachelor 432 sq.ft. Single Occupancy $1,903/mth	☐		
One Bedroom 520 sq.ft. Single Occupancy $2,296/mth	☐	Double Occupancy $3,096/mth	☐
Two Bedroom 726 sq.ft. Single Occupancy $2,698/mth	☐	Double Occupancy $3,534/mth	☐

PARKING SPACE:

Do you own a vehicle? Yes ☐ No ☐ How many parking spaces do you require? 1 ☐ 2 ☐

SCOOTER:

Do you own & operate an electric scooter or electric power chair? Yes ☐ No ☐

PHYSICIAN INFORMATION:

Applicant's Physician Name, Address & Phone Number:

Co-Applicant's Physician Name, Address & Phone Number:

APPLICANT'S MEDICAL ASSESSMENT:

Have you attached your current medical assessment? Physical/Mental Health: _____

Co-Applicant's Physician Name, Address & Phone Number (joint applicants are to be assessed seperately):
Have you attached your current medical assessment? Physical/Mental Health: _____
(See attached Resident Health Criteria and instructions for physician assessment)

Declaration
- I (we) declare that the information submitted on this form and in the medical assessment form is correct and authorize the District of Cochrane Social Services Administration Board to verify any or all of the information herein.
- Share the information given by me to the District of Cochrane Social Services Administration Board, with any Social Agency providing any form of service to me or to any provider associated with the District of Cochrane Social Services Administration Board.
- Information will not be disclosed to any other part, except in accordance with provisions of the FIPPA, MFIPPA, PHIPA, PIPEDA.
- For the purposes of PHIPA, I give consent for the collection of health information to the District of Cochrane Social Services Administration Board for the purposes of assessing eligibility.
- I (we) consent to the sharing of my (our) medical assessment information with the District of Cochrane Social Services Administration Board for the purpose of determining if the applicant (s) meet the initial and on-going health criteria.
- I (we) consent for this information to be made available to any third part as deemed necessary for my ongoing assessment.

Applicant Signature: _____ Date: _____

Co-Applicant Signature: _____ Date: _____

Please return completed application form by mail to: CDSSAB, 500 12th Ave North Cochrane ON, P0L 1C0
or by dropping it off at Cadence Residence.

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MEDICAL ASSESSMENT

CONTACT INFORMATION:
Cochrane District Social Services Administration Board
500 12th Avenue North Cochrane, ON
Phone: (705) 272-2720

DEAR DOCTOR:

Your patient is bringing this form to you for your completion as part of the application process to Cadence Residence. An information sheet is attached to help you determine the suitability of your patient for admission.

PATIENT PERSONAL INFORMATION:

Name: _____ DOB: _____

DIAGNOSIS & DATE OF ONSET: _____

Is patient aware of diagnosis: Yes ☐ No ☐

BRIEF HEALTH HISTORY:

History of VRE Yes ☐ Date: ☐ No ☐

History of MRSA Yes ☐ Date: ☐ No ☐

Date of last chest X-Ray: _____ Results: _____

Date of last TB skin test: _____ Results: _____

Date of latest flu vaccine: _____ Date of Pneumonia vaccine: _____

Do you have your COVID-19 Vaccinations? YES ☐ NO ☐ # of Vaccinations _____

PRESENT MEDICATION LIST:

1.
2.
3.
4.
5.
6.
7.
8.

ALLERGIES/DRUG SENSITIVITIES:

PRESENT FUNCTIONAL ABILITY & CONDITION

(Please outline any ambulatory problems, cognitive problems, emotional/social concerns, difficulties carrying out activities of daily living, etc. Back of paper can be used if necessary.)

SPECIAL NEEDS:

(i.e. colostomy, oxygen, diet, etc.) Please describe fully, including treatment or intervention required.

In your opinion, does this patient's care requirement exceed the health criteria as described on the attached information page? Yes ☐ No ☐

Physician's Signature: _____ Date: _____

Physician's Name (print): _____ Office Phone #: _____

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THE INDEPENDENCE YOU DESIRE WITH THE ASSISTANCE YOU NEED

Seniors looking for independent living without the responsibilities of running a household will want to live here and enjoy independence, comfort, security and companionship. This newly constructed facility offers a variety of suites, fully serviced dining room where 3 fresh meals per day are served as per the Canada's Food Guide recommendations. Seniors in an independent/supportive environment do not require round the clock assistance. This senior living facility provides a secure residence with dietary and housekeeping staff on duty 14-16 hours a day, personal emergency response equipment, prescription medication queuing as well as weekly light housekeeping and laundering of bed linen. Social activities and physical exercises are delivered in the activity room.

RESIDENT HEALTH CRITERIA

- Ambulatory, moves about independently, would be able to evacuate self in case of an emergency;
- Assistive devices permitted, if using an assistive device must be able to transfer self from wheelchair to chair, bed or toilet independently;
- Ability to make decisions independently;
- Ability to carry out activities of daily living;
- Safe to be alone without 24 hour supervision;
- Able to eat without assistance;
- Normal cognitive function;
- Must not be incontinent of bowel or bladder functioning unless able to change self;
- Able to communicate, use phone, make emergency calls;
- Ability to set up physician appointments and visit doctor's office independently;
- Must provide recent medical assessment from physician

If the resident's health deteriorates to the point where there is a safety risk to oneself or other residents and/or substantially interferes with the reasonable enjoyment of the complex, the resident will have the following options:

- Contract or otherwise make arrangements with an external health care provider for the additional care required; or
* Give notice to terminate and make arrangements to transfer to a more appropriate facility.