


APPLICATION FOR ACCOMMODATION

Senior Citizen's Self-Contained Apartments

	INTERVIEW INFORMATION
Donna J. Andres, Housing Manager	Thursdays only, on a walk-in basis
Room 137A, 5201 – 50 Avenue, Wetaskiwin, AB, T9A 0S7 Phone: 780-352-4435 Fax: 780-352-4458	9:00 to 11:30 a.m. and 1:00 – 3:30 p.m. Our office is closed between 12:00 and 1:00 p.m.

The personal information being collected on this form is pursuant to the Freedom of Information and Protection of Privacy Act Section 32(c), 37(c) and 38(c). Information required on this application is in keeping with the Alberta Housing Act and Alberta Residential Tenancies Act. Information acquired on this form will be kept secure and access is restricted. If you have any questions about the collection, contact the FOIP Coordinator at The Bethany Group Office, 4612 - 53 St., Camrose, AB T4V 1Y6. The phone number is (780) 679-2000.

I understand this application does not constitute an agreement on the part of The Bethany Group or its agents to provide me with rental accommodation.

I further acknowledge the right of The Bethany Group or its agents at any time prior to the execution and delivery to me of a lease hereby applied for, to withdraw, revoke or cancel, without penalty or liability for damages or otherwise, any acceptance or approval of this application previously made or given.

I hereby authorize The Bethany Group or its agents to investigate any or all of the statements made herein, being fully aware that discovery of any false statement shall cancel further consideration of my application.

I further agree that I am obligated to advise The Bethany Group or its agents in writing of any changes in family composition, gross family income, assets, employment or change of address, should they occur.

I hereby give permission for current or past landlords to release any information which directly affects this application for subsidized housing.

Signature of Witness

Signature of Applicant

DOMINION OF CANADA) PROVINCE OF ALBERTA) TO WIT:)	IN THE MATTER OF THIS APPLICATION FOR DWELLING ACCOMMODATION IN THE HOUSING PROJECT.
I/We, _____ of the _____ of _____, in the Province of Alberta, do solemnly declare as follows:	
1. That I am/we are the applicant(s) named in this application, 2. That the statements made by me/us in this application are to the best of my/our knowledge, information and belief, full and true in all respects, 3. That I/we have resided in the Province of Alberta for _____ years of my life/our lives, and in the City of Wetaskiwin or the Town of Millet, or the County of Wetaskiwin for _____ years,	
In addition, I/we make this solemn Declaration conscientiously believing it to be true and knowing that it is of the same force and effect as if made under oath and by virtue of the "Canada Evidence Act."	

Declared before me at the City of Wetaskiwin) in the Province of Alberta, this) _____ day of _____, 20____)	_____ Signature of Applicant _____ Signature of Applicant _____ Signature of Manager
A Commissioner for Oaths for the Province of Alberta Donna J. Andres My appointment Expires on: Sept. 5, 20____	

FOR OFFICE USE ONLY - LOCATION PREFERENCE (in order of preference):	
#1 _____	#2 _____
Received by: (whom) _____ Date received: _____	



APPLICATION FOR SENIORS SELF-CONTAINED UNITS IN WETASKIWIN & MILLET

Instructions for completing application:

Complete all questions supplying all of the requested information. If a question does not apply to your situation, mark N/A in the section. Space is allocated for any other information you would like to provide.

You are required to provide the following:

- 1. Documentation to verify income
 - A copy of your most recent federal **Notice of Assessment**
 - A copy of your most recent **Income Tax Return**
 - Verification of **Alberta Seniors Benefit**
 - A **current bank statement**, showing any direct deposits of federal or provincial seniors' payments. Statement must show your name and address.

****Applications will not be processed unless all documentation is provided and all questions are fully answered.****

Incomplete applications will be held for two (2) weeks. After 2 weeks, if the required information is not received, your application will be cancelled.

