



Application for Accommodation - Senior Citizens' Apartments

(Confidential)

Please Read Carefully

This personal information is being collected under the authority of the Alberta Housing Act and will be used for the purpose of administering the housing program. It is protected by the privacy provisions of the *Freedom of Information and Protection of Privacy Act*.

I understand that this is just an application and that it is not an agreement on the part of LEDUC FOUNDATION, or its agents, to provide me with rental accommodation.

I further acknowledge the right of LEDUC FOUNDATION, or its agents, at any time prior to the execution and delivery to me of a lease, to withdraw, or cancel, without penalty or liability for damages or otherwise, any prior approval of this application.

I authorize LEDUC FOUNDATION, or its agents to investigate any or all of the statements made by me in this application, being fully aware that discovery of any false statement shall cancel any further consideration of my application.

I further agree that I am obligated to advise LEDUC FOUNDATION, or its agents, in writing, of any changes in family composition, gross family income, assets, employment or change of address, should they occur.

Signature of Applicant

Signature of Witness

DOMINION OF CANADA)
PROVINCE OF ALBERTA)

IN THE MATTER OF THIS APPLICATION
FOR DWELLING ACCOMMODATION IN
THE HOUSING PROJECT.

I, _____, of the _____ of _____, in
the Province of Alberta, do solemnly declare as follows:

1. That I am the applicant named in this application;
2. That the statements made by me in this application are to the best of my knowledge, information and belief, full and true in all respects;
3. That I have resided in the Province of Alberta for _____ years of my life and Leduc City/County for _____ years;

And I make this solemn Declaration conscientiously believing it to be true and knowing that it is of the same force and effect as if made under oath and by virtue of the "Canada Evidence Act."

Declared before me _____)
at the _____ of _____)
in the Province of Alberta, _____)
this _____ day of _____, 20__.)

Signature of Applicant

Signature of Co-Applicant

A Commissioner for Oaths in and for the Province of Alberta

Printed Name of Commissioner of Oaths

My Appointment Expires on _____
(Day/Month/Year)

FOR OFFICE USE ONLY:

LOCATION PREFERENCE (in order of preference):

#1 _____ #2 _____ #3 _____

Received by: _____ Date Received: _____

NOTE: PLEASE ANSWER ALL QUESTIONS

APPLICANT'S INFORMATION

Applicant's Name: _____ User ID#: _____
(Last name) (First Name)

Date of Birth: _____ Personal Health Care No.: _____
(day/month/year)

Marital Status: Single Married Separated Divorced Widowed

Co-Applicant's Name: _____
(Last Name) (First Name)

Date of Birth: _____ Personal Health Care No.: _____
(day/month/year)

Are you a: Canadian Citizen Landed Immigrant or _____

Present Address: _____
(P.O Box/Apartment/Street)

_____ Home phone No.: _____
(City/Town/Village) (Code)

How long there? _____

If less than 1 year explain: _____

Do you have a will? Yes No Executor: _____

Address: _____
(Box/Apartment/Street) (Town/City) (Province) (Postal code)

Phone (home): _____ Phone (work): _____

Family Doctor's Name: _____

Address: _____
(Box/Apartment/Street) (Town/City) (Province) (Postal code)

Phone: _____ Fax: _____

EMERGENCY CONTACTS:

Name: _____ Relationship: _____ Ph(hm) _____

Address: _____ Ph(wk) _____
Box /Apartment /Street Town/City Province Code

Name: _____ Relationship: _____ Ph(hm) _____

Address: _____ Ph(wk) _____
Box /Apartment /Street Town/City Province Code

INCOME:

MONTHLY INCOME – **Provide a copy of your most recent Income Tax Return to support the following information:**

	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 Pension	_____	_____
Employment Income	_____	_____
Social Assistance	_____	_____
Other Income: Specify _____	_____	_____
	_____	_____
TOTAL:	=====	=====

ASSETS: List all investments and/or assets and interest/income derived from investments such as stocks, bonds, term deposits, bank accounts, real estate (house), registered retirement savings plan, etc.

