

**PLEASE READ CAREFULLY  
INSTRUCTIONS FOR COMPLETING APPLICATION**

- Complete ALL questions supplying ALL the requested information. If a question does not apply to your situation, mark N/A in the section.
- Prior to approving this application, you will be required to provide the following for each household member:
  1. **Notice of Assessment from the previous tax year that shows line 15000**
  2. **Previous year Income Tax Return**
  3. **Valid Alberta Health Care card**
  4. **Level-of-Care Assessment form** – completed by a Home Care nurse

In order for you to obtain the information we require; your application will be held for two (2) weeks. After two weeks, if the required information is not received, your application will be cancelled. However, it can be reactivated at any time in the following 6 months. It is not necessary to complete another application form.

**THIS APPLICATION WILL NOT BE PROCESSED  
UNLESS ALL QUESTIONS ARE FULLY ANSWERED.**

If a translator was required to complete this application, please provide their name and telephone number:

\_\_\_\_\_  
Translator's Name

\_\_\_\_\_  
Telephone Number

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**HOUSING AUTHORITY USE ONLY**

Name: \_\_\_\_\_

Date Received: \_\_\_\_\_

## CONFIDENTIAL APPLICATION FOR ACCOMMODATION

**\* (Please Note: Failure to complete application in its entirety will result in delay in processing.)**

**Complete Application and return to Mackenzie House in person; or mail or fax to:**

**Boreal Housing Foundation  
Mackenzie House 11201-100 Ave.  
PO Box 865, High Level, AB T0H 1Z0  
Phone (780) 926-4118 Fax (780) 926-4118**

### APPLICANT

Please (√) one:  Mr.  Mrs.  Miss.  Ms.

Surname:	First Name:
Address:	Postal Code:
Telephone No.:	Birth Date:(month/day/year)
Personal Health #:	SIN:
Treaty # (if applicable):	

### For Annual Government Reports, the following information is required:

Marital Status:  Married  Widowed  Single  Divorced  Separated

Are you receiving the Alberta Seniors Benefit?  Yes  No

### NEXT OF KIN / EMERGENCY CONTACT:

If we are unable to contact you, should the need arise, we will contact your next of kin.

Name:	Relationship:
Res. Phone:	Cell Phone:
Address:	Postal Code:
Email:	

Name:	Relationship:
Res. Phone:	Cell Phone:
Address:	Postal Code:
Email:	

<b>DOCTOR:</b>	Telephone Number:
Address:	Postal Code:

**CITIZENSHIP:**

Are you a Canadian Citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO	Landed Immigrant <input type="checkbox"/> YES <input type="checkbox"/> NO
How long have you lived in Canada? _____ yrs.	Independent Status <input type="checkbox"/> YES <input type="checkbox"/> NO
How long have you lived in Alberta? _____ yrs.	Private sponsorship <input type="checkbox"/> YES <input type="checkbox"/> NO
If you have answered yes above, please provide a photocopy of your immigration documents.	

**CURRENT ACCOMMODATION:**

Is your current accommodation a: <input type="checkbox"/> House <input type="checkbox"/> Motel/Hotel <input type="checkbox"/> Apartment <input type="checkbox"/> Rooming House <input type="checkbox"/> Other If paying rent \$_____ per month day	How long have you lived at your current address?  Months: _____                      Years: _____
Is your accommodation shared? <input type="checkbox"/> YES <input type="checkbox"/> NO If you share accommodation, are these relatives? <input type="checkbox"/> YES <input type="checkbox"/> NO	If your accommodation is shared, number of:  Adults (#_____)                      Bedrooms (#_____) Children (#_____)                      Bathrooms (#_____)

