Beaver Foundation
Seniors Housing

APPLICATION FOR ADMISSION

This form is created following the Alberta Housing Act.

FOR OFFICE USE ONLY

Date of Application: _____ Date of Interview: _____

Priority Rating: _____Date Move in: _____ Date Move Out: _____

PLEASE PRINT ALL ANSWERS

Please return filled out forms to the Managers office as soon as possible in order for the applicant to be placed on waiting list, if there are no vacancies.

NOTE: ALL INCOME MUST BE VERIFIED UPON ACCEPTANCE AS A RESIDENT

1.Which facility are you applying to move into:

_____ Vialta Lodge
5128-57 Ave, Viking, AB
Box 780, T0B 4N0
Ph: 780-336-3353
Fax: 780-336-3591
Email: vialta09@telus.net

_____ Holden Lodge
4820-52 Ave, Holden, AB
Box 370, T0B 2C0
Ph: 780-688-3817
Fax: 780-688-2364
Email: holdenlodge@mcsnet.ca

_____ Tofield Lodge
5824-50 St., Tofield, AB
Box 570, T0B 4J0
Ph: 780-662-3477
Fax: 780-662-7624
Email: tofieldl@telus.net

_____ Sunshine Villa
5834-51 St., Tofield, AB
Box 600, T0B 4J0
Ph: 780-662-2490
Fax: 780-662-0248
Email: sunvilla@telus.net

2. Notice of Assessment has been included with application? Yes _____ No_____

3. Personal Information:

Full Name: _____

Address: _____

Phone No: _____ Cell No: _____

Date of Birth: _____Place of Birth: _____

S.I.N. No: _____Length of Residence in Alberta: _____

Smoker: _____ Non -Smoker: _____ Religion:_____

Marital Status: Married____ Widow ____ Single____ Common-Law _____

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Optional Disclosure:

Are you a member of a target population group identified by the Minister?

Yes _____ No _____ Prefer No To Disclose _____

4. Are you a: Canadian Citizen _____ Landed Immigrant: _____or _____?

5. Do you have a will? Yes ___ No ___ Who is executor? _____

6. Medical Information:

Doctors Name: _____

Phone No: _____ Hospital: _____

Personal Health No: _____

Are you a Home Care Client? Yes _____ No_____

7. Facility Information:

Do you require a parking stall? Yes _____ No_____

Are you prepared to accept placement in another lodge if we are unable to accommodate you in your choice: Sunshine Villa _____Tofield Lodge _____ Vialta Lodge _____ Holden Lodge _____

Would you move in to the next available vacancy? Yes _____ No _____

Have you ever lived in a: Lodge_____ Manor _____ Subsidized Housing _____ Long Term Care _____ None of the Above _____

If you have lived in another facility, please name the facility: _____

_____

_____

Your Reason for Leaving: _____

_____

_____

Reason for referral and / or application: _____

_____

_____

_____

Name And Address Of Responsible Relative Or Friend To Be Notified In Case Of Emergency.

Please list contacts in order, beginning with the person you would like us to call first

1) Responsible Party: _____

Relationship: _____

Mailing Address: _____

Phone No: _____ Work No: _____

Cell Phone No: _____ Email: _____

2) Responsible Party: _____

Relationship: _____

Mailing Address: _____

Phone No: _____ Work No: _____

Cell Phone No: _____ Email: _____

3) Responsible Party: _____

Relationship: _____

Mailing Address: _____

Phone No: _____ Work No: _____

Cell Phone No: _____ Email: _____

I, _____,certify that the foregoing is correctly answered and I agree to abide by all rules and regulations as approved by the Beaver Foundation Board of Directors. I understand that home care services are provided in the lodge and that if I require special or nursing care after admission, I may be asked to accept home care services, or if necessary, find alternate lodging. I am aware that if Beaver Foundation feels that I am unable to manage on my own or with Home Care Assistance, I will be required to locate appropriate accommodations that will meet my health requirements. I authorize the Beaver Foundation to release medical information to the appropriate medical personnel to assure my immediate health and safety.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Manager Date

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Confidential Medical Report

This medical information form is required by Beaver Foundation in regard to all applicants seeking admission to a Beaver Foundation Lodge. All information must be current within one month.