<u>INVESTMENTS/ASSETS</u>	<u>VALUE</u>	<u>INTEREST/INCOME</u>
_____	\$ _____	Yearly \$ _____ Monthly \$ _____
_____	\$ _____	Yearly \$ _____ Monthly \$ _____
_____	\$ _____	Yearly \$ _____ Monthly \$ _____
TOTAL	\$ _____	TOTAL \$ _____ TOTAL \$ _____

If you or your co-applicant has employment income(s), please state the name(s) and Addresses of your employer(s):

Name of your Employer: _____
 Address: _____ Telephone No.: _____
 Name of your Co-Applicant's Employer: _____
 Address: _____ Telephone No.: _____

Do you have a pet? yes no
 If YES, what kind(s) and how many of each? _____

Will you require a parking stall? yes no
 If Yes: Year _____ Make _____ Model _____
 Color _____ License No. _____

Have you have been given a "NOTICE TO VACATE"?, yes no If YES, please submit a copy of the notice and state the reason for the eviction: _____



APPLICATION FOR SENIORS' APARTMENT ACCOMMODATION

CONFIDENTIAL MEDICAL REPORT

This medical information is required by *Leduc Foundation* for all applicants seeking tenancy in *Leduc Foundation* senior citizens' apartment accommodation.

Name: _____ Date of Birth(d/m/yr): _____

Address: _____ Phone: _____
Box #/Apartment #/Street Town/City Province Postal Code

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO LEDUC FOUNDATION

Signature of Applicant: _____ Date: _____

Examining Physician: (Please Print) _____

Address : _____ Phone: _____
Box #/Apartment #/Street Town/City Province Postal Code

How long has the applicant been your patient? _____ Date Examined: _____
(day/month/year)

NOTE: Tenancy in a seniors' apartment building is subject to the applicant being capable of maintaining their accommodation and meeting their own personal needs.

Any charge for completion of this form is the responsibility of the applicant.

PHYSICAL EXAMINATION: Height: _____ Weight : _____

	Good	Impaired	Comments
Sight			If impaired, wears glasses <input type="checkbox"/>
Hearing			If impaired, wears hearing aid <input type="checkbox"/>
Mobility			If impaired, uses: cane <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/>
Communication			If impaired, due to:

MEDICAL DIAGNOSIS	PROGNOSIS	COMMENTS
1.		
2.		
3.		
4.		
5.		

CURRENT MEDICATION	DOSAGE	FREQUENCY
Oxygen: Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes,	If yes,

Is the applicant independent in complying with their medication regime? Yes No if no, please describe the assistance you would recommend: _____

ALLERGIES, INCLUDING DRUG INTOLERANCES:

ACTIVITIES OF DAILY LIVING: place a check (✓) in the appropriate column, include comments

ASSISTANCE	NONE NEEDED	SUPERVISION	PARTIAL	FULL
Washing				
Grooming/Shave				
Dressing				
Bathing				
Feeding				
Toileting				

INCONTINENCE: place a check (✓) in the appropriate column, include comments

	NONE	PARTIAL	COMPLETE	INTERVENTION	MANAGES CARE
Bladder				Catheter <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Bowel				Colostomy <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

MENTAL CONDITION: place a check (✓) in the appropriate column, include comments

	NO	SOMETIMES	YES
Co-operative?			
Aggressive?			
Wanderer?			
Confused?			
Destructive?			
Unpleasant Habits?			
Dementia?			

Do you consider this applicant to be mentally and physically suitable to look after him/herself in a seniors' self-contained apartment? Yes No

Comments: _____

Doctor's Signature: _____ Date: _____

Please Return to:
LEDUC FOUNDATION
 5118A - 50 Avenue
 Leduc, AB T9E 6V4
 Phone: (780) 986-2814
 Fax: (780) 986-4881