La Crete Municipal Nursing Association – Heimstaed Lodge

(Date Received: _____)

CONFIDENTIAL APPLICATION FOR ACCOMMODATION

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

Complete Application and return to the Lodge in person; or mail or fax to:

La Crete Municipal Nursing Association
Heimstaed Lodge
PO Box 3999, La Crete, AB T0H 2H0
Phone (780) 841-3082

APPLICANT

Please (√) one: ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms.

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

For Annual Government Reports, the following information is required:

Marital Status: ☐Married ☐Widowed ☐Single ☐Divorced ☐Separated

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

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 your accommodation is shared, number of: Adults (#_____) Bedrooms (#_____) Children (#_____) Bathrooms (#_____)

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

☐ Occupational Therapy
☐ Socializing
☐ Bathing
☐ Physio Therapy
☐ Medical Alert System
☐ Meals on Wheels
☐ Day Program
☐ DVA Assistance
☐ Private Care (give contact name) _____
☐ Mental Health Services (give contact name) _____
☐ Home Care (give Home Care Co-ordinator's name) _____
☐ Social Assistance / A.I.S.H. Worker (give contact name) _____
☐ Other (specify) _____

HEALTH INFORMATION:

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

_____

_____

_____

2. Please check any/all of the following health concerns that apply to you:

☐ Incontinence
☐ Alcohol or other substance abuse
☐ Oxygen
☐ Hearing
☐ Sight
☐ Seizures
☐ Allergies
☐ Diabetes
☐ Mobility: use of walker, cane, wheelchair, scooter
☐ Other: _____

FINANCIAL INFORMATION:

*** Applicable only if applying for Lodge Accommodation.**

***<u>See additional attachment for breakdown of rent and fees.</u>**

Attach a copy of your current year's Notice of Assessment (which you receive following filing of your Income Tax Return) to your Application Form.

Do you have a Power of Attorney? ❑ Yes ❑ No
If yes, please attach copy.

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize La Crete Municipal Nursing Association to gather relevant Information necessary to assess my eligibility for residency in a La Crete Municipal Nursing Association lodge facility. I understand that my application for admission into a La Crete Municipal Nursing Association facility will be kept on file for a period of one (1) year only. If residency has not occurred by that time, I understand that it will be my responsibility to re-submit an application.

Applicant's signature: _____ Date: _____

Witness: _____ Date: _____

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

_____ _____
Applicant Signature Date

_____ _____
Witness: print Signature
Address: _____
_____ _____
Phone # _____ Lodge Manager

FOR OFFICE USE ONLY

If application refused, state reason: _____
_____
_____

This information is collected in accordance with Section 33 of the Alberta Freedom of Information and Protection of Privacy Act (FOIP) and is used by La Crete Municipal Nursing Association to operate its business. Personal information is protected under FOIP.

Client Assessment for Entrance

Name: _____ **Date:** _____

Check Yes or No

Do you receive Home Care **Yes** ☐ **No** ☐

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

Comment:_____

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

Do you want to have assistance with bathing? **Yes** ☐ **No** ☐

Comment:_____

Eating: Are you able to carry a plate of food to the table independently? **Yes** ☐ **No** ☐

Are you able to carry hot beverages? **Yes** ☐ **No** ☐

Do you have any dietary considerations? **Yes** ☐ **No** ☐

Comment:_____

Toileting: Are you able to get on and off the toilet independently? **Yes** ☐ **No** ☐

Are you continent? If no, continue below **Yes** ☐ **No** ☐

- ~ Urinary incontinence? **Yes** ☐ **No** ☐
- ~ Stress incontinence? **Yes** ☐ **No** ☐
- ~ Bowel incontinence? **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:_____

Meds: Do you take your own medication? **Yes** ☐ **No** ☐

Do you want the Lodge to assist with your meds? **Yes** ☐ **No** ☐

Comment:_____

Laundry: Do you wash your own laundry? **Yes** ☐ **No** ☐

Do you require assistance from your family? **Yes** ☐ **No** ☐

Do you require assistance from the Heimstaed Lodge? **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:_____

Mental Psychosocial Behaviour:

Do you suffer from or have you suffered from the following:

Anxiety ---------- **Yes** ☐ **No** ☐

Depression ---------- **Yes** ☐ **No** ☐

Paranoia ---------- **Yes** ☐ **No** ☐

Hoarding ---------- **Yes** ☐ **No** ☐

Wandering ---------- **Yes** ☐ **No** ☐

Substance abuse ---------- **Yes** ☐ **No** ☐

Alcohol abuse ---------- **Yes** ☐ **No** ☐

Vision loss ---------- **Yes** ☐ **No** ☐

Hearing loss ---------- **Yes** ☐ **No** ☐

Do you smoke ---------- **Yes** ☐ **No** ☐

Other Health Concerns:

_____

_____

_____

Family Support:

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

Comment:

_____

_____

_____

Do you have a vehicle that you would like to park at the Lodge? **Yes** ☐ **No** ☐

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** ☐

FOR OFFICE USE ONLY

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**

Your response to the following is optional and in no way prejudices your eligibility. This information is helpful in enhancing our programs and activities.

Name: _____

Skills:

_____
_____
_____
_____
_____
_____

Interests:

_____
_____
_____
_____
_____
_____

Comments:

_____
_____
_____
_____
_____
_____