



Name of Applicant: _____

LAC STE. ANNE FOUNDATION

PO BOX 299 Mayerthorpe, AB T0E 1N0

APPLICATION INFORMATION

"Lac Ste Anne Foundation is responsible for ensuring safe and caring accommodations to citizens at an affordable cost; giving priority to those within the geographical jurisdiction of the Foundation"

Eligibility: Applicants will be interviewed as part of the approval process.

Applicants must be:

- 65 years of age or older.
- Able to live independently or with Personal Care Services assistance

Please number in order of preference which lodge(s), you are applying for:

_____ Chateau Lac Ste Anne
 5123 49 Avenue
 Onoway, AB
 Phone: 780-967-0475
 Fax: 780-967-0470

_____ Pleasant View Lodge
 4407 42A Avenue
 Mayerthorpe, AB
 Phone: 780-786-2393
 Fax: 780-786-4810

_____ Spruce View Heights/Lodge, Whitecourt
 #12 Sunset Blvd
 Whitecourt, AB
 Phone: 780-778-5530
 Fax: 780-778-5215

Application Form:

All applicants must complete an application form and have it signed in the presence of a Commissioner of Oaths. A medical form must also be completed. All applicants are required to provide a current income tax Notice of Assessment and income tax return information in order to verify their income.

_____ OFFICE USE ONLY

Received On: _____

Received By: _____

Priority Rating: _____

Interviewed: _____

Priority Rating Committee Approval: _____

1. Applicant's Name: _____

(Surname)

(Given Names)

Date of Birth: _____ Social Insurance Number: _____

Day/Month/Year

Alberta Health Care Number: _____ Blue Cross Number: _____

Marital Status: Married/Common Law Divorced/Separated Widowed Single

2. Present Address: _____

(PO Box/ Apartment No. /Street)

_____ Phone number: _____

(City/Town/Village)

(Postal Code)

2-a Home owner Renter Social housing Other

3. Able to manage all financial affairs: Yes No

4. Appointed Power of Attorney: Yes No Name: _____

Physical Address: _____

Address: _____ Postal Code _____ Phone No: _____

5. Appointed Executor: Yes No Name: _____

Physical Address: _____

Mailing Address: _____ Postal Code _____ Phone No: _____

6. Are you a _____ Canadian Citizen, _____ Landed Immigrant, or _____?

7-a INCOME	Monthly	Yearly
Old Age Security &	\$	\$
Guaranteed Income Supplement	_____	_____
Alberta Assured Income Supplement	_____	_____
Spouse Allowance	_____	_____
Canada Pension Plan	_____	_____
Company Pension	_____	_____
War Veterans Allowance	_____	_____
War Disability Pension	_____	_____
Employment Income	_____	_____
Social Assistance	_____	_____
Other Income: Specify _____	_____	_____

7-b INTEREST INCOME

Please list all interest/income derived from investments such as stocks, bonds, term deposits, bank accounts, real estate, etc.

_____	_____	_____
_____	_____	_____
_____	_____	_____

TOTAL INCOME

_____	_____
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Note: ALL INCOME MUST BE VERIFIED UPON ACCEPTANCE AS A TENANT.

8. If you are on Social Assistance, please list name and office address of your Social Worker.

Name: _____ Address: _____

9. If you have employment income, please state the name and address of the employer:

Name: _____ Address: _____

10. I have filled out the Resident Release for Assistance in Self-Administration of Medications form (schedule 1) that is attached: Yes No

11. I have filled out the Authorization to Release Personal Information (schedule 2) that is attached: Yes No

12. I have filled out the Resident Responsibility form (schedule 3) that is attached: Yes No

13. I have filled out the Authorization to Display form (schedule 4) that is attached: Yes No

14. I have filled out the doctor verification (schedule 5) that is attached: Yes No

Family Doctor Name: _____ Phone: _____

Address: _____

15. Alcohol use: Yes No Smoker: Yes No

16. Able to see to appropriate personal hygiene: Yes No

17. Requires bath assistance: Yes No

18. Able to do personal laundry: Yes No

19. Need for housekeeping services: Yes No

20. Do you own a vehicle: Yes No Do you require a parking stall: Yes No

21. Interests:
 Special hobbies/interests: _____
 Personal Talents (ie. music, singing): _____
22. Reason for housing request (ie. Loneliness): _____

