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**	• 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**	• 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**	• 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. **Based on assessed need*
LEVEL 4 **LONG TERM CARE/ DEMENTIA CARE/**	• A person who requires 24/7professional 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. 24 hr. On-Site Nursing and after regular hours access to a Registered Nurse
LEVEL 5 **LONG TERM CARE/ DEMENTIA CARE/ EXTENDED CARE**	• A person who requires 24/7professional 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. 24 hr. On-Site Nursing and after regular hours access to a Registered Nurse
LEVEL 6 **PALLIATIVE CARE**	• 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: A. Home Care in person's home B. Long Term Care facility C. Hospital Acute Care D. Hospital Palliative Care 24 hr. On-Site Nursing and after regular hours access to a Registered Nurse

Updated November 2025

Northwest Territories Health and Social Services

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	Application Date - D/M/Y
( )	/ /	/ /	❑ Male ❑ Female	/ /

Name/Location (Community) of Facility	Personal Directive	Health Care Card Number (applicant)
	❑ Yes ❑ No	

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):

- ❑ House (single family - detached)
- ❑ Apartment (self contained, including attached housing)
  - Senior Citizen's Housing/Public Housing: ❑ Yes ❑ No
  - Supported Living Housing: ❑ Yes ❑ No
- ❑ Special Care Home
- ❑ Care in Hospital
- ❑ Other Care Home (group, approved, etc.)
- ❑ Boarding House/Rooming House/Hotel
- ❑ 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:

- ❑ Home Care
- ❑ Hospital - Outpatient
- ❑ Hospital - Inpatient
- ❑ Hospital - Emergency
- ❑ Night Care
- ❑ Adult Day Program
- ❑ Temporary Care (respite, convalescence, etc.)
- ❑ Long Term Care
- ❑ Mental Health
- ❑ Addiction Counselling
- ❑ Rehab/Therapy

Main Factor Contributing to Application:

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

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.

Northwest Territories Health and Social Services

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.

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.

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 $1000 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)
☐ **I agree to pay $1000 per month on the first day of each month.**		
Source of Income for Payment:	**Method of Payment:** ☐ Postdated Cheques ☐ Direct Deposit	

Name of Applicant/Designated Decision Maker (Please Print)	X _____ Signature of Applicant/Designated Decision Maker	Date (dd/mm/yyyy)
Name of Witness (Please Print)	X _____ 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.

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

The personal information on this form 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 867-767-9030 extension 49205.

Government of Northwest Territories | Gouvernement des Territoires du Nord-Ouest

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 1000$ 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)

☐ **L'accepte de payer 1000$ tous les premiers du mois.**

Source de revenus :	**Mode de paiement :** ☐ Chèque postdaté ☐ Virement automatique

Nom du demandeur ou décideur désigné (en caractères d'imprimerie)	X _____ Signature du demandeur ou décideur désigné	Date (jj/mm/aaaa)
Nom du témoin (en caractères d'imprimerie)	X _____ 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.

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

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 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 PLEASE PRINT FORM TO SIGN _____ _____

Signature of Physician, Nurse Practitioner, or Community Health Nurse | Date (dd/mm/yyyy)

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– 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 PLEASE PRINT FORM TO SIGN

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.