



TERRITORIAL ADMISSIONS COMMITTEE APPLICATION COVER SHEET

ALL of the forms listed below must be completed and sent by FAX or SECURE FILE TRANSFER to the Chair of the TERRITORIAL ADMISSIONS COMMITTEE for admission to a long term care (LTC) or supportive living (SL) facility within the Northwest Territories.

REQUIRED FORMS: (Please ensure ALL forms are complete before submitting)

- Appendix B - Long Term Care/Supported Living Admission Application Form
Appendix C - Consent for Admission & Payment Form
Appendix D- Pages 1 & 2 Medical Assessment – Client Information Form
Appendix D- Page 3 - Public Health Form
Appendix E - Continuing Care Assessment Package (CCAP) Available online at: http://www.professionals.hss.gov.nt.ca/tools/forms/long-term-care

Please submit completed applications to:

ATTN: Chair of the Territorial Admission Committee
Health System Planning
Department of Health & Social Services Government of the Northwest Territories
P.O. Box 1320 Yellowknife, NT, X1A 2L9
Phone: (867) 767-9062 extension 49205
CONFIDENTIAL FAX: (867) 920-3088
SECURE FILE TRANSFER: https://sft.gov.nt.ca/ to email TAC@gov.nt.ca

Primary Care Provider / Case Manager Contact Info (please print):

Name: _____ Position: _____
Community: _____ Region: _____
Phone: (867) _____ Fax: (867) _____ Email: _____

As Case Manager for _____ (client’s name), I declare the attached forms have been completed in consultation with the applicant, and to the best of my knowledge the information is complete and correct. I agree to be the primary contact for any communication related to this client’s application for admission to Long Term Care or Supportive Living. If I am not available for any reason: job share, vacation, sick or special leave, etc., I will provide the name and contact information of the next case manager to the Chair of the TAC.

NAME OF CASE MANAGER SIGNATURE OF CASE MANAGER DATE (D/M/Y)

APPENDIX A CONTINUING CARE LEVELS OF SERVICES

Levels of Service	Description
LEVEL 1 HOME CARE/Other Community Supports	<ul style="list-style-type: none"> • A person who is independently mobile, with or without mechanical aids, requires minimal assistance with ADL / IADL. • A person who can remain in a home/community setting with minimal supports and is considered to be at a level of risk that can reasonably be considered acceptable.
LEVEL 2 HOME CARE/Other Community Supports	<ul style="list-style-type: none"> • A person who is independently mobile, with or without mechanical aids and requires assistance with ADL / IADL. • A person requiring Home Care, Nursing, or other professional supports, interventions, and/or supervision. • The person can be independent with supports or live in a group living setting.
LEVEL 3 HOME CARE/*LTC	<ul style="list-style-type: none"> • A person who may or may not be independently mobile, with or without mechanical aids, and requires assistance with ADL/IADL. • A person requiring Home Care, Nursing, or other professional supports, interventions, and/or supervision. • The person can be independent with supports or live in a group living setting. <p><i>*Based on assessed need</i></p>
LEVEL 4 LONG TERM CARE/ DEMENTIA CARE/	<ul style="list-style-type: none"> • A person who requires 24/7 professional nursing and/or other professional support services/monitoring, medical supervision, and requires facility-based residential care/support on a permanent basis. • A person who needs 1 or 2 persons to assist with mobility and ADL / IADL. A person who is at risk of harm to self/others resulting from complex and multiple medical conditions, cognitive impairment. • A person who may experience be sudden, unanticipated changes in condition. <p>24 hr. On-Site Nursing and after regular hours access to a Registered Nurse</p>
LEVEL 5 LONG TERM CARE/ DEMENTIA CARE/ EXTENDED CARE	<ul style="list-style-type: none"> • A person who requires 24/7 professional nursing and/or other professional support services/monitoring, medical supervision, and requires facility-based residential care/support on a permanent basis. • A person who needs 1 or 2 persons to assist with mobility and ADL / IADL. • A person who is at risk of harm to self/others resulting from complex and multiple medical conditions, physical frailty and or cognitive impairment. • A person who may experience be sudden, unanticipated changes in condition. <p>24 hr. On-Site Nursing and after regular hours access to a Registered Nurse</p>
LEVEL 6 PALLIATIVE CARE	<ul style="list-style-type: none"> • A person who is approaching end-of-life and who requires continuous medical support, and formal / informal psychosocial support. • Palliative care is provided in the following locations as appropriate: <ul style="list-style-type: none"> A. Home Care in person's home B. Long Term Care facility C. Hospital Acute Care D. Hospital Palliative Care <p>24 hr. On-Site Nursing and after regular hours access to a Registered Nurse</p>

