GREATER NORTH FOUNDATION
"Affordable Senior & Community Housing
4102-50 STREET ATHABASCA, ALBERTA T9S 0A6

APPLICATION FOR OCCUPANCY

(Check One)

Pleasant Valley Lodge ☐ — **4102-50 STREET. Athabasca, AB T9S 0A6**

Lacalta Lodge ☐ — **Box 900, Lac La Biche, AB T0A 2C0**

Wildrose Villa ☐ — **Box 420, Boyle, AB T0A 0M0**

****

Full Name: _____
Surname **(Please Print)** **First Name (s)**

Present Address: _____

_____**Postal Code:** _____

Phone ( ) _____ **Date of Birth: _____**

Cell: ( ) _____ **Are You a Canadian Citizen: ☐ YES ☐ NO**

List Name, Address, Phone Number, and Relationship of responsible relative or friend to be notified in case of an Emergency.

1. **Name: _____** **Relationship: _____**
   Address:_____ **Phone: ( ) _____**
2. **Name: _____** **Relationship: _____**
   Address:_____ **Phone: ( ) _____**
3. **Name: _____** **Relationship: _____**
   Address:_____ **Phone: ( ) _____**

****State which relative to be notified in case of an Emergency.**

PAYMENT OF ROOM AND BOARD:

Is Applicant able to meet cost of room and board from own resources.

$ _____/Calendar Month ☐ YES ☐ NO

If **NO**, state arrangements for payment of Room and Board, Hospital, Medical, and Other Expenses:

_____

_____

Name of Bank/Credit Union you deal with: _____

Address of Bank: _____

INCOME: **(Please complete and do not leave blank)**

Old Age Security & Guaranteed Income Supplement: $_____

Alberta Seniors Benefit: $_____

Canada Pension: $_____

Yearly Interest: $_____

Other Income: $_____

Notice of Assessment (Income Tax): $_____

A copy of Notice of Assessment from most recent taxation year is required to be submitted with application.

Alberta Personal Health No: _____

Social Insurance No: _____

AN UP-TO-DATE MEDICAL ASSESSMENT IS REQUIRED BEFORE ADMISSION

I HEREBY UNDERSTAND AND AGREE THAT SPECIAL CARE SHALL NOT BE PROVIDED BY LODGE STAFF.

SHOULD I REQUIRE CARE BEYOND WHAT CAN BE PROVIDED BY COMMUNITY BASED SERVICES, I UNDERSTAND THAT I WILL BE REQUIRED TO SEEK OTHER ACCOMODATION.

IMPORTANT NOTICE TO APPLICANTS: ***ONCE YOUR APPLICATION HAS BEEN GIVEN APPROVAL IN PRINCIPLE, AND YOU ACCEPT THE ACCOMODATIONS OFFERED, YOU WILL BE PROVIDED WITH A CONTRACT FOR LODGING, WHICH TOGETHER WITH THIS APPLICATION SHALL FORM THE BASIS OF YOUR OCCUPANCY AT THE LODGE.***

I HEREBY CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IS CORRECT.

_____ _____

WITNESS (Administration) **SIGNATURE OF APPLICANT**

_____

DATE

OFFICE INFORMATION NEEDED:

1. Date Received: _____ Date of Remittance/Refusal_____

   Assessed by: _____ Reasons For Refusal: _____

2. Name of Family doctor: _____

   Address: _____

   Phone: ( )_____

3. Known Allergies (List): _____
   _____
   _____

FOR OFFICE USE ONLY:

1. The Executor of Resident's Will: _____
   Address: _____
   _____

   Phone: ( )_____

2. Signature of Assessor: _____

3. Any Concerns:_____
   _____
   _____
   _____
   _____

The personal information collected on this form will be used for the purpose of determining eligibility for Lodge accommodations and providing benefits under the Lodge program. The information will be protected under the provisions of the Alberta Freedom of Information and Protection of Privacy Act.

