

APPLICATION FOR LODGE ACCOMMODATION

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*.

Planeview Manor & Planeview Place **Lodge Room** **1-Bedroom Suite**
5119 - 52 Street, Leduc, AB T9E 6K9 Ph: 986-2835 Fax: 986-1670

Cloverleaf Manor
Box 490, 5304 - 52 St., Warburg, AB T0C 2T0 Ph: 848-7717 Fax: 848-7608

APPLICANT'S INFORMATION

Name: _____ Phone: _____ User ID: _____
Last Name First Name

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

How long there? _____ If less than one year, explain: _____

Residency of applicant (years): **Alberta** _____ **Leduc County/City:** _____

Residency of Primary Relative (years): **Alberta** _____ **Leduc County/City:** _____

Are you a: Canadian Citizen? Landed Immigrant? or other (specify) _____

Personal Health Care Number: _____ Date of Birth: _____
day/month/year

Marital Status: Single Married Separated Divorced Widow

Doctor's Name: _____ Phone: _____

Do you have a will? Yes No Executor: _____

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

Phone (Res.): _____ Phone: (Bus.): _____

INCOME:

- Annual Income from Line 150 of most recent Income Tax Return \$ _____

Please attach a copy of your most recent Income Tax Return and Notice of Assessment from Canada Revenue and Taxation.

EMERGENCY CONTACTS:

Name: _____ Relationship: _____ Phone(hm): _____

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

Name: _____ Relationship: _____ Phone(hm): _____

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

Name: _____ Relationship: _____ Phone(hm): _____

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

CURRENT ACCOMMODATION:

Is current accommodation: Owned? Rented? Rent or house payment: \$_____/month
Plus \$____ for heat, \$____ for lights, and \$____ for water & sewer/month
If renting, provide name of landlord:_____

Phone:_____

Box#/Apartment#/Street

Town/City/Province

Postal Code

House Apartment with elevator Apartment without elevator Lodge Motel/Hotel

Rooms: Kitchen Living Room Dining Room # Bedrooms ____ # Bathrooms ____

Number of person(s) sharing your present accommodation: Adults ____ Children ____

Number of person(s) sharing the: kitchen ____ bathroom ____ bedroom ____

ACTIVITIES OF DAILY LIVING:

Do you complete? vacuuming washing floors dusting laundry seasonal yard care

If no to any of the above, describe how they are completed: _____

Do you prepare your own meals? Yes No If no, describe _____

How do you manage your medication? Vials Dosette Blister Pac Is it satisfactory? _____

Do you have access to transportation? Own car Taxi/Handibus Family Volunteers

Do you receive any assistance from Home Care? Yes No

If yes, describe

SOCIALIZATION:

What are your special interests/hobbies?

How often do you attend activities/functions outside of your home?

At least once per week Once every 2 weeks once per month rarely

Why are you applying for Lodge or Supportive Housing accommodation? _____

APPLICANT'S ACKNOWLEDGEMENT

I hereby acknowledge my understanding that special care/assistance is NOT provided by lodge staff, and that I must be functionally independent, with the assistance available through existing community-based services, while residing in the lodge. I agree that, should I require special care/assistance beyond that available to me in the lodge, I will move from the lodge as soon as requested to do so.

Applicant's Signature

Date

RESPONSIBLE RELATIVE/FRIEND

I _____ being the responsible relative/friend of the applicant, do hereby agree that, should the applicant require special care/assistance beyond that available to him/her in the lodge, I will assist in every way possible in making arrangements to have him/her moved from the lodge as soon as requested to do so.

Relative/Friend's Signature

Date

Witness's Signature

Date



APPLICATION FOR LODGE ACCOMMODATION CONFIDENTIAL MEDICAL REPORT

This medical information is required by *Leduc Foundation* for all applicants seeking tenancy in *Leduc Foundation* senior citizens lodge and supportive housing accommodation.

Name: _____	Date of Birth(d/m/yr): _____
Address: _____	
Box #/Apartment #/Street	Town/City
Province	Postal Code
Phone: _____	
I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO LEDUC FOUNDATION	
Signature of Applicant: _____	
Date: _____	

Examining Physician: (Please Print) _____	
Address : _____	
Box #/Apartment #/Street	Town/City
Province	Postal Code
Phone: _____	
How long has the applicant been your patient? _____	Date Examined: _____
	(day/month/year)
<p>NOTE: Admission to the lodge is subject to the applicant being capable of meeting their own personal needs, with the assistance available through community based services.</p> <p>Any charge for completion of this form is the responsibility of the applicant.</p>	

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 lodge where special care, nursing care, and special diets are NOT provided? **Yes** **No**

Would you recommend that Home Care or other community based services, be involved in the support of the applicant while in the lodge? **Yes** **No**

Comments: _____

Doctor's Signature: _____ Date: _____

This Confidential Medical Form may be returned to:

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