



Mills Community Support Corporation





67 Industrial Drive, P.O. Box 610, Almonte ON, K0A 1A0

Tel: (613) 256-1031
Fax: (613) 256-1185

info@themills.on.ca
www.themills.on.ca



North Lanark Assisted Living Program Person Centered Support Plan

Name:		Date:	
Address:			
OHIP #:		Telephone:	Date of Birth
Emergency Contact #1:		Telephone:	
Emergency Contact #2:		Telephone:	
Physician:		Telephone:	
Diagnoses:			
Allergies:			
<p>Please describe yourself. How would others describe you? What do others like and admire about you?</p> 			
<p>What are you interested in? What brings you joy?</p> 			
<p>What are the significant relationships in your life? Is there anyone else that you would like us to talk to about the support that you need? How do you feel about support from family/friends?</p> 			
<p>What is your routine like (include sleep)? What makes a good day/bad day?</p> 			



What kinds of things make it difficult to get through your day?



On a scale of 1-10, how satisfied are you with the amount of support you receive?








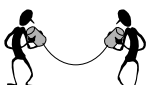

What kind of help and support do you feel you need to get through your day/night? Imagine someone was in the next room/apartment and available 24 hours/day. What kinds of things would you call them for in the:

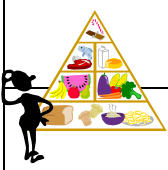




a) Morning/Afternoon



b) Evening/Night

Description	Support Required Legend: I = Independent, P = Shared Participation, F = Full Help	
 Mobility	Aids:	
 Transferring/positioning		
 Dressing/undressing		
 Bathing	Tub/shower:	Frequency:
 Personal Hygiene	Hair:	Oral:
 Toileting/continence	Aids:	
 Medication administration (See attached list)		
 Communication (Hearing, sight, speech)		
 Cognitive issues		

	Meal preparation	Typical routine:
	Diet	Like/dislikes:
		Special needs:
	Laundry/ changing bed	
	Housecleaning (floors, bath, dust, kitchen)	
		Preferred time: _____

On a scale of 1-10, tell me about how comfortable you feel when you are on your own. What kind of service would provide you with reassurance? (Calls, checks)



What kinds of things upset you? What kinds of support do you need when that happens?



What qualities would you like to see in someone who is caring for you?