If you have any questions about the collection and use of this information, contact the Greater North Foundation FOIP Coordinator at:

4102-50TH STREET Athabasca, Alberta T9S 0A6
Phone: (780) 675-9660

GREATER NORTH FOUNDATION
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MEDICAL ASSESSMENT FORM

(To Be Completed By A Physician)

****

Name of Applicant: _____
Surname Given Names

Sex: ☐ Male ☐ Female **Date of Birth: Year (_____) Month(_____)Day(_____)**

Address: _____
Street/PO Box **Town/City**

_____
Province **Postal Code**

Date of Examination:_____

Physician's Name:_____ **Address:**_____

Phone Number: _____ **How long have you know this patient?___ _____**

DIAGNOSIS:

A. Physical: Please check the following indicating the conditions applicable to the patient.

☐ Alzheimer's ☐ Arthritis ☐Cancer ☐ Cardiovascular Disease
☐ Diabetes ☐ Epilepsy ☐ Kidney Disease ☐ Parkinson's
☐ Respiratory

B. Allergies: (Please Specify) _____
_____
_____

C. Sensory: (Please indicated degree of impairment according to number :)

1. Nil ☐ 2. Mild☐ 3. Moderate ☐ 4. Severe ☐

☐ **Visual** ☐ **Hearing** ☐ **Mental Illness** ☐ **Cognitive Impairment**

D. Tuberculosis:

Date of Mantoux/ Chest X-ray: _____ Results: _____

(Must be within previous (3) Months)

E. Medical Conditions:

(I) _____

(II) _____

(III) _____

F. Physical Examination:

☐ Height: ☐ Weight: ☐ Blood Pressure:

1. Is patient incontinent of urine/feces? ☐Yes ☐No

2. Do you consider this Individual mentally and physically fit for residence in a senior citizen's lodge?
   ☐ Yes ☐ No

_____

PLEASE NOTE: That our units are rented only to senior citizens who are capable of administering to their own needs.

G. Medication: (Please Print)

1. **NAME OF MEDICATION** **DOSAGE** **FREQUENCY** **PURPOSE**

_____

_____

_____

_____

_____

_____

2. Does the prescribed medication interfere with cognitive or physical function in relation to this person's ability to live in a senior lodge? ☐ YES ☐NO

A. If YES, explain: _____

_____

B. Please indicate any serious possible side effects: _____

_____

H. Substance Abuse:

1. Does this person have a substance abuse problem? ☐ YES ☐NO
If YES, describe nature of problem: _____

I. Special Diet: ☐ YES ☐NO

If YES, indicate type:_____

If Diabetic, indicate Caloric intake:_____

J. ACTIVITIES OF DAILY LIVING:

A. Given this person's medical condition, degree of disability and prognosis, what limitations are there in this individuals' level of functioning in daily activities?
Please indicate by checking off **"YES"** or **"NO"**

Personal Hygiene:	☐ YES	☐NO	**Eating:**	☐ YES	☐NO
Dressing:	☐ YES	☐NO	**Toileting:**	☐ YES	☐NO
Bathing:	☐ YES	☐NO	**Mobility:**	☐ YES	☐NO
Social Interaction:	☐ YES	☐NO			

B. Can this person walk unaided, if there are limitations, please indicate, e.g. ***distance***, **walker, cane** etc.
_____

C. **Does this person require oxygen?** ☐ YES ☐NO
If *YES,* do they require it for mobility? ☐ YES ☐NO
Can they manage equipment independently? ☐ YES ☐NO

D. **Does this person wear a hearing aide?** ☐ YES ☐NO

E. **Are there difficulties in verbal communications?**
If *YES*, is this due to:

Deafness/Muteness	☐ YES	☐NO
Cognitive Function	☐ YES	☐NO
Speech Difficulties	☐ YES	☐NO (Please Specify)_____
Language Barrier	☐ YES	☐NO (Please Specify)_____

GENERAL COMMENTS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I, _____ AM A LEAGALLY QUALIFIED MEDICAL PRACTITONER.

THIS REPORT CONTAINS MY FINDINGS AND CONSIDERED OPINION AT THIS TIME.

_____ Phone: (780)_____
Signature

Dated this _____Day of 20___.