Grande Spirit Foundation

9505-102 Ave, Grande Prairie, Alberta, T8V 7G9
Telephone: 532-2905, Fax: 539-3155

SENIOR HOUSING APPLICATION

Applicant

Name: ❑Mr. ❑Mrs. ❑Ms. ❑Miss Last Name:______________________________First Name:_________________

Home Phone: (______)__________________________ Other Phone: (______)__________________________

Birthdate: (dd/mm/yyyy)____________________ SIN #: ______________________________

Health Care #: ______________________________ Blue Cross #: ______________________________

Co-Applicant

Name: ❑Mr. ❑Mrs. ❑Ms. ❑Miss Last Name:______________________________First Name:_________________

Home Phone: (______)__________________________ Other Phone: (______)__________________________

Birthdate: (dd/mm/yyyy)____________________ SIN #: ______________________________

Health Care #: ______________________________ Blue Cross #: ______________________________

Next of Kin / Emergency (Would you like this person to be the first point of contact for this application ❑Yes ❑No)

Name: ______________________________ Relationship: ______________________________

Address: ______________________________ City: ____________________Postal:________

Home ph: (______)______________ Work ph: (______)___________ Cell ph: (______)___________

(Note: Grande Spirit Foundation will share information regarding application with next of kin on file.)

Are you: ❑ Canadian Citizen ❑ Landed Immigrant ❑ Other:________________________

Length of Residence in Alberta: _____________ Length of Residence in Grande Prairie/Community/Area: ____________
Are you applying for:

❑ Lodge (full service) ❑ Enhanced Apartment (meals are available) ❑ Self-Contained Apartment (independent)

Would you accept a bachelor unit: ❑ Yes ❑ No

Do you require a 2-bedroom unit? ❑ Yes ❑ No If yes, why? ____

Preferred Facility 1.________________________ 2.________________________ 3.______________________
Please only submit an application if you will move when offered and only list facilities that you will accept if offered. Refusal of a unit will result in application being placed inactive (with exception of special circumstances)

Are you currently a resident with Grande Spirit Foundation? If Yes where do you live?____________________
Have you resided with Grande Spirit Foundation in the past? If Yes where did you live?___________________
Are you currently receiving a rental subsidy through Grande Spirit Foundation? ❑Yes ❑No

HOUSING INFORMATION:

Mailing Address: ____ Postal Code: __________________

Do you rent or own your present accommodation? ❑ Rent ❑ Own ❑ Live with Family/Friend

If living with family or friends, is the household overcrowded? Is anyone without a bedroom or sharing a bedroom as a result (other than couples or same sex siblings)? ❑Yes ❑No Explain:____

Present Rental or Mortgage payment is $ ___________________ per month.

If renting, name of your present Landlord: ________________________________ Telephone: (______)_____________

Do you pay for: ❑ Heat ❑ Light ❑ Water and Sewer

Present housing unit: ❑ House ❑ Apartment ❑ Rooming House ❑ Hotel/Motel ❑ Other:_____________

Does your accommodation have: ❑ Kitchen ❑ Bathroom ❑ Living Room ❑ Yard ❑ Elevator

Reason for Application: (Please check ALL those that apply)

❑ Unable to prepare meals and / or not eating properly

❑ Services such as meals on wheels/ FCSS (Family community support services) are not available in my community

❑ Unable to participate in social/spiritual/physical/ /cultural activities ❑ These activities not available in my community

❑ Limited Access to services and amenities because: ❑ Can't access public transportation ❑ No DTS in community

❑ Have no license ❑ No family/friend support for transportation ❑ Dr/Medical support is outside my community

❑ Current environment is placing my safety and security at risk:

❑ forgetful with tasks (eg. leaving stove on), ❑ fearful of where I am living, ❑ living in an abusive environment

❑ Require assistance with personal care. (Personal care needs can be met on a regular routine and schedule)

❑ Have unstable, and/or unpredictable personal care needs that can not be managed on a routine or schedule

❑ Noticing a decline in mental capacity to manage day to day activities

❑ Mobility concerns within current accommodations

❑ No family/friends to assist with daily living tasks

❑ There are no other suitable or affordable housing options in my community

❑ Unable to do my own housekeeping ❑ Unable to do minor repairs or maintain home ❑ Unable to do yard work

❑ Accommodation is not accessible or adaptable (eg. stairs or cannot adapt place to meet needs)

❑ Current accommodations require major repairs (eg. structural, electrical or heating defects; fire/health hazards)