23. Have you previously applied with Lac Ste. Anne Foundation? Yes No
 Have you rented from or received a rent subsidy from Lac Ste. Anne Foundation?
 Yes No
24. Other related information you wish to provide: -please attach separate page if more space is needed. _____

I _____ (applicant), certify that the foregoing is answered correctly and I agree by all rules and regulations as approved by the Lac Ste. Anne Foundation Board of Directors. I further agree not to bother, in any manner, other residents of the Lodge. I understand that Personal Care Services are provided in the Lodge, and that if I require increased special or nursing care after admission I may be asked to accept Personal Care Services or if necessary, find alternate lodgings.

X _____
 (Signature of Applicant)

**DOMINION OF CANADA)
 PROVINCE OF ALBERTA)
 TO WIT)**

**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 the said application;
2. That the statements made by me in the said 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 in the district 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, _____,) X _____
 Signature of Applicant

In the town of _____,)

In the Province of Alberta, this _____ day of _____, 20____.

 A Commissioner of Oaths in and for the Province of Alberta

My Appointment Expires on: _____
 Printed Name of Commissioner _____

Resident Release - Assistance in Self-Administration of Medications

1. I, the applicant for accommodation in Spruce View Lodge/Pleasant View Lodge/Chateau Lodge understand that my stay at the Lodge may involve the need to take medications prescribed by qualified physicians and filled by registered pharmacists.
2. I acknowledge these medications will be self-administered by me whenever possible and as long as possible.
3. I acknowledge that my general state of health may at some time in the future impair my ability and / or awareness in self-administering these medications.
4. In the event or such inability of lack of awareness, assistance with medication in the Lodge is done by Personal Care Services.
5. I will request Personal Care Services to assist me with my medications.
6. I hereby release and forever discharge the Lac Ste. Anne Foundation and its staff from all liability and claims of any nature whatsoever which I or my estate may have for any matters arising out of the assistance I may require in self-administration of medications throughout my stay at Spruce View Lodge/Pleasant View Lodge/Chateau Lac Ste Anne.
7. I understand Lodge staff can not assist me with any medications.
8. I have read over this Release, I understand its contents and I sign same freely and voluntarily.

DATED AT _____, THIS _____ DAY OF _____, 20__.

Applicant

Witness

AUTHORIZATION TO RELEASE PERSONAL INFORMATION

I, _____(applicant), authorize the Lac Ste. Anne Foundation to exchange information concerning my health and social needs with Personal Care Services, its agents and employees, health professionals, and any other agency or social service provider.

I understand that this information will be kept confidential and will be used only in my best interest for assessing my health and social needs, for planning services to meet those needs, and for determining appropriate housing for me.

I release the Lac Ste. Anne Foundation, its employees and agents, from all claims which may arise as a result of the release of the information described above.

This authorization shall be valid during the time that I am a resident in the Lac Ste. Anne Foundation housing unless terminated at an earlier date by myself in writing.

Dated this _____ day of _____, 20____.

APPLICANT:

WITNESS:

(Signature)

(Signature)

RESIDENT RESPONSIBILITY FORM

APPLICANTS NAME: _____

PERSON(S) RESPONSIBLE FOR ABOVE NAMED APPLICANT:

