



APPLICATION FOR ACCOMMODATION
(CONFIDENTIAL WHEN COMPLETED)

Self-Contained Accommodation for Seniors

Jubilee Manor is a self-contained facility built in 1976 and contains 16 apartments. Golden Crest Manor was built in 1981 and has 32 apartments. Both Jubilee Manor and Golden Crest Manor are connected to the Hillcrest and Klondike Place lodges by pedways.

Pembina Court was built in 1986 and has 24 self-contained apartments.

All three of these buildings are located within the Town of Barrhead.

We also have a self-contained complex located in Fort Assiniboine. Roach Park Manor contains 6 apartments.

Seniors who wish to reside in one of our facilities must complete an application form and are then placed on a waiting list. Each facility has its own separate waiting list, prioritized based on provincial point scoring standards.

Please check which accommodation applies to you:

**SELF-
CONTAINED**

Golden Crest Manor

Jubilee Manor

Pembina Court

JDR Manor (Fort Assiniboine)

ASSESSMENT OF RISK AND INDEPENDENCE

Applicants are point-scored according to the Provincial Point-Scoring Guidelines. Please contact your physician for a medical assessment. It **must** be completed by your physician and returned with the application.

PLEASE READ CAREFULLY

I understand that this application does not constitute an agreement on the part of BARRHEAD & DISTRICT SOCIAL HOUSING ASSOCIATION to provide me with rental accommodation.

I further acknowledge the right of BARRHEAD & DISTRICT SOCIAL HOUSING ASSOCIATION, or its agents, at any time prior to the execution and delivery to me of a lease hereby applied for, to withdraw, revoke, or cancel, without penalty or liability for damages or otherwise, any acceptance or approval of this application previously made or given.

I hereby authorize BARRHEAD & DISTRICT SOCIAL HOUSING ASSOCIATION, or its agents, to investigate any or all of the statements made herein, being fully aware that discovery of any false statements shall cancel any further consideration of my application.

I further agree that I am obligated to advise BARRHEAD & DISTRICT SOCIAL HOUSING ASSOCIATION, or its agents, in writing, of any changes in family composition, gross family income, assets, employment or change of address, should they occur.

I ALSO AGREE THAT THE INFORMATION PROVIDED BY ME PERTAINS TO ALL PERSONS NAMED WITHIN THIS APPLICATION.

APPLICANT

WITNESS

PLEASE ANSWER ALL QUESTIONS

1. Applicant's Name: _____
(Last) (First)
Date of Birth: _____
Telephone: _____
Alberta Health Care No. _____

2. Spouse's Name: _____
(Last) (First)
Date of Birth: _____
Telephone: _____
Alberta Health Care No. _____

3. Are you a Canadian Citizen? _____
Permanent Resident? _____
Other Status? _____

4. Current living situation
____ Own
____ Rent
____ Staying with friends/family
____ Living in shelter
____ Living in hotel
____ Living in vehicle
____ Living in holiday trailer/RV
____ Living in institution or hospital
____ Other

5. Current Address: _____
(PO Box/Apartment No./Street)

(City/Town/Village) (Province) (Postal Code)

Current rent or mortgage payment is \$ _____ per month.

Do you pay utilities? Yes _____ No _____

6. If renting, please name your present landlord: _____
And type of unit: _____

7. Number of person(s) sharing your present accommodation:

8. Adults _____ Children _____

9. Reasons for moving: _____

If you have been given an eviction notice, please provide a copy of the notice.

10. Emergency Contact #1:

Name _____

Phone# (H/Cell) _____ (W) _____

Address _____

Emergency Contact #2:

Name _____

Phone#(H/Cell) _____ (W) _____

Address _____

11. If you are on Social Assistance, please state the name and office of your Social Worker:

Name _____ Tel. No. _____

Address _____

12. **Total from line 15000 of most recent Notice of Assessment: _____**
(Please provide a copy of the NOA - PLEASE NOTE: We cannot process your application without this information.)

