Lakeside Legion Manor

"Promote stability within your community."
Lesser Slave Lake Regional Housing Authority

THIS SECTION IS FOR OFFICE USE ONLY

Move In Date: _____ **Monthly Rate $** _____
Unit Address: _____ **Other Charges $** _____
Location Preference: _____ **Point Score:** _____

APPLICATION FOR ACCOMODATION – Senior Self Contained

(Confidential)

PLEASE READ CAREFULLY, ANSWER ALL QUESTIONS AND PLEASE PRINT

Application Date: _____

1. Applicant's Name: _____

Date of Birth(mm/dd/yyyy): _____ **Social Insurance No.** _____

Alberta Personal Health No. _____ **Treaty No.** _____

2. Co-Applicant's Name: _____

Date of Birth: _____ **Social Insurance No.** _____

Alberta Personal Health No. _____ **Treaty No.** _____

3. Present Mailing Address: _____

Address _____ **City/Town:** _____

Province: _____ **Postal Code:** _____

Telephone No. _____ **Alternate Telephone No.** _____

4. List the name, address, telephone number and relationship of responsible relative, friend or guardian to be notified in the case of an emergency.

Name _____ **Relationship** _____

Address _____ **City/Town:** _____

Province: _____ **Postal Code:** _____

Telephone No. _____ **Email address:** _____

Name _____ **Relationship** _____

Address _____ **City/Town:** _____

Province: _____ **Postal Code:** _____

Telephone No. _____ **Email address:** _____

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5. Do you have a Will?

Executor's Name

Address City/Town:

Province: Postal Code:

Telephone No. Alternate Telephone No.

6. If you are receiving Social Assistance, please state the name, phone number and office address of your social worker

7. Income- must be verified upon acceptance as a tenant.

	Applicant	Co-Applicant
Line 150 of Income Tax return	$	$
RRSP, RRIF, Annuity income included above		

8. Do you own or rent your present accommodation?

How much is your monthly house payment or rent?

How much do you pay each month for electricity? Heat, water, sewer

9. If you are renting, name your landlord

Address Telephone No.

10. Describe your present accommodations (eg. House, apartment, rooming house, room & board, other)

If you live in an apartment, does the apartment building have an elevator?

11. Does your present accommodation have a kitchen? Living room?

bathroom? How many bedrooms?

12. How many people share your present accommodations? Adults Children

13. Do you share the use of the kitchen, bathroom, or your bedroom?

If Yes, Number of persons sharing kitchen

Number of persons sharing bathroom

Number of persons sharing bedroom

14. Do you/co applicant require accommodation adapted for a special need (eg. wheel chair, accessibility, etc.)?

Family Doctors Name

Address City/Town:

Province: Postal Code:

Telephone No.

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15. Do you have a pet?

If YES, please give description of what kind and how many.

16. What are your reasons for wanting to move?

If you have been given a "NOTICE TO VACATE", please submit a copy of the notice and state the reason for the eviction

17. Other related information you may wish to provide:

I understand this is just an application and it is not an agreement on the part of Lesser Slave Lake Regional Housing or its agents to provide me with rental accommodation.

I further acknowledge the right of Lesser Slave Lake Regional Housing, 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 Lesser Slave Lake Regional Housing, 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 my further consideration of my application.

This information is collected pursuant to the provisions of the Housing Act, and its regulations, and pursuant to Section 32(c) of the FOIPP Act. For more information
Lesser Slave Lake Regional Housing Administrator, 301-6th Ave NE, Slave Lake, AB T0G 2A2 (780)849-2927

Witness- Administrator

Signature of Applicant

Lesser Slave Lake Regional Housing Authority

Confidential Medical Report for Senior Housing Applicant

To Attending Physician: **Please print to complete and return directly to:**

Vanderwell Heritage Place 301 6 Ave NE Slave Lake, AB T0G 2A2 Fax: 780-849-5251

Name of Applicant:_____ **Age:**_____

Examining Physician:_____ **Date Examined:**_____

Physician Address:_____ **Phone:**_____

How long has the applicant been your patient:_____

Note to Examining Physician

The lodge applicant must be able to feed themselves, get the meals and toilet independently. The need for home care, and other services should be arranged prior to moving in. Home Care is provided by the Health Authority