If a translator was required to complete this application, please provide the following:

Translator's name: _____ Telephone number: _____

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Please note that the applicant will be the person contacted should a room become available and in regards to approval and placement status. If we should be notifying anyone else also, please put the information here. If there is no requested alternate or copy of information listed here, there will be no expectation that anyone else will be notified.

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APPLICATION FOR SENIORS SELF-CONTAINED UNITS IN WETASKIWIN & MILLET

APPLICANTS' INFORMATION

Applicant's Name: _____
(Last name) (First Name & Initial)

Date of Birth: _____ Personal Health Care Number: _____
(Month/day/year)

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Co-applicant's Name: _____
(Last name) (First Name & Initial)

Date of Birth: _____ Personal Health Care Number: _____
(Month/day/year)

Are you a: Canadian Citizen _____ Landed Immigrant _____ Other _____

Present Address: _____

City: _____ Postal Code: _____ Home phone number: _____

Length of time at this address: _____ If less than 1 year, please give your previous address: _____

Family Doctor's Name: _____ Phone Number: _____

Address: _____

Do you have a pet? No _____ Yes _____ Type: _____ (Please note, pets are **not** allowed in our buildings.)

Do you or anyone living with you smoke? No _____ Yes _____ (Smoking Allergy?) _____

Will you require a parking stall? No _____ Yes _____

Make of vehicle: _____ Year of vehicle: _____ License: _____

Have you been given a "Notice to Vacate" your current residence? No _____ Yes _____ If so, please submit a copy of the notice and state the reason for the eviction: _____

ACCOMMODATION:

Current accommodation: Rent _____ Own _____ Shared _____ Other _____

Rent or house payment is \$ _____ per month, plus
\$ _____ for heat, \$ _____ for lights \$ _____ for water and sewer.

If renting, name of your present Landlord: _____

Address: _____ Phone number: _____

Is your present accommodation: House _____ Apartment _____ Rooming House _____ Other _____

Rooms in your present accommodation:

Kitchen _____ Living room _____ Dining Room _____ Number of Bathrooms _____ Number of Bedrooms _____

Number of person(s) sharing your present accommodation: _____ Adults, _____ Children

Do you or any members of your household require special need accommodation? (i.e. wheelchair accessibility)

Specify: _____

Do you share with other occupants the use of the kitchen? No _____ Yes, how many? _____

Do you share with other occupants the use of the bathroom? No _____ Yes, how many? _____

Are your shower and/or bathtub, toilet and washbasin all located in your bathroom? _____ Yes _____ No _____

Please give details: _____

Is your stove, refrigerator, cupboards; counter space and sink, all located in your kitchen? _____ Yes _____ No _____

Please give details: _____

1. Do you receive a cash benefit from the Alberta Seniors Benefit Program? YES _____ NO _____
Please include a copy of a cheque or letter from Alberta Seniors Benefit to verify.

2. Have you applied for or do you receive the Guaranteed Income Supplement as part of your Old Age Security?
YES _____ NO _____

3. Would you like us to assist you in applying for the Guaranteed Income Supplement and or the Alberta Seniors Benefits?
YES _____ NO _____

MONTHLY INCOME – All incomes must be verified by the most recent Notice of Assessment and the Income Tax Return or a current Bank Statement.

	INCOME SOURCE	APPLICANT	CO-APPLICANT
	Old Age Security		
	Guaranteed Income Supplement		
	Alberta Seniors Benefit		
	Spousal Allowance		
	Canada Pension Plan		
	Company Pension		
	Veterans Allowance		
	War Disability Pension		
	Employment Insurance		
	Interest		
	Other Income - Specify		
	TOTAL MONTHLY INCOME		

Please list all investments and assets: (i.e. term deposits, real estate, savings, R.R.S.P., stocks, bonds, homes, boats, cars, RV, or any such assets)

INVESTMENT	ASSET	VALUE

Reason for wanting to move and any other related information you wish to provide to help in the placement process: _____

Rent is based on 30% of your TOTAL GROSS INCOME therefore, you must provide a copy of your most recent Notice of Assessment and the Income Tax Return and a current Bank Statement. There is an additional charge for parking and utilities which is reviewed yearly.

