APPLICATION FOR LODGE ACCOMMODATION
GOLDEN HILLS LODGE
Box 337, 814 1st Street North, Three Hills Alberta T0M 2A0
Telephone: 403-443-5333 Fax: 403-443-5271 Email:
lodgemanager@kneehillhousing.com

PART 1: APPLICANT INFORMATION

NAME:____
Surname First Middle

STREET ADDRESS:____

MAILING ADDRESS:____
[if different than above]

TELEPHONE #: HOME: ____________________CELL: ______________________

DATE OF BIRTH:_____________________ MARITAL STATUS______________

SIN #___________________________________

ALBERTA PERSONAL HEALTH #____________________________________

DOCTOR'S NAME:_________________________TELEPHONE:______________

HOME CARE CLIENT: **YES / NO** (PLEASE CIRCLE)

YEARS OF RESIDENCE AT PRESENT ADDRESS_________________________

DO YOU HAVE FAMILY RESIDING IN KNEEHILL COUNTY: **YES / NO** (PLEASE CIRCLE)

ARE YOU A CANADIAN CITIZEN? _______IF NO, EXPLAIN__________________

DO YOU RECEIVE THE ALBERTA SENIOR'S BENEFIT? **YES / NO** (PLEASE CIRCLE)

DO YOU REQUIRE A PARKING STALL? **YES / NO** ($15.00 Monthly Charge)

DO YOU REQUIRE PERSONAL LAUNDRY SERVICES? **YES / NO** ($50.00 Monthly Charge)

APPLICANTS ARE REQUIRED TO SUPPLY KNEEHILL HOUSING CORPORATION WITH A COPY OF THEIR MOST RECENT NOTICE OF ASSESSMENT FROM THE CANADA REVENUE AGENCY. PLEASE SPECIFY AMOUNT STATED ON LINE **150** OF YOUR MOST RECENT NOTICE OF ASSESSMENT: $________________________

ARE YOU A SMOKER? **YES / NO** (PLEASE CIRCLE)

DO YOU HAVE ANY FOOD RELATED ALLERGIES OR ANY SPECIAL DIETARY REQUIREMENTS?
Y / N (PLEASE CIRCLE)

If "YES" PLEASE PROVIDE
DETAILS:____
____

PLEASE CHECK ANY/ALL OF THE FOLLOWING HEALTH CONCERNS THAT APPLY TO YOU:

- ☐ Incontinence
- ☐ Alcohol or other substance abuse
- ☐ Oxygen Therapy Required
- ☐ Hearing
- ☐ Vision
- ☐ Seizures
- ☐ Other:
  ____
  ____
- ☐ Depression/Mental Health Issues
- ☐ Cardiac/respiratory
- ☐ Allergies
- ☐ Diabetes
- ☐ Mobility-use of cane
- ☐ Mobility-use of walker
- ☐ Dementia/Wandering Behavior

REASON FOR LODGE APPLICATION:
Please check all that apply:

- ☐ Palliative Care Support Required
- ☐ Difficulty maintaining current accommodation
- ☐ Current housing not adequate
- ☐ Moving for family support
- ☐ No affordable housing in current community
- ☐ Cannot easily access transportation/community services
- ☐ Difficulty preparing meals or not eating properly
- ☐ Does not have assistance from family and/or community services
- ☐ Not able to participate in activities that meet your recreational preferences
- ☐ In current environment you are at risk for injury, abuse or emergency situation(i.e. falls):
  ____
- ☐ Require Lodge environment because of physical or mental health concerns (please provide details):____
- ☐ Eviction: Reason: ____
- ☐ Other: ____

SPECIAL HOBBIES OR INTERESTS____

____

PART 2: EMERGENCY INFORMATION

NEXT OF KIN AND/OR EMERGENCY CONTACT

NAME:____ PHONE:__________________________

ADDRESS:____CELL#:_______________________

RELATIONSHIP:____________________________ EMAIL:________________________________

NAME:____ PHONE:__________________________

ADDRESS:____CELL#:_______________________

RELATIONSHIP:____________________________ EMAIL:________________________________

DO YOU HAVE A PERSONAL DIRECTIVE? **YES / NO** (PLEASE CIRCLE)
IF YES, WHO IS YOUR AGENT? ____

PHONE # OF NAMED AGENT ____

TRUSTEE/GUARDIAN/POWER OF ATTORNEY (IF APPLICABLE)
NAME:______________________________________PHONE #__________________
TRUSTEE _______ GUARDIAN _______ POWER OF ATTORNEY _________

EXECUTOR OF WILL
NAME: _______________________________ PHONE #__________________
LOCATION OF WILL ____

PART 3: CERTIFICATION
I CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS CORRECT:

____
(SIGNATURE OF APPLICANT) (DATE)

Note: Information requested is required for the purpose of determining eligibility and suitability of applicants for residency in the Kneehill Housing Lodge Program.

A current and acceptable Medical Examination Report fully completed by a physician will be required **BEFORE** applicants can be considered for residency.

I hereby understand and agree that special care or supervision is not provided by Kneehill Housing Corporation and should I require a higher level of care or supervision I will be willing to find alternate and more appropriate accommodation as soon as possible.