❑ Environmental conditions are poor (eg. noise, pollution, allergens, no utility services available, rodents, bed bugs)

❑ Current housing not adequate – overcrowding, dysfunctional, loss of accommodation (not due to eviction)

❑ Eviction (Please provide a copy of the Eviction Notice)

Are you CURRENTLY receiving any of the above services? If Yes which ones?__________________________________

Who is providing them to you?(eg. Family, FCSS Home Support, Private)____________________________________

APPLICANT MEDICAL INFORMATION: Applicant Name: ______________________________

Doctor Name: ______________________________ Phone: ______________________________

How long have you been seeing this doctor?____________ Do you have routine check ups? ❑ Yes ❑ No

When was your last visit to the doctor? ______________ Last annual?______________________

Medical Condition: Is current health stable? ❑Yes ❑No Are there any chronic health conditions? ❑Yes ❑No

Please explain and list medical history and or conditions:______________________________

____

Have you been hospitalized in the past year? ❑Yes ❑No If Yes, List number of times in past year:__________

Cognitive & Behavorial: Is there any evidence of decline in cognition? ❑Yes ❑No

Memory Recall: ❑ Good ❑ Needs some cueing ❑ Severely Impaired

Cognitive Skills for Daily Decision Making: ❑ Good ❑ Needs some cueing ❑ Severely Impaired

❑ Alzheimer's Disease: ❑ Mild ❑ Medium ❑ Severe

❑ Dementia Disease other than Alzheimer's ❑ Mild ❑ Medium ❑ Severe Describe:__________________

Is there any past or present evidence of:

❑ Depression: ❑ Mild ❑ Medium ❑ Severe Describe:______________________________

❑ Anxiety: ❑ Mild ❑ Medium ❑ Severe Describe:______________________________

❑ Mental Illness: ❑ Mild ❑ Medium ❑ Severe Describe______________________________

❑ Learning Disability: ❑ Mild ❑ Medium ❑ Severe Describe______________________________

❑ Tendency to Wander ❑ Resists Care ❑ Smoker

❑ Uncontrolled Aggressive or Violent Behavior: Describe______________________________

❑ Socially Inappropriate/Disruptive Behavior: Describe______________________________

❑ Alcohol or Drug Abuse: Describe:______________________________ ❑ Past ❑ Present

❑ Past or present evidence of an Infectious disease or antibiotic resistance disease. Describe__________________

Any ongoing treatments, medications and or consultations for any of the above issues? Please describe:

____

Communication & Vision:

Hearing: ❑ Normal ❑ Impaired ❑ Absent ❑ Hearing Aid

Vision: ❑ Normal ❑ Good with glasses ❑ Impaired ❑ Absent

❑ Communication difficulty? Due to: ❑ Mental Causes ❑ Deafness ❑ Speech Impediment ❑ Language Barrier

Describe:____

APPLICANT PERSONAL CARE:

Choose one that best describes current situation:
❑ I can manage independently with my personal care
❑ I can manage my personal care with regularly routine and scheduled assistance
❑ I have unstable/ unpredictable care needs that can not be managed on a routine or schedule

❑ Require assistance transferring in/out of bed and/or to the bathroom

❑ Requires a 2-person assist when transferring or mechanical lift

❑ Requires assistance using toilet and or special devices (ostomy/catheter) Describe:______________________________

Bladder Continence: ❑ Continent ❑ Incontinent, but manages independently with devices and or limited assistance
❑ Incontinent, and can't manage devices independently, relies on full assist

Bowel Continence: ❑ Continent ❑ Incontinent, but manages independently with devices and or limited assistance
❑ Incontinent, and can't manage devices independently, relies on full assist

Requires assistance with: ❑ Dressing ❑ Feeding ❑ Bathing ❑ Personal hygiene (combing hair, brushing teeth etc…)

Requires assistance with: ❑ Monitoring Blood Pressure ❑ Foot Care ❑ Other Nursing:_________________________

❑ Will require meal reminders ❑ Will require assistance to and from dining room in lodge

❑ Requires Oxygen: If yes, can manage independently ❑ Yes ❑ No ❑ Epilepsy

❑ Diabetic ❑ Type 1 ❑ Type 2 ❑ Insulin dependent – I can self administer the insulin ❑ Yes ❑ No

❑ Requires Medication Assistance: ❑ Scheduled (at meal times etc) ❑ Unscheduled (when necessary eg. pain meds)