13. Do you receive the Alberta Seniors Benefit? Yes ___ No ___

If so, how much do you receive? Yearly \$ _____ Monthly \$ _____

NOTE: All income must be verified upon acceptance as a resident

14. Do you cook your own meals? Yes _____ No _____
15. Do you receive help with meals (meals on wheels, food delivery services, family help, etc.)? Yes _____ No _____

16. Do you drive? Yes _____ No _____

If NO, please state your mode of transportation:

17. Do you manage your own personal hygiene? _____ Yes ____ No _____

If NO, who assists you with managing it?

18. Please give details regarding your mobility:

19. Do you have available family or community support? Yes ____ No _____

20. Are you able to manage and maintain your current accommodation? (e.g., housekeeping, yard work, minor repairs)? Yes _____ No _____

21. Do you have a pet? Yes _____ No _____

If YES, what kind(s) and how many of each? _____

22. Please state any physical disabilities you may have:

Family Doctor's Name: _____

Address: _____ Tel No. _____

23. Please check off any of the following population groups that apply to any members of your household (**optional**):

Indigenous peoples	<input type="checkbox"/>
People with disabilities	<input type="checkbox"/>
Individual fleeing violence or leaving second stage shelter*	<input type="checkbox"/>
At risk of, or transitioning out of homelessness*	<input type="checkbox"/>
People dealing with mental health or recovering from addiction*	<input type="checkbox"/>
Youth exiting government care	<input type="checkbox"/>
Veteran	<input type="checkbox"/>
Recent Immigrant or Refugee (in Canada less than 5 years)	<input type="checkbox"/>
Racialized group	<input type="checkbox"/>
Identify with diverse concepts of gender identity and expression or sexual orientation	<input type="checkbox"/>
<i>*Please contact our resident services team if you check this category as supporting documentation may be required.</i>	

24. Other information you wish to provide (if any):

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, 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)

at the _____ of _____)

in the Province of Alberta.)

this _____ day of _____, 20____)

Signature of Applicant

Commissioner for Oaths in and for the
Province of Alberta

The personal information in this form is being collected by Barrhead & District Social Housing Association under section 4(c) of the Protection of Privacy Act and is used for the purpose of administering applications for subsidized house or rental benefits. If you have any questions regarding the collection of this information, please contact Tyler Batdorf, Chief Administrative Officer, 780-674-2787, by email at tbatdorf@bdsha.org or by mail at 4321 52 Avenue, Barrhead AB T7N 1M6

The Following Pages Must Be Completed for Each Applicant.



Applicant's Name: _____

Gender: Male _____ Female _____

Marital Status:

- _____ Single
- _____ Married
- _____ Widowed
- _____ Divorced/Separated

Meals:

- _____ By Self
- _____ With Assist
- _____ Total Assist

Monthly Income:

- _____ \$1500+
- _____ \$1200 - \$1499
- _____ \$900-\$1199
- _____ <\$899

Telephone Use:

- _____ By Self
- _____ With Assist
- _____ Total Assist

Living Arrangements:

- _____ Lives Alone
- _____ With Spouse Only
- _____ With Spouse and Others
- _____ With Other Family
- _____ With Others

Mobility Devices:

- _____ Cane
- _____ Walker
- _____ Wheelchair
- _____ Motorized Wheelchair

Type of Residence:

- _____ House/Apartment
- _____ Housing
- _____ Housing With Supports
- _____ Assisted Living, Group
- _____ No Fixed Address

Self-Rated Health:

- _____ Good
- _____ Fair
- _____ Poor

Level of Activity:

- _____ 2-3 Times/Week
- _____ No Regular Activity

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TO BE COMPLETED BY PHYSICIAN

Return to: Barrhead and District Social Housing Association, 4321-52 Ave, Barrhead, AB T7N 1M6. Phone: (780) 674-2787 Fax: (780) 670-0417. Email: zoie@bdsha.org