Updated November 2025

LONG TERM CARE AND SUPPORTED LIVING ADMISSION APPLICATION FORM APPENDIX B

Name of Applicant - Last Name		First Name		Middle Name
Mailing Address				Postal Code
Telephone Number ()	Social Insurance Number / /	Date of Birth - D/M/Y / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Application Date - D/M/Y / /
Name/Location (Community) of Facility			Personal Directive <input type="checkbox"/> Yes <input type="checkbox"/> No	Health Care Card Number (applicant)

*The TAC strives to place applicants as close to home as possible. Placement decisions are made after an assessment of each individual's care needs. Where there is no long term care facility in the applicant's home community or where the community long term care facility has no beds available, a **bed in another facility will be offered to applicants.** All patients waiting in acute care or waiting urgently in the community are expected to transfer to the first available bed in an appropriate care facility. People taking a first available bed will automatically be waitlisted for their location of choice. Those **who refuse a bed that is offered for placement will remain on the territorial wait list** with a priority applicable to their identified care needs.*

Marital Status Single Married Common-law Divorced Separated Widowed

If Married or Common-law, please complete:

Name of Spouse - Last Name		First Name		Middle Name
Telephone Number ()				Date of Birth - D/M/Y / /

Type of Current Residence (place normally resided):

<input type="checkbox"/> House (single family - detached)	<input type="checkbox"/> Special Care Home
<input type="checkbox"/> Apartment (self contained, including attached housing)	<input type="checkbox"/> Care in Hospital
- Senior Citizen's Housing/Public Housing: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other Care Home (group, approved, etc.)
- Supported Living Housing: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Boarding House/Rooming House/Hotel
	<input type="checkbox"/> Rehab Facility

Current Living Arrangements:

Lived Alone With Spouse Only With Spouse and Others With Other Family Member(s) With Others

The following should be completed with the help of your primary care provider or home care nurse

If Applicable: Transfer from another facility Waiting LTC placement

Services Received Within Previous Year:

<input type="checkbox"/> Home Care	<input type="checkbox"/> Night Care	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Hospital - Outpatient	<input type="checkbox"/> Adult Day Program	<input type="checkbox"/> Addiction Counselling
<input type="checkbox"/> Hospital - Inpatient	<input type="checkbox"/> Temporary Care (respite, convalescence, etc.)	<input type="checkbox"/> Rehab/Therapy
<input type="checkbox"/> Hospital - Emergency	<input type="checkbox"/> Long Term Care	

Main Factor Contributing to Application:

<input type="checkbox"/> Accident or Illness of Resident	<input type="checkbox"/> Client Needs Exceed Home Care/Facility
<input type="checkbox"/> Gradual Loss of Functional Abilities	<input type="checkbox"/> Respite for Supporter in Community
<input type="checkbox"/> Death or Serious Illness of Resident's Spouse/Supporter	<input type="checkbox"/> Lack of Social Contact
<input type="checkbox"/> Breakdown in Support Previously Provided by Another Supporter	<input type="checkbox"/> Other, Explain: _____

LONG TERM CARE AND SUPPORTED LIVING ADMISSION APPLICATION FORM APPENDIX B Client Information Part 2

Declaration and Consent

I declare that all of the information I have provided is complete and correct. I consent to the use of this information by GNWT Health and Social Services for the purpose of determining my entitlement for other health care benefits or programs, but not for disclosure to any person or organization without my approval.

Name of Applicant/Responsible Party (Please Print)

x

Signature of Applicant/Responsible Party

Date - D/M/Y

Name of Health and Social Services Authority Case Manager (Please Print)

x

Signature of Health and Social Services Authority Case Manager

Date - D/M/Y

**For more information on how to apply for Long Term Care or Supported Living placement,
please call your local Health and Social Services Authority.**

The personal information on this application is being collected under the authority of *Hospital Insurance and Health and Social Services Administration Act* and will be used to determine eligibility for Long Term Care or Supported Living placement. It is protected by the privacy provisions of the *Access to Information and Protection of Privacy Act*. If you have any questions about the collection or use, please contact the Territorial Admissions Committee by calling 1-867-873-7459.



