LCMNA
La Crete Municipal Nursing Association

Application for Accommodation - Senior Housing

PLEASE READ CAREFULLY
INSTRUCTIONS FOR COMPLETING APPLICATION

- Complete ALL questions supplying ALL the requested information. If a question does not apply to your situation, mark N/A in the section.
- Prior to approving this application, you will be required to provide the following for each household member:

1. **Notice of Assessment from the previous tax year that shows line 15000**
2. **Previous year Income Tax Return**
3. **Valid Alberta Health Care card**
4. **Level-of-Care Assessment form –** completed by a Home Care nurse

In order for you to obtain the information we require; your application will be held for two (2) weeks. After two weeks, if the required information is not received, your application will be cancelled. However, it can be reactivated at any time in the following 6 months. It is not necessary to complete another application form.

THIS APPLICATION WILL NOT BE PROCESSED
UNLESS ALL QUESTIONS ARE FULLY ANSWERED.

If a translator was required to complete this application, please provide their name and telephone number.

_____ _____
Translator's Name Telephone Number

HOUSING AUTHORITY USE ONLY

Name:_____ Date Received: _____

La Crete Municipal Nursing Association

CONFIDENTIAL APPLICATION FOR ACCOMMODATION

*** (Please Note: Failure to complete application in its entirety will result in delay in processing.)**

Complete application and return to our office in person, or mail or fax to:

Heimstaed Lodge
Box 3999, La Crete, AB, T0H 2H0
Phone (780) 841-3082 Fax (780) 928-4435

APPLICANT

Please (√) one: ☐ Mr. ☐ Mrs. ☐ Ms.

Surname:	First Name:
Mailing Address:	Postal Code:
Physical Address:	
Telephone No.:	Birth Date: (month/day/year)
Email Address:	
Alberta Health #:	SIN:
Treaty # (if applicable)	

Co-applicant information:

Surname:	First Name:
Telephone No.:	Birth Date: (month/day/year)
Email Address:	
Alberta Health #:	SIN:
Treaty # (if applicable)	

Marital Status ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Separated ☐ Common-Law

Are you receiving the Alberta Seniors Benefit? ☐ Yes ☐ No

NEXT OF KIN / EMERGENCY CONTACT:

If we are unable to contact you, should the need arise, we will contact your next of kin.

1. Name:	Relationship:
Res./Cell Phone:	Bus. Phone:
Address:	Postal Code:

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2. Name:	Relationship:
Res./Cell Phone:	Bus. Phone:
Address:	Postal Code:

DOCTOR:	Telephone Number:
Address:	Postal Code:

CITIZENSHIP:

Are you a Canadian Citizen? ☐ YES ☐ NO How long have you lived in Canada?____yrs. How long have you lived in Alberta?____yrs.	Landed Immigrant ☐ YES ☐ NO Independent Status ☐ YES ☐ NO Private sponsorship ☐ YES ☐ NO If you have answered yes above, please provide a photocopy of your immigration documents.

CURRENT ACCOMMODATION:

Is your current accommodation a ☐ House ☐ Motel/Hotel ☐ Apartment ☐ Rooming House ☐ Other If paying rent $_____per Month / Day	How long have you lived at your current address? Months:_____ Years: _____
Is your accommodation shared? ☐ YES ☐ NO If you share accommodation, are these relatives? ☐ YES ☐ NO	If yes, number of: Adults #_____ Bedrooms #_____ Children #_____ Bathrooms #_____

Do you have a pet? ___Yes ___No

If yes; we have a **NO Pet policy**, so you **cannot** bring it with you to a La Crete Municipal Nursing Association unit.

PLEASE CHECK IF YOU ARE RECEIVING ANY OF THE FOLLOWING SERVICES:

☐ Medical Alert System ☐ Meals on Wheels ☐ Day Program
☐ Housekeeping Services
☐ Mental Health Services (give contact name) _____
☐ Home Care (give Home Care Co-ordinator's name) _____
☐ Social Assistance / AISH Worker (give contact name) _____
☐ Other (specify) _____

If you are not receiving any of the above services, would you like to?

La Crete Municipal Nursing Association

HEALTH INFORMATION:

If you require accommodation for a special need, please explain:

_____

_____

_____

_____

Attach the form from Health Care Professionals confirming your ability to live independently.

EMPLOYMENT INFORMATION:

If any household member has employment income, please state the names(s) and address(s) of the employer(s).

Household member: _____

Name of Employer: _____

Address:_____Telephone No. _____

Household member: _____

Name of Employer _____

Address:_____Telephone No. _____

FINANCIAL INFORMATION:

1. MONTHLY INCOME	applicant	co-applicant
Old Age Security and Guaranteed Income Supplement	_____	_____
Alberta Seniors Benefit	_____	_____
Spouse Allowance	_____	_____
Canada Pension Plan	_____	_____
Company Pension	_____	_____
War Veterans Allowance	_____	_____
War Disability	_____	_____
Employment Income	_____	_____
Social Assistance	_____	_____
Other Income: Specify _____	_____	_____
_____	_____	_____
_____	_____	_____

Assets: Please list all investments/assets and interest/income derived from investments such as stocks, bonds, term deposits, bank accounts, real estate, etc.