1-NAME: _____

MAILING ADDRESS: _____ Postal Code _____

PHYSICAL ADDRESS: _____

PHONE: (HOME) _____ (BUSINESS) _____

RELATIONSHIP TO APPLICANT: _____

EMAIL ADDRESS: _____

2-NAME: _____

MAILING ADDRESS: _____ Postal Code _____

PHYSICAL ADDRESS: _____

PHONE: (HOME) _____ (BUSINESS) _____

RELATIONSHIP TO APPLICANT: _____

EMAIL ADDRESS: _____

I, (we) _____; certify that I (we) will be totally responsible for the above named applicant. If the applicant does not abide by all the rules and regulations as set up from time to time by the Board of Directors of the Lac St. Anne Foundation, I (we) agree to remove the applicant from the Lodge within thirty (30) days of being notified. I (we) understand and agree that any damages to the building by the applicant over and above normal wear shall the responsibility of the applicant and / or the responsible party. I (we) further agree that the Board's decisions are final and binding on all parties concerned. I (we) understand that Personal Care Services are provided in the Lodge and if a resident requires special or Nursing Care after admittance they may be asked to accept Personal Care Service or find alternate lodgings.

Signature of Responsible - Name 1

Date

Witness

Signature of Responsible - Name 2

Date

Witness

AUTHORIZATION TO DISPLAY

I, authorize the Lac Ste. Anne Foundation to use my name, and / or picture/video for display purposes in and around the lodge. On occasion, the Lac Ste. Anne Foundation may release to the newspapers for publication purposes my name or picture.

I release the Lac Ste. Anne Foundation, its employees and agents, from all claims which may arise as a result of the release of the information described above.

This authorization shall be valid during the time that I am a resident in the Lac Ste. Anne Foundation housing unless terminated at an earlier date by myself in writing.

Dated this _____ day of _____, 20____.

APPLICANT:

WITNESS:

(Signature)

(Signature)

LAC STE ANNE FOUNDATION

CONFIDENTIAL MEDICAL REPORT

All of the information on this Medical Form is collected in order to determine eligibility for senior citizens who are capable of administering to their own personal needs in a lodge setting with Lac Ste Anne Foundation in accordance with the Freedom of Information & Protection of Privacy Act.

Name: _____ Date of Birth: _____

I, _____ hereby authorize my physician to release the medical information of this form to Lac Ste Anne Foundation.

I have filled out the Authorization to Release Personal Information (schedule 2) that is attached: Yes No

Able to Medicate Self: Yes No Known Allergies: _____

Reaction Type: _____

Known Medical Conditions: _____

X _____
Signature of Applicant

Name of Examining Physician (Please Print): _____

Telephone Number: _____ How long has the applicant been your patient? _____

PHYSICAL EXAMINATION

Mobility: Walks without help _____

Uses the following mobility aids: Walker Wheelchair Other (cane, etc.)

Is there a communication difficulty? Yes No

If yes, please explain _____

ACTIVITIES OF DAILY LIFE

Is the applicant able to prepare his/her own meals? Yes No

Is the applicant able to do his/her own housekeeping as required? Yes No

Can the applicant manage his/her own personal hygiene? Yes No

Are there any concerns with incontinence? Yes No

INDEPENDENCE FACTORS

Does the applicant show any signs of dementia? Yes No

Does the applicant have a history of alcohol or substance abuse? Yes No

Has the applicant been diagnosed with any deteriorating physical or mental health medical condition(s) that may impair his/her ability to manage independently at present or in the near future? Yes No

If yes, please explain _____

Do you consider this applicant to be suitable mentally and physically to look after himself/herself in a Lodge setting where no special care or nursing care, (except for Personal Care Services) is available? Yes No

If no, please explain _____

DATE

DOCTOR'S SIGNATURE

Any charge for the completion of this form is the responsibility of the applicant. This certificate is valid for six months only. Please return this form to one of the following address via mail or fax:

East
Chateau Lac Ste. Anne
Box 1225, Onoway, AB T0E 1V0
Fax: 780-967-0470

Central
Pleasant View Lodge
Box 299, Mayerthorpe, AB T0E 1N0
Fax: 780-786-4810

West
Spruce View Lodge
12 Sunset Blvd, Whitecourt, AB T7S 1S9
Fax: 780-778-5215