Dr: _____

Date Completed: ___/___/___

Label/Addressograph (include Name, PHN, DOB)

Name:
Address:
Phone:
PHN:
DOB:

Caregiver Support:

- ___ Stable, Avail
- ___ Stable, Limited
- ___ Unstable, Avail
- ___ Unstable, Limited
- ___ Short Term, Occasional
- ___ No Significant

Hospital Within Last 12 Months:

- ___ No Visits
- ___ Once
- ___ Twice
- ___ More Than 2x

Hospital Total Days:

- ___ No Days
- ___ 1-7Days
- ___ 8-14Days
- ___ 15+ Days

IADL Medications:

- ___ Other _____
- ___ By Self
- ___ With Assist
- ___ Total Assist

ADL Dressing:

- ___ By Self
- ___ With Assist
- ___ Total Assist

Mental Status:

- ___ Symptoms of Depression
- ___ Hx Major Mental Illness
- ___ MMSE 26-30
- ___ MMSE 21-25
- ___ MMSE 16-20
- ___ MMSE 15 or less
- ___ Acquired Brain Injury/Dev. Disability
- ___ Palliative

IADL Transportation:

- ___ By Self
- ___ With Assist
- ___ Total Assist

ADL Bathing:

- ___ By Self
- ___ With Assist
- ___ Total Assist

ADL Eating:

- ___ By Self
- ___ With Assist
- ___ Total Assist

ADL Urinary:

- ___ By Self
- ___ With Assist
- ___ Total Assist
- ___ Bladder Protection
- ___ Urinary Catheter

Diet:

- ___ Diabetic
- ___ Low Sodium
- ___ High Protein
- ___ Low Protein
- ___ High Carbohydrate
- ___ Low Carbohydrate
- ___ Low Fat
- ___ Gluten Free

Medications:

- ___ Diabetic
- ___ Diet Controlled
- ___ Oral Med
- ___ Insulin
- ___ Cardiac
- ___ HBP
- ___ Diuretic
- ___ Epilepsy
- ___ Depression

Primary/Secondary

- ___ Cardiac
- ___ CHF
- ___ COPD
- ___ Diabetic
- ___ Epileptic
- ___ Parkinson's
- ___ Tuberculosis
- ___ Hepatitis
- ___ Renal Failure
- ___ HIV/STIs

ADL Transfers:
 By Self
 With Assist
 Total Assist

ADL Bowel:
 By Self
 With Assist
 Total Assist
 Colostomy

Primary/Secondary ...cont.
 Stroke
 Ischemic
 TIA
 Hemorrhagic
 Ca
 Stage

OTHER:
 Pacemaker
 Defibrillator
 DNR Order
 Green Sleeve

Uses and Abuses:
 ETOH use
 ETOH known abuse
 Nicotine
 Medicinal Marijuana
 Drug abuse – pharmaceutical, illicit, holistic
Explain: _____

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- ___ Diuretic
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- ___ CHF
- ___ COPD
- ___ Diabetic
- ___ Epileptic
- ___ Parkinson's
- ___ Tuberculosis
- ___ Hepatitis
- ___ Renal Failure
- ___ HIV/STIs

ADL Transfers:
____ By Self
____ With Assist
____ Total Assist

ADL Bowel:
____ By Self
____ With Assist
____ Total Assist
____ Colostomy

Primary/Secondary ...cont.
____ Stroke
____ Ischemic
____ TIA
____ Hemorrhagic
____ Ca
____ Stage

OTHER:
____ Pacemaker
____ Defibrillator
____ DNR Order
____ Green Sleeve

Uses and Abuses:
____ ETOH use
____ ETOH known abuse
____ Nicotine
____ Medicinal Marijuana
____ Drug abuse – pharmaceutical, illicit, holistic
Explain: _____

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