SCOPE
All employees.

RATIONALE
To provide guidelines for intake and assessment to ensure an appropriate balance between the individual client's needs, strengths, eligibility, timely service delivery, available resources, and legal requirements.

POLICY
Community Care Peterborough will ensure that the intake and assessment process is timely, appropriate to the type and level of service to be provided, and is directed by the client and/or their caregiver(s).

The Coordinator or designate will respond to service inquiries and referrals within 10 business days of receipt. At that time an assessment may be completed by phone or a home visit or second phone call may be scheduled for a more in-depth assessment. The scheduling of a home visit is dictated by the nature of the service being requested or to accommodate client/caregiver preference or need.

The breadth of the intake and assessment process will be determined by the type of service being requested. To determine eligibility the Coordinator or designate will consider the individual's abilities, strengths, challenges, and capacity of their informal caregiver network. The Coordinator may also access formal assessment tools to help understand the client's needs and abilities.

PROCEDURES

1. Upon receipt of a service inquiry or referral, the local Coordinator or designate will contact the applicant or their representative, as appropriate. The initial contact will begin by determining what type of service/outcome the individual and/or their caregivers are seeking.

2. During the intake process, the Coordinator or designate will obtain general information to initiate a client file in CIMS. General information, at minimum, will include:
    a) Full legal name and preferred name;
    b) full street address and mailing address;
    c) phone number(s);
    d) birth date;
    e) emergency contact(s); and

f) any accommodations or conditions related to functional abilities.

3. If the client is registering for any of the following services only the basic intake information is required, as described in procedure two (2):
   a) Blood Pressure Clinics;
   b) Brokered Home Maintenance;
   c) Diners' Club;
   d) Exercise and Falls Prevention classes;
   e) Home at Last;
   f) Wellness and Fitness classes; and
   g) workshops, drop-in programs, etc.

4. The Coordinator or designate will take a guided conversation-based approach to assessment to record the following:
   a) Basic information including: Full legal name; preferred name; birth date; Ontario health card number; full street and mailing address; and phone number(s);
   b) Consent to keep, use, and disclose information;
   c) emergency contact details;
   d) personal health information relevant to the service in question, with an emphasis on functional abilities;
   e) information about the client's home environment including other individuals living in the home, pets, smoking, safety concerns, etc;
   f) personal preferences relevant to service delivery;
   g) consent for mailing;
   h) financial information, if relevant; and
   i) any other information pertinent to providing service.

5. The Coordinator may offer to schedule a home visit to complete the assessment. This decision to complete the assessment in the client's home versus over the telephone is based on the individual's needs, preferences, and complexity. An in-home assessment is a requirement only for clients requesting in-home Friendly Visiting.

6. For clients requesting Transportation, Meals on Wheels, or Friendly Visiting the Coordinator will complete the interRAI Preliminary Screener in accordance with CLI-1-21.

7. Once the Coordinator or designate has determined that the individual is eligible for the service(s) requested, they will review the following with the individual and/or their caregiver(s):
   a) The objectives of the specific service;
   b) the person(s) who will deliver the service;
   c) where and how the service will be delivered;
   d) the emergency response procedure, if applicable;
   e) limits of the service;
   f) any customized approaches to service delivery to address the unique needs of the client;
   g) financial costs to the client, where applicable;
   h) procedures for cancellation and termination of service; and
   i) they will indicate that a Service Plan will be provided to summarize service delivery.

8. All client/caregiver communication about assessment will be documented in the client's file with a narrative summary and by completing relevant files branches. Any rough notes written on paper during the assessment will be used to inform data entry and then destroyed.

Approved: DBelair
(Signature – Executive Director)

Date: 27 Aug. 2018

REFERENCE

CLI-1-10: Client Service Criteria
CLI-1-21: interRAI Community Health Assessment (CHA) Preliminary Screener
CLI-1-22: Client Consent
CLI-1-30: Client Service Plan