1. **Condition:**

Is there any past or present evidence of:

Depression __Yes __ No If yes, __ Mild __Medium __ Severe

Cognitive Impairment __ Yes __No If yes, __ Mild __Medium __Severe

Alzheimer's Disease __ Yes __ No If yes, __ Mild __Medium __Severe

Mental Illness __ Yes __No If yes, describe_____

_____

Tendency to wander __ Yes __ No

Uncontrolled Aggressive or Violent Behavior: __ Yes __No

Infectious Diseases/Antibiotic Resistance Diseases: __ Yes __No If Yes, type:_____

Alcohol or Drug Abuse: __ Yes __ No If Yes, __ Past __ Present

2. **Physical Examination:**

Physical Disability: __ Yes __ No Describe: _____
Require assistance transferring in and out of bed and to the bathroom: __ Yes __ No
Mobility Aids: __ Cane __ White cane __Walker __Wheelchair __ Scooter
Hearing: __Normal __ Impaired __ Absent __Hearing Aid
Vision: __ Normal __ Impaired __ Absent __ Glasses
Speech: __ Normal __ Impaired __ Absent
If yes, due to: __ Mental Causes __ Deafness __ Speech Impediment
__ Language Barrier

Does the patient have the following?	__ Oxygen	__ Pacemaker
Is your patient on Home Care?	__ Yes	__ No
Does your patient require medical assistance?	__ Yes	__ No
Does your patient require dressing assistance?	__ Yes	__ No
Does your patient require bathing assistance?	__ Yes	__ No
Does your patient have any allergies or drug intolerances?	__ Yes	__ No

If Yes, describe: _____
_____

Is your patient diabetic?	__ Yes	__ No		
Does your patient use insulin?	__ Yes	__ No		
If yes, can they self-administer the insulin?	__ Yes	__ No		
Does your patient have a special diet?	__ Yes	__ Diabetic*	__ Cut up food*	__No

**Please note, there is no dieticians on site, therefore special diets beyond these will have to be managed by the resident.*

Is your patient urine continent? __ Yes __ No Is your patient bowel continent? __ Yes __ No

3. **TB Screening:** Does your patient's history and/or symptom inquiry indicate a need for TB testing prior to communal living in a senior's lodge? __ Yes __ No
If yes, has the referral been made to Public Health? __ Yes __ No

4. **Medical Diagnosis and other pertinent information:**_____

_____
_____
_____
_____
_____

_____ _____
Physician Signature Date

Alberta Health Services

Affix patient label within this box

Goals of Care Designation (GCD) Order

Date *(yyyy-Mon-dd)*	Time *(hh:mm)*

Goals of Care Designation Order

To order a Goals of Care Designation for this patient, check the appropriate Goals of Care Designation below and write your initials on the line below it. *(See reverse side for detailed definitions)*

Check ▶	☐ **R1**	☐ **R2**	☐ **R3**	☐ **M1**	☐ **M2**	☐ **C1**	☐ **C2**
Initials ▶							

Check ✓ here ☐ if this GCD Order is an interim Order awaiting the outcome of a Dispute Resolution Process. Document further details on the ACP/GCD Tracking Record.

Specify here if there are specific clarifications to this GCD Order. Document these clarifications on the ACP/GCD Tracking Record as well.

Patient's location of care where this GCD Order was ordered *(Home; or clinic or facility name)*

Indicate which of the following apply regarding involvement of the Patient or alternate decision-maker (ADM)

☐ This GCD has been ordered after relevant conversation with the patient.

☐ This GCD has been ordered after relevant conversation with the alternate decision-maker (ADM), or others. *(Names of formally appointed or informal ADM's should be noted on the ACP/GCD Tracking Record)*

☐ This is an interim GCD Order prior to conversation with patient or ADM.

History/Current Status of GCD Order

Indicate one of the following

☐ This is the first GCD Order I am aware of for this patient.

☐ This GCD Order is a revision from the most recent prior GCD *(See ACP/GCD Tracking Record for details of previous GCD Order).*

☐ This GCD Order is unchanged from the most recent prior GCD.

Name of Physician/Designated Most Responsible Health Practitioner who has ordered this GCD	Discipline
Signature	Date *(yyyy-Mon-dd)*