



# SUPPORTIVE LIVING ACCOMMODATION APPLICATION

**Planeview Place**  Studio Room  1-Bedroom Suite

5105 - 52 Avenue, Leduc, AB T9E 8P1 Ph: 780.986.2835 Fax: 780.986.1670

**Cloverleaf Manor**  Studio Room

Box 490, 5304 - 52 St., Warburg, AB T0C 2T0 Ph: 780.848.7717 Fax: 780.848.7608

## 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: \_\_\_\_\_  
Month-day-year

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Marital Status: Single  Married  Separated  Divorced  Widow

Do you have a will? Yes  No  Executor: \_\_\_\_\_

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

Phone (Res/Bus/Cell): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Do you have a Personal Directive? Yes  No  Agent: \_\_\_\_\_

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

Phone(Res/Bus/Cell): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## 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.**

## PERSONAL CONTACTS:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone(hm): \_\_\_\_\_

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

E-Mail: \_\_\_\_\_ Phone(CEL): \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone(hm): \_\_\_\_\_

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

E-Mail: \_\_\_\_\_ Phone(CEL): \_\_\_\_\_

PLANEVIEW WAITLIST yes no \_\_\_\_\_ Int.

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*.

**CURRENT ACCOMMODATION:**

Is current accommodation: Owned?  Rented?  Rent or house payment: \$ \_\_\_\_\_/month  
Plus \$ \_\_\_\_\_ for heat, \$ \_\_\_\_\_ for power, 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 \_\_\_\_\_

**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: \_\_\_\_\_

What kind of meals do you prepare? Describe \_\_\_\_\_

How do you manage your medication? Vials  Dosome  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? \_\_\_\_\_

What could you show others how to do?  
\_\_\_\_\_

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 Supportive Living/Housing Accommodation?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**APPLICANT'S ACKNOWLEDGEMENT**

I hereby acknowledge my understanding that special care/assistance is NOT provided by the staff, and that I must be functionally independent, with the assistance available through existing community-based services, while being a resident. I agree that, should I require special care/assistance beyond that available to me while here, I will move 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, I will assist in every way possible in making arrangements to have him/her moved to a new residence as soon as requested to do so.

\_\_\_\_\_  
Relative/Friend's Signature Date

\_\_\_\_\_  
Witness's Signature Date



**APPLICATION FOR SUPPORTIVE LIVING ACCOMMODATION  
CONFIDENTIAL MEDICAL REPORT**

**This medical information is required by *Leduc Foundation* for all applicants seeking tenancy in *Leduc Foundation* supportive living and supportive housing 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: Admission to the program is subject to the applicant being capable of meeting their own personal needs, with the assistance available through community based services.**

**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 residence 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 supportive living residence? **Yes**  **No**

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This Confidential Medical Form may be returned to the Manager:**

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 Leduc, AB T9E 8P1  
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