INVESTMENTS/ASSETS	INTEREST/INCOME	
_____	Yearly $_____	Monthly $_____
_____	Yearly $_____	Monthly $_____
_____	Yearly $_____	Monthly $_____

NOTE: All incomes must be verified upon acceptance as a tenant

Attach a copy of all household members current year's Notice of Assessment and Income Tax Return to your Application Form. If you do not have your Notice of Assessment, please attach a copy of the current year's Income Tax Return along with all income verification slips, such as T3's, T4's and T5's.

If someone other than yourself (family or friend) is responsible for paying your rent, please complete the following:

Name:_____

Address:_____

Phone #: _____

REASONS FOR WANTING TO MOVE INTO SENIORS INDEPENDENT LIVING:

_____

_____

_____

_____

_____

If you have been given a "NOTICE TO VACATE", please submit a copy of the notice and state the reason for eviction: _____

La Crete Municipal Nursing Association

AUTHORIZATION FOR RELEASE OF INFORMATION

I/We,_____, hereby authorize La Crete Municipal Nursing Association to gather relevant information necessary to assess my/our eligibility for residency in a La Crete Municipal Nursing Association Senior Housing. I/We understand that Administration has the authority to request a medical assessment at any time during my/our tenancy with La Crete Municipal Nursing Association.

My/Our application for admission into a La Crete Municipal Nursing Association facility will be kept on file for a period of six (6) months only. If residency has not occurred by that time, I/we understand that it will be my/our responsibility to re-submit an application.

Date:_____ Applicant's Signature: _____

Date:_____ Co-applicant's Signature: _____

Date:_____ Witness:_____

The personal information in this form is being collected by La Crete Municipal Nursing Association under section 33(c) of the Freedom of Information and Protection of Privacy Act for the purpose of administering applications for subsidized housing or rental benefits. If you have questions regarding the collection of this information, please contact the Lodge Manager at 780-841-3082.

I understand the terms as mentioned above and agree to the terms as presented.

_____ _____

Applicant Signature Co-applicant Signature

_____

Witness

_____

Date

_____ _____

Manager Date

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If application refused, state reason: _____

_____

_____

_____ _____

Manager Date

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Client Assessment for Entrance (fill out one for each household member)

Senior Housing Assessment: _____

Date: _____

Name: _____

Check Yes or No

Dressing: Do you manage independently? **Yes** ☐ **No** ☐

Does Home Care assist you? **Yes** ☐ **No** ☐

Comment: _____

Bathing: Do you bath yourself? **Yes** ☐ **No** ☐

Do you require assistance from Home Care? **Yes** ☐ **No** ☐

Comment: _____

Mobility: Do you use a mobility aid? If yes, continue below. **Yes** ☐ **No** ☐

~ Walker? **Yes** ☐ **No** ☐

~ Wheelchair? **Yes** ☐ **No** ☐

~ Scooter? **Yes** ☐ **No** ☐

Comment: _____

Self-Managed Health Care

Are you currently receiving the following services or treatment?

Home Care **Yes** ☐ **No** ☐

Physiotherapy **Yes** ☐ **No** ☐

Social Worker **Yes** ☐ **No** ☐

Day Support from Hospital **Yes** ☐ **No** ☐

Respiratory Therapy **Yes** ☐ **No** ☐

~ Oxygen **Yes** ☐ **No** ☐

~ Inhaler **Yes** ☐ **No** ☐

Comment: _____

Do you smoke **Yes** ☐ **No** ☐

Other Health Concerns:

_____

_____

Family Support:

Does your family live in the community? **Yes** ☐ **No** ☐

Comment:

_____

_____

_____

SELF-CONTAINED: Household Management

Do you currently prepare your own meals?	**Yes** ☐	**Requires Assistance** ☐
Do you clean your own household?	**Yes** ☐	**Requires Assistance** ☐
Do you do your own shopping?	**Yes** ☐	**Requires Assistance** ☐
Do you fill out your own personal documents?	**Yes** ☐	**Requires Assistance** ☐

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Management Perception

Communication	**Good** ☐	**Impaired** ☐
Orientated to date, place, and time	**Good** ☐	**Impaired** ☐
Exhibit good judgement	**Good** ☐	**Impaired** ☐
Able to answer questions with little or no queuing	**Good** ☐	**Impaired** ☐
Cognitive state	**Good** ☐	**Impaired** ☐

Comment:

_____

_____

_____

Assessment Summary:

_____

_____

_____

_____ _____

SIGNATURE OF ASSESSOR **DATE**