**PLEASE CHECK IF YOU ARE RECEIVING ANY OF THE FOLLOWING SERVICES:**

- |  |   |
|--|---|
| <input type="checkbox"/> Occupational Therapy  | <input type="checkbox"/> Medical Alert System |
| <input type="checkbox"/> Socializing   | <input type="checkbox"/> Meals on Wheels      |
| <input type="checkbox"/> Bathing   | <input type="checkbox"/> Day Program          |
| <input type="checkbox"/> Physio Therapy  | <input type="checkbox"/> DVA Assistance       |
| <input type="checkbox"/> Private Care (give contact name) _____                        |   |
| <input type="checkbox"/> Mental Health Services (give contact name) _____              |   |
| <input type="checkbox"/> Home Care (give Home Care Co-ordinator's name) _____          |   |
| <input type="checkbox"/> Social Assistance / A.I.S.H. Worker (give contact name) _____ |   |
| <input type="checkbox"/> Other (specify) _____   |   |

**HEALTH INFORMATION:****1. If you require accommodation for a special need, please explain:**


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**2. Please check any/all of the following health concerns that apply to you:**

- |   |                                   |                                    |
|---|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Incontinence                                       | <input type="checkbox"/> Hearing  | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Alcohol or other substance abuse                   | <input type="checkbox"/> Sight    | <input type="checkbox"/> Diabetes  |
| <input type="checkbox"/> Oxygen   | <input type="checkbox"/> Seizures |                                    |
| <input type="checkbox"/> Mobility: use of walker, cane, wheelchair, scooter |                                   |                                    |
| <input type="checkbox"/> Other: _____                                       |                                   |                                    |

**FINANCIAL INFORMATION:**

**\* Applicable only if applying for Lodge Accommodation**

Attach a copy of your current year's Notice of Assessment (which you receive following filing of your Income Tax Return) to your Application Form.

The Mackenzie House rent rate is based upon each resident's line 15000 of their Notice of Assessment, with a minimum of \$613.00/month and the maximum amount of \$1200.00/month.

Residents using a parking space, or wanting Satellite TV or internet, will be charged additional fees monthly. Rent is due on or before the first day of every month. Rent reviews are done in accordance with the Alberta Housing Act and Boreal Housing Foundation Policies. New rental rates will be established annually from the new Notice of Assessment. A new rental rate comes into effect each July 1. If the current Notice of Assessment is not received each year before June 15 the rental rate will be set at max (\$1200) until it is received. If you have any questions please talk to the Manager.

Do you have a Power of Attorney?  Yes  No

If yes, please attach copy.

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_, hereby authorize Boreal Housing Foundation to gather relevant Information necessary to assess my eligibility for residency in a Boreal Housing Foundation lodge facility. I understand that my application for admission into a Boreal Housing Foundation facility will be kept on file for a period of one (1) year only. If residency has not occurred by that time, I understand that it will be my responsibility to re-submit an application.

Applicant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

I understand the terms as mentioned above and agree to the terms as presented.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness: print

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Address:

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Lodge Manager

**FOR OFFICE USE ONLY**

If application refused, state reason: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This information is collected in accordance with Section 33 of the Alberta Freedom of Information and Protection of Privacy Act (FOIP) and is used by Boreal Housing Foundation to operate its business. Personal information is protected under FOIP.

# Client Assessment for Entrance

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Check Yes or No

Do you receive Home Care Yes  No

Dressing: Do you manage independently? Yes  No

Comment: \_\_\_\_\_

Bathing: Do you bath yourself? Yes  No

Do you want to have assistance with bathing? Yes  No

Comment: \_\_\_\_\_

Eating: Are you able to carry a plate of food to the table independently? Yes  No

Are you able to carry hot beverages? Yes  No

Do you have any dietary considerations? Yes  No

Comment: \_\_\_\_\_

Toileting: Are you able to get on and off the toilet independently? Yes  No

Are you continent? If no, continue below Yes  No

~ Urinary incontinence? Yes  No

~ Stress incontinence? Yes  No

~ Bowel incontinence? Yes  No

Comment: \_\_\_\_\_

Mobility: Do you use a mobility aid? If yes, continue below. Yes  No

~ Walker? Yes  No

~ Wheelchair? Yes  No

~ Scooter? Yes  No

Comment: \_\_\_\_\_

Meds: Do you take your own medication? Yes  No

Do you want Mackenzie House staff to assist with your medications? Yes  No

Comment: \_\_\_\_\_

- Laundry:** Do you wash your own laundry? **Yes**  **No**   
Do you require assistance from your family? **Yes**  **No**   
Do you require assistance from Mackenzie House staff? **Yes**  **No**

Comment: \_\_\_\_\_

**Self-Managed Health Care**

Are you currently receiving the following services or treatment?

