SUPPORTIVE LIVING HOUSING APPLICATION

833-9 Street SW, High River, AB, T1V 1C3
P: 403-652-8600
F: 403-652-8608
E: admin@westwindscommunities.ca

DATE:

To complete this document please include:

- ☐ Current Year Notice of Assessment
- ☐ Personal Alberta Health Care Card
- ☐ **Medical Form - To be Completed by Family Physician**

Please check which Communities you wish to live in (check all that apply):	**Community:**		**Preference** (rate 1-3):
	☐ **High Country Lodge – Diamond Valley**		
	☐ **Sandstone Lodge - Okotoks**		
	☐ **Medicine Tree Manor – High River**		
	☐ **First Available Community**		
Our supportive living properties do allow pets in a percentage of our units per building, a pet deposit will be required.			
Suite Preference (select all that apply):	☐ **Studio (small)** ☐ **Studio (large)** ☐ **Barrier free**	☐ **1 bedroom (no kitchenette)** ☐ **1 bedroom (kitchenette)** ☐ **1 bedroom with kitchen** ☐ **2 bedroom with kitchen**	
Applicant:	**Last Name:**	**Given Name:**	
Street Address:	(Municipal Address-Unit Number, Street, Avenue, Postal Code)		
Mailing Address:	(Mailing Address & postal code, if different from above)		
Home Telephone:		**Cellular Telephone:**	
Date of Birth: (mm/dd/yr)		**Email Address:**	
Do you receive Alberta Seniors Cash Benefit?	☐ Yes ☐ No	**Marital Status:**	☐ Married ☐ Single ☐ Widow/er
Is there a co- applicant? (Please complete separate application)	☐ Yes ☐ No	**If Yes; Provide Co-Applicants Name:**	
		Do you require a connected room?	☐ Yes ☐ No
Years of Residency in the Municipal District of Foothills #31 Region:			
Years of Residency in Alberta:			
Are you a Canadian Citizen? **If no, provide copies of immigration papers**			☐ Yes ☐ No

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Current Housing:

I currently:	☐ Live Alone	☐ Live with Others			
My Home:	☐ Meets my needs	☐ Does not meet my needs and is a hardship for me			
Comments:					
Special Hobbies and Interests:			**Languages Spoken:**		
I currently receive Home Care Services:	☐ Yes ☐ No	**If Yes, what services:**	☐ Medication assistance ☐ Bathing assistance ☐ Housekeeping	☐ Dressing assistance ☐ Wound dressing ☐ :_____	

Self-Management:

Level of Mobility (check all that apply):	☐ Unaided	☐ Cane	☐ Scooter	☐ Walker	☐ Wheelchair
Personal Care and Hygiene (i.e. dressing, bathing):	☐ Without Assistance		☐ Require Assistance		
Comments:					
Medication	☐ Able to manage on own		☐ Difficulty remembering to take properly		
Comments:					
Nutrition:	☐ Feel needs are being met		☐ Feel needs are not being met		
Household Activities: (are you able to do unassisted)	☐ Shopping	☐ Laundry	☐ Meal Preparation	☐ Housekeeping	
Comments:					
Social and Community	☐ Prefer to be by myself most of the time		☐ Currently participate in outside activities and events		
Comments:					

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Physician:

Last Name:		**First Name:**	
Address:		**Telephone Number:**	
Town / City:		**Postal Code:**	
Date of last Physical:		**Length of Time as family physician:**	

Additional Contact: (Person to be notified in case of emergency and that you authorize to have access to your personal, financial and medical information)

Contact:	**Last Name:**	**Given Name:**	
Relationship:		**Email Address:**	
Street Address:	(Municipal Address-Unit Number, Street, Avenue, Postal Code)		
Mailing Address:	(Mailing Address & postal code, if different from above)		
Home Telephone:		**Cellular Phone:**	
Do you authorize Westwinds Communities to contact this person when a room is offered?			☐ Yes ☐ No
CONSENT TO RECEIVE EMAILS AND NOTIFICATIONS Do you consent to communicating via email with Westwinds Communities regarding your application and supporting documents? All correspondence via email and any personal information will be kept strictly confidential.			☐ Yes ☐ No

Other Information:

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Declaration:

I / We		, of the	

Of _____ In the Province of Alberta, to solemnly declare as follows:

1. That I/We am/are the applicant(s) named in the said application;
2. The I/We have resided in the Province of Alberta _____ years of my/our life / lives and in the District for _____ Years;
3. I/We understand that this application does not constitute an agreement on the part of Westwinds Communities, or its agents, to provide me with accommodation;
4. I/We further agree that I/We am/are obligated to advise Westwinds Communities, or its agents, in writing, or any changes in family composition, gross family income, assets, employment or change of address, should they occur; and
5. Pursuant to the Freedom of Information and Protection of Privacy Act, I/We give Westwinds Communities my/our consent to make inquiries that are necessary to verify the information given in this application including conducting a credit check, and I/we authorize any person, corporation or social agency to release to Westwinds Communities any information pertinent to the assessment of my/our application being fully aware that discovery of any false statements shall cancel any further consideration of my/our application.

And I/We 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".

