# CONFIDENTIAL APPLICATION FOR ACCOMMODATION – Seniors Housing

**(Date Received: _____)**

*** (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: |

| | |
|---|---|
| **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<br>How long have you lived in Canada?___yrs.<br>How long have you lived in Alberta?___yrs. | Landed Immigrant ☐ YES ☐ NO<br>Independent Status ☐ YES ☐ NO<br>Private sponsorship ☐ YES ☐ NO<br>If you have answered yes above, please provide a photocopy of your immigration documents. |

***CURRENT ACCOMMODATION:***

| | |
|---|---|
| Is your current accommodation a<br>☐ House ☐ Motel/Hotel<br>☐ Apartment ☐ Rooming House<br>☐ Other<br>If paying rent $_____per M o n t h ☐ Day ☐ | How long have you lived at your current address?<br>Months:_____ Years: _____ |
| Is your accommodation shared?<br>☐ YES ☐ NO<br>If you share accommodation, are these relatives?<br>☐ YES ☐ NO | If yes, number of:<br>Adults #_____ Bedrooms #_____<br>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?**

_____

***HEALTH INFORMATION:***

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

_____

_____

_____

_____

***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: _____

**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.

Applicant's Signature: _____ Date: _____

Co-applicant's Signature: _____ Date: _____

Witness:_____ Date: _____

**The personal information in this form is being collected by La Crete Municipal Nursing Association under section 4 of the Protection of Privacy Act (POPA)/Access to Information Act (ATIA) 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.**

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

_____ _____

Translator's Name Telephone Number

_____ _____

Manager Signature Date

**FOR OFFICE USE ONLY**

If application refused, state reason:

_____

_____

_____

## Client Assessment for Entrance (fill out one for each applicant)

**Applicant 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** ☐ |

## 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**

## Client Assessment for Entrance (fill out one for each applicant)

**Co-Applicant 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?

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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**

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|---|---|---|
| Do you currently prepare your own meals? | **Yes** ☐ | **Requires Assistance** ☐ |
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Comment:

_____

_____

_____

**Assessment Summary:**

_____

_____

_____

_____ _____

**SIGNATURE OF ASSESSOR** **DATE**