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/CityProvince 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 **$**_____ρ

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 ☐ 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?_____

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 ☐
Hearing			If impaired, wears hearing aid ☐
Mobility			If impaired, uses: cane ☐ walker ☐ wheelchair ☐
Communication			If impaired, due to:

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

CURRENT MEDICATION	DOSAGE	FREQUENCY
Oxygen: Yes ☐ No ☐	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 ☐	YES ☐ NO ☐
Bowel				Colostomy ☐	YES ☐ NO ☐

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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