CONSENT FOR ADMISSION AND PAYMENT FOR LONG TERM CARE AND SUPPORTED LIVING APPENDIX C

All residents of Long Term Care (LTC) and Supported Living (SL) facilities must pay a fee of \$1021 per month on the first day of each month for room and board. The LTC and SL room and board rate is subject to an annual increase based on the Consumer Price Index (CPI) adjustment that is calculated at the end of each calendar year.

Please Note: Long Term Care and Supported Living placement is not an insured service. Therefore, medical travel costs of the client (and escort, if necessary) to/from the facility are the responsibility of the client/family.

Applicant's Last Name:	First Name:	Middle Name:
Telephone Number:	Health Care Card Number:	Date of Birth: (dd/mm/yyyy)
<input type="checkbox"/> I agree to pay \$1021 per month on the first day of each month.		
Source of Income for Payment:	Method of Payment: <input type="checkbox"/> Postdated Cheques <input type="checkbox"/> Direct Deposit	
_____	X	_____
Name of Applicant/Designated Decision Maker (Please Print)	Signature of Applicant/Designated Decision Maker	Date (dd/mm/yyyy)
_____	X	_____
Name of Witness (Please Print)	Signature of Witness	Date (dd/mm/yyyy)

This section is to be completed by the Interpreter/Translator

I, _____ (Interpreter's/Translator's name), confirm I have explained the contents of the Consent for Admission and Payment for Long Term Care and Supported Living, to _____ (above named Applicant and/or Designated Decision Maker) in the presence of _____ (name of Witness).

To the best of my ability and to the best of my knowledge, the Applicant or Designated Decision Maker fully understands the contents of this agreement.

_____	X	_____	_____
Name of Interpreter/Translator (Please Print)	Signature of Interpreter/Translator	Date (dd/mm/yyyy)	
_____	X	_____	_____
Name of Witness (Please Print)	Signature of Witness	Date (dd/mm/yyyy)	

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CONSENTEMENT À L'ADMISSION ET AU PAIEMENT POUR LES SOINS DE LONGUE DURÉE ET L'AIDE À LA VIE AUTONOME ANNEXE C

Tous les résidents des établissements de soins de longue durée et d'aide à la vie autonome doivent, tous les premiers du mois, payer 1 021 \$ pour leur chambre et leur pension. Ce montant fait l'objet d'une augmentation annuelle en fonction de la hausse de l'indice des prix à la consommation (IPC), calculé à la fin de chaque année civile.

Remarque : Les soins de longue durée et l'aide à la vie autonome en établissement ne sont pas remboursés par le régime d'assurance-maladie. Voilà pourquoi les frais de déplacement médical (et de l'accompagnateur, s'il y a lieu) en provenance et à destination de l'établissement incombent au client (ou à sa famille).

Nom de famille du demandeur :	Prénom :	Second prénom :
Numéro de téléphone :	Numéro de carte d'assurance-maladie :	Date de naissance : (jj/mm/aaaa)
<input type="checkbox"/> L'accepte de payer 1 021 \$ tous les premiers du mois.		
Source de revenus :	Mode de paiement : <input type="checkbox"/> Chèque postdaté <input type="checkbox"/> Virement automatique	
_____ X _____ Nom du demandeur ou décideur désigné (en caractères d'imprimerie)	Signature du demandeur ou décideur désigné	_____ Date (jj/mm/aaaa)
_____ X _____ Nom du témoin (en caractères d'imprimerie)	Signature du témoin	_____ Date (jj/mm/aaaa)

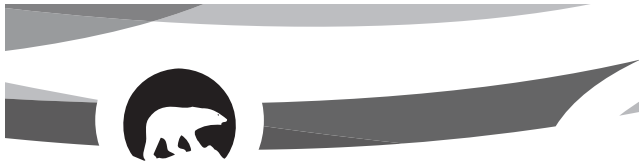
La partie suivante doit être remplie par l'interprète

Je, _____ (nom de l'interprète), confirme que j'ai expliqué le contenu du présent formulaire de demande de consentement à l'admission et au paiement pour les soins de longue durée et l'aide à la vie autonome à _____ (nom du demandeur précité ou du décideur désigné) et en présence de _____ (nom du témoin).

