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

HOUSING AUTHORITY USE ONLY

Name: _____ Date Received: _____

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) 841-2010 Fax (780) 821-1333

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:	

DOCTOR:	Telephone Number:
Address:	Postal Code:

CITIZENSHIP:

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

CURRENT ACCOMMODATION:

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

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

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

HEALTH INFORMATION:

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

_____
_____
_____

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

☐ Incontinence
☐ Alcohol or other substance abuse
☐ Oxygen
☐ Hearing
☐ Sight
☐ Seizures
☐ Allergies
☐ Diabetes
☐ Mobility: use of walker, cane, wheelchair, scooter
☐ Other: _____

FINANCIAL INFORMATION:

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 Supportive Living accommodation rate, which includes utilities, meals, and scheduled housekeeping, is based upon each resident's line 15000 of their Notice of Assessment; with a minimum equal to the current senior rate set by the Alberta government and maximum as per Continuing Care – Accommodation Rates. Any resident using the laundry service, a parking space, or who want satellite TV or internet in their room 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 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 require assistance 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:

_____

_____

_____

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** ☐

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:

_____

_____

_____

Assessment Summary:

_____

_____

_____

_____

_____ _____

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:

_____
_____
_____
_____
_____
_____

Interests:

_____
_____
_____
_____
_____
_____

Food Preferences:

_____
_____
_____
_____
_____
_____

Comments:

_____
_____
_____
_____
_____
_____

BOREAL HOUSING FOUNDATION

Mackenzie House
11201 100 Ave.
High Level, Alberta
T0H 1Z0
Phone: 780-841-2010
Fax: 780-821-1333

Level-of-Care Assessment

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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 Space: Mackenzie House

_____ DSL1 – Supportive Living Space: The tenant can live on their own but need help for cooking and weekly cleaning (Supplied by BHF).

_____ DSL2 – Supportive Living Space: The tenant can live on their own but need help from Home Care (Set up by the tenant), and for cooking and weekly cleaning (Supplied by BHF).

_____ DSL3 – Continuing Care Space: The tenant requires daily assistance for care (AHS) and for cooking and cleaning (BHF). *AHS Placement will be placing this applicant.*

_____ DSL4 – Continuing Care Space: The tenant cannot live on their own and need scheduled help from HCAs and LPNs. *AHS Placement will be placing this applicant.*

_____	_____	_____
Signature of Home Care Nurse	Print Name of Home Care Nurse	Date of Assessment