Signature of Applicant	Signature of Applicant	Guardian

Declared before me at the		of		In the Province of Alberta	
This		Day of		Year, 20	

My Appointment expires on (Month/Day/Year)):	
Printed Name of Commissioner for Oaths:	
Signature *(A Commissioner of Oaths in the Province of Alberta):*	

It is incumbent upon the applicant to notify Westwinds Communities of any changes in information provided in this application.

Application for Seniors Lodge - Medical Report

(TO BE COMPLETED BY FAMILY PHYSICIAN)

Please return completed form to:

Westwinds Communities, 833-9 Street SW, High River, AB T1V 1C3
P: 403-652-8600 F:403-652-8608 E: admin@westwindscommunities.ca

Applicant:	Last Name:	Given Name:	
Date of Birth: (MM/DD/YY)		Alberta Health Care Number:	
Date of Last Examination:		Last Annual Physical:	

Physicians Name:(printed)			
Address:	Street/Box	Town/City	Postal Code
Office Phone:		Date of Examination:	
Hospital Affiliation:		Physician's Signature:	

Authorization For Release Of Medical Information

I hereby authorize the release of information requested by Westwinds Communities and waive any and al claims against the person or organization releasing the report, or any of its of officers, servants, agents, staf members or employees for any purpose whatsoever in connection with the communication and disclosure of the said information.

I understand that this personal information is being collected in accordance with the Freedom of Information and Protection of Privacy Act (FOIPP), and I consent to the said collection. For questions about the collection and use of your personal information, contact the FOIPP Coordinator at Westwinds Communities at 403.652.8600.

Applicants Signature:		**Date:**	
Witness:		**Date:**	

Is the Applicant's current health stable?	☐ Yes ☐ No
Has the Applicant had serious medical issues within the past year?	☐ Yes ☐ No
If "yes" please provide details and current management:	

Does the Applicant Have:	Yes	No	Applicant ability to manage without assistance:
Pacemaker			
Colostomy Bag			
Oxygen			
Ileostomy Bag			
Artificial Limb			
Other Aids to Daily Living (specify)			

Hearing	☐ Normal ☐ Impaired ☐ Absent ☐ Hearing Aid	
Visual	☐ Normal ☐ Impaired ☐ Absent ☐ Good with Glasses	
Mobility	☐ Excellent – no mobility aid ☐ Good – but dependent on mobility aid ☐ Confined to a wheelchair	☐ Good – minimal help with mobility aid ☐ Uses a wheelchair and can transfer in/out
	Check any of the following mobility aids and frequency of use:	
	☐ Cane ☐ Regular ☐ Occasionally	☐ Walker ☐ Regular ☐ Occasionally
	☐ Wheelchair ☐ Electric or ☐ Manual ☐ Regular ☐ Occasionally	
	☐ Scooter ☐ Electric or ☐ Manual ☐ Regular ☐ Occasionally	
Special Diet	☐ Diabetic ☐ Cut-up Food ☐ Low Cholesterol ☐ Gluten Free	
	☐ Low Fat ☐ Minced Food ☐ Pureed ☐ Other:	
Allergies	☐ Food ☐ Medication ☐ Environment Describe:	

Westwinds Communities

Application for Seniors Lodge - Medical Report

Does the Applicant have any of the following disorders/conditions?

Condition	Current		If "yes" please provide particulars (please attach addition informal if required)
	Yes	No	
Heart Disease			
High Blood Pressure			
Stroke			
Diabetes			
Arthritis			
Epilepsy			If yes, ☐ Mild ☐ Moderate ☐ Severe
Renal Failure			If yes, ☐ Mild ☐ Moderate ☐ Severe
Incontinence (bladder)			If yes, ☐ Mild ☐ Moderate ☐ Severe
Incontinence (bowel)			If yes, ☐ Mild ☐ Moderate ☐ Severe
Respiratory Deficiencies			
Parkinson's Disease			If yes, ☐ Mild ☐ Moderate ☐ Severe
Cognitive Impairment			If yes, ☐ Mild ☐ Moderate ☐ Severe
Alzheimer's Disease			If yes, ☐ Mild ☐ Moderate ☐ Severe
Wandering			
Mental Illness			
Uncontrolled, Aggressive or Violent Behaviour			
Socially inappropriate or Disruptive behaviour			
Depression			
Alcohol or Drug Abuse			If yes, ☐ Past ☐ Present Details:
Infectious Diseases			If yes, Type:
Smoking			
Tuberculosis			
Nutritional Deficiencies			
Communication Difficulty?			Due to: ☐Mental Causes ☐Deafness ☐ Speech Impediment ☐Language Barrier Details:

Westwinds Communities provides meals, Housekeeping Services and 24 Hour Non-Medical Supervision. Given this information is your patient, without assistance, able to:

	Yes	**No**	**Comments**
Administer own medications			
Physically manage care including dressing			
Maintain appropriate level of personal hygiene			
Is the Applicant able to independently ambulate to and from the dining room in the lodge setting?			
Live in a lodge setting without assistance such as reminders and prompting			
Socially fit in and interact with other seniors			
Does the Applicant require Home Care Services?			
Is there any other support agency involved?			

Any special concerns that have not been captured on the medical form, please attach explanation on a separate page.