Any concerns with medications?____

Requires: ❑ Lifeline ❑ Personal response system in building (eg Nurse call)
❑ Routine checks (eg. at meal times) ❑ 24 hr Non-medical staff ❑ 24 Registered nurse on call

Is Home Care CURRENTLY providing any of the above services to you? If Yes which ones?___________________
____How often do you currently receive home care?_____________

Mobility: Please rate your mobility:

❑ Excellent - independent with no mobility aids ❑ Good –with minimal help with mobility aids

❑ Good – but dependent on my mobility aid ❑ Use a wheelchair but can transfer in/out ❑ Confined to wheelchair

Check any of the following mobility aids and frequency of use:

❑ Cane ❑ Regularly ❑ Occasionally ❑ White Cane ❑ Regularly ❑ Occasionally

❑ Walker ❑ Regularly ❑ Occasionally

❑ Wheelchair Electric OR Manual (Please circle one) ❑ Regularly ❑ Occasionally

❑ Scooter Indoor OR Outdoor use (Please circle one) ❑ Regularly ❑ Occasionally

Special Diet: ❑ Diabetic ❑ Cut-up Food ❑ Low Cholesterol ❑ Low Fat
❑ Minced Food ❑ Pureed ❑ Gluten Free ❑ Other: _______________________

❑ Medical condition requires a special diet (eg. Celiac, diverticulitis, dairy sensitivity)? Describe:_____________________

Allergies/Intolerances: ❑ Food❑ Medication ❑ Environmental Describe:______________________________________

Any special circumstances that have not been captured on application, please attach explanation on a separate page

CO-APPLICANT MEDICAL INFORMATION: **Co-Applicant Name:** ___________________________________

Doctor Name: ____ Phone: ____

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❑ Walker ❑ Regularly ❑ Occasionally

❑ Wheelchair Electric OR Manual (Please circle one) ❑ Regularly ❑ Occasionally

❑ Scooter Indoor OR Outdoor use (Please circle one) ❑ Regularly ❑ Occasionally

Special Diet: ❑ Diabetic ❑ Cut-up Food ❑ Low Cholesterol ❑ Low Fat

❑ Minced Food ❑ Pureed ❑ Gluten Free ❑ Other: ______________________

❑ Medical condition requires a special diet (eg. Celiac, diverticulitis, dairy sensitivity)? Describe:____________________

Allergies/Intolerances: ❑ Food❑ Medication ❑ Environmental Describe:______________________________________

Any special circumstances that have not been captured on application, please attach explanation on a separate page

FINANCIAL INFORMATION:

****ALL applicants must provide a copy of your most recent tax summary and notice of assessment.**

(If you do not have a copy of your notice of assessment, please contact Canada Revenue Agency on their toll free line 1-800-959-8281)

*****Apartment applicants ONLY: If you receive RRSP income or RIF's please provide a copy of those T-slips in addition to the tax summary and notice of assessment.**

Monthly Income:	**Applicant**	**Co-Applicant**	
Old Age Security (OAS)	______________	______________	
Guaranteed Income Supplement (GIS)	______________	______________	
Alberta Seniors Benefit (ASB)	______________	______________	
Canadian Pension Plan (CPP)	______________	______________	
Spouse Allowance	______________	______________	
Employment Income	______________	______________	
Investment Income	______________	______________	
RRSP or RIF's ***	______________	______________	
Other (Specify)	______________	______________	______________
			Monthly Total OR Combined Total**

Assets: (list description and estimated NET value)

Real Estate: Description: ________________________________ Value: ______________________________

Machinery & Other Description: ________________________________ Value: ______________________________

Vehicles: Description: ________________________________ Value: ______________________________

Do you have an enduring power of attorney appointed to deal with your financial affairs? ❑Yes ❑No

If yes, please list: Name:____________________________Ph #:_______________Relationship:________________________

Is this power of attorney currently in effect (has it been enacted by doctor?) ❑Yes ❑No

Applicant Signature: ____ **Date:** ______________________________

Co-applicant Signature: ____ **Date:** ______________________________

The information on this application is being collected under the authority of M.O. H:091/94 under the Alberta Housing Act. The Grande Spirit Foundation will use this information to verify and assess housing services required by the applicant. The information is protected from public disclosure by sections 38, 40 and 41 of the Freedom of Information and Protection of Privacy Act.

PLEASE NOTE: Any omission of information causing inappropriate placement, will terminate the residency contract/lease immediately.