Name: _____

Address: _____

Date of Birth: _____ Date Examined: _____

I _____, authorize the Physician to release medical
Name (please print)
information to Beaver Foundation.

_____ _____
Signature of Applicant Date

****

To Be Completed by Physician:

_____ _____
Examining Physician (please print) Telephone Number

_____

_____
Address

_____ _____
Physician Signature Date

How long has the applicant been your patient? _____

Physical Examination

Sight: Good _____ Impaired _____

Hearing: Good _____ Impaired _____

Weight: _____ Height: _____

Mobility: Walks without help _____
Walks with walker _____
Uses wheelchair _____

Blood Pressure _____

Diabetic Yes _____ No _____ If yes, Medication _____

Any significant impairment: _____

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Does the applicant suffer from any communicable disease whereby their presence in the lodge would jeopardize the physical welfare of the other residents? Yes _____ No _____

Comments: _____

_____

Has the applicant been tested for T.B. _____ If yes date tested _____

Results _____

Doctor/Nurse administering and checking test: _____

Please list any follow up requirements: _____

Is the applicant suffering from any chronic disease, which incapacitates them to the point where they require special care? Yes _____ No _____

If yes, please give details

_____

_____

Does the applicant use oxygen: Yes _____ No _____ If yes to what degree _____

_____

Activities of Daily Life	Full Assistance Needed	Partial Assistance Needed	Supervision Only	None Needed
Washing face & hands				
Grooming & shaving				
Dressing				
Bathing				
Feeding				
Toileting				
Use of incontinent supplies				

	Complete	Partial	Occasional	None
Bladder Incontinence				
Bowel Incontinence				

Catheter: Yes _____ No _____ Colostomy: Yes _____ No _____

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Intellectual Level of Functioning:

	Yes	At Times	No
Cooperative			
Aggressive			
Tendencies to Wander			

	Yes	At Times	No
Confused			
Destructive			
Unpleasant			

Does the applicant show any signs of Dementia _____ If so to what degree: _____

_____

Has the applicant ever been diagnosed with mental illness: Yes _____ No _____

Has the applicant had any of the following exams completed:

MMSE (Mini-mental state exam): Yes _____ No _____ Score _____

SLUMS (Saint Louis University mental status) Yes _____ No _____ Score _____

MOCA (Montreal Cognitive Assessment) Yes _____ No _____ Score _____

Is the applicant being treated at this time: Yes _____ No _____

Medical Diagnosis:

_____

_____

_____

History:

_____

_____

_____

Medications:

_____

_____

_____

Allergies or Drug Intolerance:

_____

_____

_____

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Has there ever been substance abuse: Yes _____ No _____

If Yes, Please Explain: _____

_____

_____

Is there a communication difficulty: Yes _____ No _____

If yes is this due to: Mental Causes _____ Deafness _____ Speech Difficulty _____

Language Barrier _____ Other _____

_____

Do you consider him/her to be suitable mentally and physically to enter a lodge where no special nursing care is available? Yes _____ No _____

Should he/she be placed on Homecare where limited medical and social care is provided?

Yes _____ No _____ If yes what type of care is required _____

_____

How many times has the applicant been admitted to a Health Care Facility in the last six months:

_____

_____

Diet:

Regular _____ Low Salt _____ Diabetic _____ Other _____

_____

_____

Any Other Comments

_____

_____

_____

Please fax or mail to the applicable Lodge:

Vialta Lodge: Fax: 780-336-3591 Mail: Vialta Lodge, Box 780, Viking AB, T0B 4N0

Tofield Lodge: Fax: 780-662-7624 Mail: Tofield Lodge, Box 570, Tofield AB, T0B 4J0

Holden Lodge: Fax: 780-688-2364 Mail: Holden Lodge, Box 370, Holden AB, T0B 2C0

Sunshine Villa: Fax:780-662-0248 Mail: Sunshine Villa, Box 600, Tofield AB, T0B 4J0

***Any charge for the completion of this form is the responsibility of the Applicant.**

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