



Haven of Hope Elderly Residential Service Application Form

For Internal Use Only

TotalCare Code : _____ Case No. : _____

Client No. : _____ Name of Home : WPH/ SAS Block/ WW Block

A. Applicant's Information

Name: (Chinese) _____ (English) _____

Date of Birth : _____ Age : _____

Gender : _____ HKID : _____

Nationality : _____ Province : _____

Dialect : _____

Address : _____

Contact No.: (Residential) _____ (Mobile) _____

B. Warrantor/Sponsor & First Contact Person Information

Name : _____ (Mr/Ms/Miss) Occupation : _____

Relationship with Applicant : _____ HKID No. : _____

Address : _____

Contact No. : (Residential) _____ (Mobile) _____

Email : _____

C. 2nd Contact Person Information

Name : _____ (Mr/Ms/Miss) Occupation : _____

Relationship with Applicant : _____ HKID No. : _____

Address : _____

Contact No. : (Residential) _____ (Mobile) _____

Email : _____

D. Date of Entry (Please put a "✓" in the appropriate box)

Present Within one to two weeks Within three to four weeks

E. Type of Residential Period (Please put a "✓" in the appropriate box)

Long-term Residential

Respite Care Residential (Residential Period: From ____ / ____ / ____ to ____ / ____ / ____)

F. Type of Rooms (Please indicate your preference by marking the order in the boxes, “1” is the first choice and “2” is the second choice and so on)

Haven of Hope Woo Ping Care & Attention Home

- Single Room Twins 3 bed Room 4 bed Room

Haven of Hope Sister Annie Skau Holistic Care Centre (Sister Annie Skau Block)

- 7-8 bed Room 4 bed Room 3 bed Room Single bed Room
 Extra-large single bed Room Family Suite

Haven of Hope Sister Annie Skau Holistic Care Centre (Wah Wing Block)

- 2 bed Room 4 bed Room Single bed Room with toilet and bathroom
 Extra-large single bed Room Extra-large single bed Room with toilet and bathroom
 Family suite with toilet and bathroom

Remarks: Charges will depend on the type of room selected and the nursing care level needed of the elderly. The care level will be assessed by the staff of the home and the type of residential unit will be discussed after the assessment.

G. Source of Payment of Home Charges (Please put a “✓” in the appropriate boxes)

- Family / Relatives Pensions
 Personal Savings Personal Investment
 Old Age Allowance: Yes No Disability Allowance: Yes No
 Others (Please note)_____

H. Health and Physical Functions (Please put a “✓” in the appropriate boxes)

In order to have an initial understanding about the health situation of the elderly, please choose the appropriate boxes according to his/her present condition and the past diagnosis:

Activities: Physically-abled Walk with Equipment

Wheel chair-bound Bed-bound

Excretion: Incontinence of feces Urine incontinence

Urinary catheter Stoma site

Eating: Eat by himself/herself Fed by others

Tube-feeding

Medical Equipment: Oxygen concentrator Positive airway pressure device

Peritoneal dialysis Haemodialysis

Other points to be noted/ special care items _____

Medical Record (Please indicate the diagnosis year)

Stroke: ____ times; ____ Year High blood pressure Coronary heart disease

Dementia Diabetes: Year _____ Parkinson’s disease: Year _____

Others _____



Present Regular Consultation Details

- _____Hospital_____Specialty Private Hospital/Clinic_____Specialty
 General Out-patient Clinic Public Specialty Clinic

I. How do you learn about this service) (Please put a “✓” in the appropriate boxes)

- Used HOHCS Services Friends Poster Websites Leaflet
 Newspaper Magazine MTR Bus Tram Shelter Rehab. Van
 Referrals-HOHCS Referrals-Institutional Other (Please Specify) : _____

J. Personal Data (Privacy) Ordinance (Please put a “✓” in the appropriate boxes)

- I **agree** to be contacted by Haven of Hope Christian Service and its service unit(s) for direct marketing purposes relating to promotional activities (including introducing, informing and publicizing our service)
 I **disagree** to be contacted by Haven of Hope Christian Service and its service unit(s) for direct marketing purposes relating to promotional activities (including introducing, informing and publicizing our service)

(I understand that if this box is checked, then my name, address and other personal data will be removed from the database and circulation list of SEP and its service unit(s) in relation to such purposes.)

Notes for Applicant/ Warrantor:

- Applicant has to submit the latest medical check report and medical record for vetting purpose.
- Please fax the completed application form to the Haven of Hope - TotalCare at 2177 0951 OR mail to Room B, LG/F, Block A, Ming Wah Dai Ha, 25 A Kung Ngam Road, Shau Kei Wan, HK, OR email to tc_cs@totalcare.org.hk, Should you have any enquiries, please contact 2663 3001.
- Home/hospital visit for in-take assessment will be arranged to determine the nursing care level and the type of residential unit.
- The assessment fee should be paid before the said assessment and payment details to be informed in due course.
- Any change in the information provided such as the warrantor details should be notified to the admitted elderly home immediately.

I agree to provide the information needed regarding to my application and the necessary arrangement for resident vetting purpose. I declare all the information in this form is true. If there is any false information, the application will be cancelled.

Applicant/ Warrantor Signature: _____

Date: _____