

Applicant Name: _____

Date Application received: _____



SENIORS SELF-CONTAINED APARTMENTS APPLICATION

660 - 28 Street

P.O. Box 790

Fort Macleod, AB T0L 0Z0

Phone: 403-553-3662

Fax: 403-557-5258

This application *CANNOT* be processed unless *ALL* questions are fully answered.

All Seniors Self-contained Apartments offer a smoke-free environment.

Please indicate which community you are applying for:

<input type="checkbox"/> Fort Macleod	<input type="checkbox"/> Granum
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It is important to pay close attention to the following portions of your application form:

- Include a copy of your Income Tax Assessment with your full name and showing Line 15 000 for the immediately preceding taxation year
- Medical form completed by your family physician (included as page 7 and 8 in this application package)

All information is being collected for the purpose of the application process. All information collected for this purpose will be kept confidential as per the Freedom of Information and Protection of Privacy Act.

Applicant's Last Name		Applicant's First Name	Date of Birth
Co-Applicant's Last Name		Co-Applicant's First Name	Date of Birth
Street/P.O Box	City	Province	Postal Code
Email Address		Home phone	Cell phone
Are all applicants Canadian Citizen or Permanent Residents? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If NO, provide copies of immigration papers for members who are not Canadian Citizens or Permanent Residents.			

Next of Kin (Emergency Contact)

Last Name	First Name	Relationship
Email Address		Phone #

Do you have a will? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Executor's Name	Phone Number

Do you own or rent your present accommodations? <input type="checkbox"/> Own <input type="checkbox"/> Rent			
Present Accommodation: <input type="checkbox"/> House <input type="checkbox"/> Townhouse <input type="checkbox"/> Apartment <input type="checkbox"/> Roaming House <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> Other:			
Rent/House Payment \$	Heat \$	Electricity \$	Water/Sewer \$
Rooms in Your Present Accommodation: <input type="checkbox"/> Kitchen <input type="checkbox"/> Living Room <input type="checkbox"/> Dining Room		# of Bathrooms	# of Bedrooms
Present Landlord's Name			Phone Number
Previous Landlord's Name (if applicable)			Phone Number
May we contact your present/previous landlord(s) for reference? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Do you share your accommodations with any person(s) other than listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If YES, how many other person(s)? # of Adults: # of Children:	
What part of the accommodations is shared?	
If you do not pay rent, do you contribute financially? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If YES, please specify:	
Have you ever been a recipient of subsidized housing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If YES, when?	If YES, where?
Have you ever been asked to vacate your premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If YES, when?	If YES, why?
Are any of the applicants disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If YES, please specify:	
Do you require an accessible unit? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you currently use any of the following? <input type="checkbox"/> Electric wheelchair <input type="checkbox"/> Wheelchair <input type="checkbox"/> Scooter	

Do you require a parking stall? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Colour	Year	Make	Model

Sources of Monthly Income. Please check ALL that apply.

Important! Please enclose a copy of your most recent income tax **Notice of Assessment** showing line 15 000.

Source of Monthly Income	Applicant	Co-Applicant
Social Assistance	<input type="checkbox"/>	<input type="checkbox"/>
Assured Income for the Severely Handicapped (AISH)	<input type="checkbox"/>	<input type="checkbox"/>
Department of Veteran Affairs	<input type="checkbox"/>	<input type="checkbox"/>
Old Age Security	<input type="checkbox"/>	<input type="checkbox"/>
Canada Pension	<input type="checkbox"/>	<input type="checkbox"/>
Guaranteed Income Supplement	<input type="checkbox"/>	<input type="checkbox"/>
Alberta Income Supplement	<input type="checkbox"/>	<input type="checkbox"/>
Company or Group Pension	<input type="checkbox"/>	<input type="checkbox"/>
Self-employed Income	<input type="checkbox"/>	<input type="checkbox"/>
Employment Income	<input type="checkbox"/>	<input type="checkbox"/>
Other Income (specify)	<input type="checkbox"/>	<input type="checkbox"/>
Carbon Tax Rebate	<input type="checkbox"/>	<input type="checkbox"/>

If you receive employment income, please provide contact information for your employer(s)

Employer	Contact Number
Employer	Contact Number
Employer	Contact Number
May we contact your present/previous employers for reference? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please describe your current situation. What are your reasons for wanting to move?

Note: If you have been given a "NOTICE TO VACATE" please submit a copy of the notice stating the reason for eviction.

Colonel Macleod Manors & Chinook Arch Manor

MEDICAL REPORT

I, _____, hereby authorize my physician to release the medical information on this form to the Willow Creek Foundation.

Applicant Signature

Co-Applicant Signature

This section to be filled out by Primary Care Physician

Name of Applicant: _____ Birth Date: _____

Name of Co-Applicant: _____ Birth Date: _____

Name of Physician: _____ Physician phone #: _____

How long has applicant been your patient? _____

Mobility: <input type="checkbox"/> Walks without assistance <input type="checkbox"/> With Assistance <input type="checkbox"/> Wheelchair		
Applicant can prepare their own meals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Applicant can do his/her own laundry?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Applicant can manage his/her own hygiene?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any concerns with hearing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does applicant require homecare?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has a referral been made to homecare?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does applicant have any serious medical conditions that we should be aware of?	Please explain:	

Does applicant show any signs of dementia? If yes, explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does applicant have a history of alcohol or substance abuse? If yes, explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has applicant been diagnosed with any deteriorating physical or mental health condition that may impair his/her ability to manage independently at present or in near future? If yes, explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you consider applicant to be suitable mentally and physically to look after him/herself in a self-contained apartment building where no special care, nursing care or monitored diets are available? If no, explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Additional Comments:

Date

Physicians signature

This medical report is valid for six (6) months only. Applicant is responsible for notifying the Willow Creek Foundation if his/her circumstances change, effecting health and the validity of this application.

Applicants Acknowledgement

I understand that this is an application for accommodation and not an agreement on the part of the Willow Creek Foundation to provide me with rental accommodation.

I further acknowledge the right of the Willow Creek Foundation, at any time prior to the execution and delivery to me of a lease, to withdraw, or cancel without penalty or liability for damages or otherwise, any prior approval of this application.

I authorize the Willow Creek Foundation to investigate all the statements made in this application, being aware that discovery of any false statement may cancel any further consideration of this application.

I further agree that I am obligated to advise the Willow Creek Foundation, in writing, of any changes in family composition, gross family composition, gross family income, assets, employment or change of address should occur.

I understand that this information is being collected under the authority of the Freedom of Information and Protection of Privacy ACT (32-C) as is required for the purpose of administering a housing program. Any questions or concerns regarding the use and/or handling of my personal information should be directed to the FOIP Coordinator at the Willow Creek Foundation.

That I/we have resided in the Province of Alberta ____ years of my/our life/lives and in the MD of Willow Creek for ____ years.

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.

Applicant Signature

Witness Signature

Co-Applicant Signature

Witness Printed Name

Application Date (DD/MM/YYYY)
(Application to expire 12 months from this date)