Au mieux de ma connaissance et de mes capacités, le demandeur ou le décideur désigné comprend le contenu de cette entente.

_____ X _____ Nom de l'interprète (en caractères d'imprimerie)	Signature de l'interprète	_____ Date (jj/mm/aaaa)
_____ X _____ Nom du témoin (en caractères d'imprimerie)	Signature du témoin	_____ Date (jj/mm/aaaa)

Les renseignements personnels de la présente demande sont recueillis en vertu de la *Loi sur l'assurance-hospitalisation et l'administration des services de santé et des services sociaux* et serviront à déterminer votre admissibilité aux soins de longue durée et à l'aide à la vie autonome. Ils sont protégés par les dispositions relatives à la confidentialité de la *Loi sur l'accès à l'information et la protection des renseignements personnels*. Pour toute question sur la collecte ou l'utilisation de ces renseignements, communiquez avec le Comité territorial d'admission au 867-767-9030, poste 49205.



MEDICAL ASSESSMENT FORM – CLIENT INFORMATION APPENDIX D

– CONFIDENTIAL –

Please Note: This form should be completed by a Physician, Nurse Practitioner, or Community Health Nurse. The TAC realizes that Physicians and Nurse Practitioners are not always available in many of the smaller NWT communities. In these cases, a Community Health Nurse may complete this form.

To be Completed by Physician, Nurse Practitioner, or Community Health Nurse		
Name of Applicant		
Last Name:	First Name:	Middle Name:
Mailing Address:		Postal Code:
Telephone Number:	Health Care Card Number:	
Date of Birth: (dd/mm/yyyy)	Date of Examination: (dd/mm/yyyy)	
Allergies:	Diet:	
Active Medical Diagnosis in Order of Priority		
1.	6.	
2.	7.	
3.	8.	
4.	9.	
5.	10.	
History: (to include medical, surgical, mental health, substance use, communicable diseases, and specialist consult reports)		
Current Medications: (attach typed list)		

**MEDICAL ASSESSMENT FORM – CLIENT INFORMATION
APPENDIX D**

– CONFIDENTIAL –

To be Completed by Physician, Nurse Practitioner, or Community Health Nurse		
Name of Applicant		
Last Name:	First Name:	Middle Name:
Mailing Address:		Postal Code:
Telephone Number:	Health Care Card Number:	
Date of Birth: (dd/mm/yyyy)	Date of Examination: (dd/mm/yyyy)	
Physical Exam	Laboratory Findings (Most Recent Results)	
BP _____ WT _____ (kg)	CBC:	
Head and Neck:	Renal Function:	
Chest:	TSH:	
Cardiovascular:	Glucose:	
Abdomen:	Calcium:	
Neuro:	Albumin:	
Musculoskeletal:		
Skin:		

Name of Physician, Nurse Practitioner, or Community Health Nurse (Please Print)

X

Signature of Physician, Nurse Practitioner, or Community Health Nurse

Date (dd/mm/yyyy)

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Translation into other NWT official languages will be provided upon reasonable request. La traduction dans une autre langue officielle des T.N.-O. sera fournie sur demande raisonnable.

– CONFIDENTIAL –

To be Completed by Public Health Nurse/Community Health Nurse		
Name of Applicant		
Last Name:	First Name:	Middle Name:
Mailing Address:		Postal Code:
Telephone Number:	Health Care Card Number:	
Date of Birth: (dd/mm/yyyy)	Date of Examination: (dd/mm/yyyy)	

Please Provide the Following Information on the Above Client	
TB Status: (e.g. Mantoux, chest x-ray, sputum for AFB and/or TB treatment)	
MRSA/VRE:	Date of Last CXR: (dd/mm/yyyy) (attach copy of results)
Immunization Status, Including Hepatitis B: (attach record)	

Name of Public Health Nurse/Community Health Nurse (Please Print)

X

Signature of Physician, Nurse Practitioner, or Community Health Nurse

Date (dd/mm/yyyy)

The personal information on this application is being collected under the authority of *Hospital Insurance and Health and Social Services Administration Act* and will be used to determine eligibility for Long Term Care or Supported Living placement. It is protected by the privacy provisions of the *Access to Information and Protection of Privacy Act*. If you have any questions about the collection or use, please contact the Territorial Admissions Committee by calling 1-867-873-7459.