- Home Care ..... **Yes**  **No**   
Physiotherapy ..... **Yes**  **No**   
Social Worker ..... **Yes**  **No**   
Day Support from Hospital ..... **Yes**  **No**   
Respiratory Therapy ..... **Yes**  **No**   
~ Oxygen **Yes**  **No**   
~ Inhaler **Yes**  **No**

Comment: \_\_\_\_\_

**Mental Psychosocial Behaviour:**

Do you suffer from or have you suffered from the following:

- Anxiety ..... **Yes**  **No**   
Depression ..... **Yes**  **No**   
Paranoia ..... **Yes**  **No**   
Hoarding ..... **Yes**  **No**   
Wandering ..... **Yes**  **No**   
Substance abuse ..... **Yes**  **No**   
Alcohol abuse ..... **Yes**  **No**   
Vision loss ..... **Yes**  **No**   
Hearing loss ..... **Yes**  **No**   
Do you smoke ..... **Yes**  **No**

**Other Health Concerns:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family Support:**

Does your family live in the community?

Yes  No

Comment:

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**SELF-CONTAINED: Household Management**

Do you currently prepare your own meals?

Yes  Requires Assistance

Do you clean your own household?

Yes  Requires Assistance

Do you do your own shopping?

Yes  Requires Assistance

Do you fill out your own personal documents?

Yes  Requires Assistance

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**FOR OFFICE USE ONLY**

**Management Perception**

Communication

Good  Impaired

Orientated to date, place and time

Good  Impaired

Exhibit good judgement

Good  Impaired

Able to answer questions with little or no queuing

Good  Impaired

Cognitive state

Good  Impaired

Comment:

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**Assessment Summary:**

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\_\_\_\_\_  
SIGNATURE OF ASSESSOR

\_\_\_\_\_  
DATE

Your response to the following is optional and in no way prejudices your eligibility. This information is helpful in enhancing our programs and activities.

Name: \_\_\_\_\_

**Skills:**

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**Interests:**

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**Food Preferences:**

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**Comments:**

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# Boreal Housing Foundation

Box 865  
9916-100 Ave  
High Level, Alberta  
T0H 1Z0  
Phone: 780-926-4118  
Fax: 780-926-4118



## Level-of-Care Assessment

I, \_\_\_\_\_ am applying for a unit at Mackenzie House and am requesting to be assessed to determine what level of care I will require.

I, \_\_\_\_\_ give AHS home care personnel permission to share the level of care I will require with Boreal Housing personnel so they can better assist me in choosing the right type of accommodation.

### Studio Suite: (Mackenzie House)

\_\_\_\_\_ DSL1 – Lodge Suite: The tenant can live totally on their own but need help for cooking and weekly cleaning (Supplied by BHF).

\_\_\_\_\_ DSL2 – Home Care Suite: The tenant can live totally on their own but need help from Home Care (Supplied by AHS); as well as for cooking and weekly cleaning (Supplied by BHF).

\_\_\_\_\_ DSL3 – Home Care Suite: The tenant can live totally on their own but need more scheduled help from Home Care (AHS) and for cooking and cleaning (BHF). AHS Placement will be placing this applicant.

\_\_\_\_\_ DSL4 – Supportive Living Suite: The tenant cannot live on their own and need scheduled help from HCAs and LPNs. This tenant needs to live in a Supportive Living Facility. AHS Placement will be placing this applicant.

### Independent Suite: (Seniors Independent Living)

\_\_\_\_\_ Independent Suite: The tenant can live totally on their own and need NO help for cooking and cleaning.

\_\_\_\_\_  
Signature of Home Care Nurse

\_\_\_\_\_  
Print Name of Home Care Nurse

\_\_\_\_\_  
Date of Assessment