



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.

_____	_____	_____
_____	_____	_____
_____	_____	_____
<b>TOTAL INCOME</b>	_____	_____

**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: \_\_\_\_\_

**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: \_\_\_\_\_

2-NAME: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ Postal Code \_\_\_\_\_

PHYSICAL ADDRESS: \_\_\_\_\_

PHONE: (HOME) \_\_\_\_\_ (BUSINESS) \_\_\_\_\_

RELATIONSHIP TO APPLICANT: \_\_\_\_\_

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 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