



Grande Spirit Foundation

9503-102 Ave, Grande Prairie, Alberta, T8V 7G9

Telephone: (780)532-3276, Fax: (780)882-6774

SENIOR HOUSING APPLICATION

Name: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss	Last Name: _____	First Name: _____
Home Phone: (____) _____	Other Phone: (____) _____	
Birthdate: (dd/mm/yyyy) _____	SIN #: _____	
Health Care #: _____	Blue Cross #: _____	

Co-Applicant

Name: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> 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: (____) _____	Cell ph: (____) _____ Email: _____

(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 cannot 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 checkups? 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 & Behavioral: 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 cannot 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 mealtimes 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 mealtimes) 24 hr Non-medical staff 24 Registered nurses 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

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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.**

<u>Monthly Income:</u>	<u>Applicant</u>	<u>Co-Applicant</u>	
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.