KNEEHILL HOUSING CORPORATION

BOX 370, THREE HILLS, AB T0M 2A0

Phone: (403) 443-5216 Fax: (403) 443-5271

HEALTH INFORMATION AUTHORIZATION

I hereby, Authorize any Physician, Medical Clinic, Home Care, Hospital or other person that has any records or knowledge of my health to provide full information to the KNEEHILL HOUSING CORPORATION or any authority acting on their behalf.

I understand this information will be kept confidential.

This authorization shall be valid during the time that I am a resident with the Kneehill Housing Corporation.

DATE:____________________________

SIGNATURE:____________________________   WITNESS:______________________________

Box 337, 814 1st Street North Three Hills, Alberta T0M 2A0
Telephone: 403-443-5333 Fax 403-443-5271

Medical Examination Report
Golden Hills Lodge

Applicant Name: ______________________________ Examination Date: ________________
Address: ____________________________________ Telephone No. __________________
Date of Birth: ________________________ Height: __________ Weight: ___________

PLEASE NOTE: THIS REPORT CANNOT BE ACCEPTED IF IT IS NOT COMPLETELY FILLED OUT.

APPLICANTS AUTHORIZATION:
I hereby, authorize any Physician, Medical Clinic, Homecare, Hospital or other person that has any records or knowledge of my health to provide full information to Kneehill Housing Corporation. The information gathered in this report is for the confidential use of the Corporation to determine applicant's eligibility/suitability for a Lodge environment.

DATE: __________________ SIGNATURE: _________________________________

HAS THE APPLICANT BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

CONDITION	IN YOUR MEDICAL OPINION WHAT IS THE APPLICANTS DEGREE OF IMPAIRMENT (Circle appropriate choice)	PROVIDE DETAILS OF DIAGNOSIS, ONSET & CURRENT TREATMENT (USE NOTE SECTION AT END OF FORM IF MORE SPACE IS REQUIRED)
Memory Loss	None Mild Moderate Severe	
Wandering	None Mild Moderate Severe	
Confusion	None Mild Moderate Severe	
Aggressive/violent behavior	None Mild Moderate Severe	
Depression/suicidal ideation or tendencies	None Mild Moderate Severe	
Alcoholism/substance abuse	None Mild Moderate Severe	
Incontinence	None Mild Moderate Severe	
Cardiovascular Illness	None Mild Moderate Severe	
Respiratory Illness	None Mild Moderate Severe	
Liver Disease	None Mild Moderate Severe	
Epilepsy	None Mild Moderate Severe	
Diabetes	None Mild Moderate Severe	
Nutritional Deficiencies	None Mild Moderate Severe	
Allergies	None Mild Moderate Severe	
Visual	None Mild Moderate Severe	
Hearing	None Mild Moderate Severe	
Mental Illness (including personality disorders)	None Mild Moderate Severe	

Eating Disorder	None Mild Moderate Severe	
Arthritis	None Mild Moderate Severe	
HIV Positive	Yes No	
Tuberculosis (If yes, attach chest X-Ray results)	Yes No	
Smoker?	Yes No	
Bariatric Patient? If yes, include BMI & any special physical requirements	Yes No	
Has this applicant been diagnosed with an MRSA infection?	Yes No	
Any behavior that in your medical opinion could be considered dangerous or disruptive to the applicant or to others in a communal Lodge living setting (If yes please describe)	Yes No	

Does Applicant Have or Require	Yes	No	Does Applicant Have or Require	Yes	No
Hearing Aid			Artificial Limb/ Prosthesis		
Pacemaker			Colostomy Bag		
Oxygen Therapy			Walking/Mobility Aid		
Urinary Bag			Wheelchair		
BiPap Machine					

OTHER AIDS TO DAILY LIVING:

____

____

DOES APPLICANT REQUIRE HOMECARE SERVICES? YES / NO
IF "YES" WHAT SERVICES ARE REQUIRED:

____

____

OTHER SUPPORT SERVICES INVOLVED (IF ANY):

____

____

FUNCTIONAL EVALUATION:

Golden Hills Lodge provides meals, housekeeping and 24 hour non-medical monitoring. Some Homecare services including personal care & medication assistance are also available. Personal laundry services are also available. Given this information, is your patient able to:

	YES	NO
Administer his/her own medications		
Physically able to function in a group setting independently including dressing		
Safely ambulate to and from dining room and eat independently		
Maintain appropriate level of personal hygiene and grooming		
Mentally able to function in a group setting independently without assistance (reminders and prompting)		
Socially fit in with other seniors in a communal lodge environment		
Able to shower/bathe independently		

DIET:
__ Regular __ Low salt __ Low fat __ Diabetic
__ Other (please explain): ____
____

MEDICATIONS(attach list if needed):
____
____
____

ALLERGIES:
____

IS APPLICANT DIAGNOSED WITH ANY CHRONIC CONDITION WHICH REQUIRES:

SPECIAL CARE? _________________ MEDICAL TREATMENT? ________________
PALLIATIVE CARE? ______________ OT/PT?_______________________________
REMARKS:
____
____

ANY ADDITIONAL REMARKS THAT MAY BE HELPFUL IN EVALUATING THE APPLICANT:
____
____
____
____
____
____
____
____
____
____

SIGNATURE OF PHYSICIAN: _______________________________________

PRINTED NAME: ____

COMPLETE ADDRESS: ____

TELEPHONE NO.: ___________________

After completion please return with/to applicant or fax to 403-443-5271 Attention Janice Chalmers, Lodge Manager and mail original to Golden Hills Lodge Box 337, Three Hills AB, T0M 2A0