



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:

- | | |
|-----------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Depression/Mental Health Issues |
| <input type="checkbox"/> Alcohol or other substance abuse | <input type="checkbox"/> Cardiac/respiratory |
| <input type="checkbox"/> Oxygen Therapy Required | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Mobility-use of cane |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Mobility-use of walker |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 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