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:

☐ **Fort Macleod** ☐ **Granum**

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? ☐ Yes ☐ 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? ☐ Yes ☐ No	
Executor's Name	Phone Number

Do you own or rent your present accommodations? ☐ Own ☐ Rent			
Present Accommodation: ☐ House ☐ Townhouse ☐ Apartment ☐ Roaming House ☐ Hotel/Motel ☐ Other:			
Rent/House Payment $	Heat $	Electricity $	Water/Sewer $
Rooms in Your Present Accommodation: ☐ Kitchen ☐ Living Room ☐ 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? ☐ Yes ☐ No			

Do you share your accommodations with any person(s) other than listed above? ☐Yes☐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? ☐Yes ☐No	
If YES, please specify:	
Have you ever been a recipient of subsidized housing? ☐Yes ☐No	
If YES, when?	If YES, where?
Have you ever been asked to vacate your premises? ☐Yes☐No	
If YES, when?	If YES, why?
Are any of the applicants disabled? ☐Yes ☐No	
If YES, please specify:	
Do you require an accessible unit? ☐Yes ☐No	
Do you currently use any of the following? ☐Electric wheelchair ☐Wheelchair ☐Scooter	

Do you require a parking stall? ☐Yes ☐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	☐	☐
Assured Income for the Severely Handicapped (AISH)	☐	☐
Department of Veteran Affairs	☐	☐
Old Age Security	☐	☐
Canada Pension	☐	☐
Guaranteed Income Supplement	☐	☐
Alberta Income Supplement	☐	☐
Company or Group Pension	☐	☐
Self-employed Income	☐	☐
Employment Income	☐	☐
Other Income (specify)	☐	☐
Carbon Tax Rebate	☐	☐

What is the source of your highest income: _____

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? ☐Yes ☐No	

Please describe your current situation. What are your reasons for wanting to move (for example: are you fleeing abuse, at risk of homelessness, feeling lonely or unsafe in your current situation, etc)?

_____

_____

_____

_____

_____

_____

_____

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

Do you belong to any of these groups (check all that apply):

☐ Indigenous peoples

☐ People with disabilities

☐ Women & children fleeing violence

☐ People at risk of homelessness or transitioning out of homelessness supports

☐ People dealing with mental health and addiction

☐ Youth exiting government care

☐ Veterans

☐ Recent Immigrants & Refugees

☐ Racialized groups

☐ LGBQ2S+ people

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: ☐ Walks without assistance ☐ With Assistance ☐ Wheelchair		
Applicant can prepare their own meals?	☐ Yes	☐ No
Applicant can do his/her own laundry?	☐ Yes	☐ No
Applicant can manage his/her own hygiene?	☐ Yes	☐ No
Any concerns with hearing?	☐ Yes	☐ No
Does applicant require homecare?	☐ Yes	☐ No
Has a referral been made to homecare?	☐ Yes	☐ 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:	☐ Yes	☐ No
Does applicant have a history of alcohol or substance abuse? If yes, explain:	☐ Yes	☐ 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:	☐ Yes	☐ 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:	☐ Yes	☐ 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)

RESET SUBMIT