RESPONSIBLE PARTY STATEMENT



THE BETHANY GROUP (Wetaskiwin Office)
 Room 137A, 5201 – 50 Avenue
 Wetaskiwin, Alberta, T9A 0S7
 Phone: 780-352-4435 Fax: 780-352-4458

DIRECTIONS FOR COMPLETION:

Please print clearly in all sections, and make sure that all blanks are properly filled. This statement is to be signed by an adult living outside of the facility. Couples cannot use each other as the responsible party, as we will expect that you will answer for each other if one of you should become disabled or incapacitated. This statement is to assist us in the event that you should become incapacitated during your stay at the facility. All information is confidential and required only in case of an emergency.

APPLICANT'S NAME: _____

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PERSON OR PERSONS ASSUMING EMERGENCY RESPONSIBILITY FOR THE ABOVE APPLICANT

NAME: _____	NAME: _____
ADDRESS: _____	ADDRESS: _____
CITY: _____	CITY: _____
Postal Code: _____	Postal Code: _____
HOME PHONE #: _____	HOME PHONE #: _____
WORK PHONE #: _____	WORK PHONE #: _____
OTHER PHONE #: _____	OTHER PHONE #: _____
RELATIONSHIP TO APPLICANT: _____	RELATIONSHIP TO APPLICANT: _____

I (we) certify that I (we) will be totally responsible for the above named applicant in the event that the applicant is unable to answer for him/herself. If the applicant does not abide by all the rules and regulations as set up from time to time by The Bethany Group, I (we) agree to remove the applicant from the facility within thirty (30) days of being notified. I (we) further agree that The Bethany Group's decisions are final and binding on all parties concerned. I (we) understand that Home Care Service is provided in the facility and if a resident requires special or nursing care after admission, they may be asked to accept Home Care Services in order to continue their residency at the facility, or else be requested to find alternate accommodation. If the requirements are beyond the capability of Home Care to supply, I (we) will be requested to find alternate accommodation for the applicant and assist in supplying the applicant's needs until such time as alternate placement is arranged.

Signature of responsible parties: _____

Date: _____ Print name of Witness: _____

Witness signature: _____

Housing Manager: _____

ATTENTION: PLEASE GIVE THE FOLLOWING PAGE TO YOUR DOCTOR

APPLICANT'S MEDICAL INFORMATION

This medical information is required by The Bethany Group for all applicants wishing to obtain tenancy in senior housing. Please ensure that a physician completes all required sections (with the exception of the "Authorization for Release of Information" section, which is to be completed by the applicant).

*****ANY COST ASSOCIATED WITH THE COMPLETION OF THIS FORM ***
IS THE RESPONSIBILITY OF THE APPLICANT**

All information must be current within a six-month time frame.



CONFIDENTIAL MEDICAL REPORT
FOR SENIORS' ACCOMMODATION WITH THE BETHANY GROUP

Client seeks admission to our senior's self-contained apartment facilities in Wetaskiwin.

Please return this report directly to:

THE BETHANY GROUP (Wetaskiwin Office)
ROOM 137 A, 5201 50 AVENUE, WETASKIWIN, ALBERTA, T9A 0S7
Phone 780-352-4435 Fax 780-352-4458
Attention: Donna J. Andres, Housing Manager

APPLICANT AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the examining physician, medical clinic, or hospital, to disclose information on my health and physical condition to The Bethany Group, or its' designate, as it pertains to the viability of living in one of their self-contained apartment facilities.

Print applicant name: _____ Birth date: _____

Applicant signature: _____ Date: _____

The information collected for this application is confidential and will only be used by the Bethany Group for the purpose of evaluating the applicant for accommodation. Additional information or an updated report may be requested if deemed necessary.

PRINT NAME OF EXAMINING PHYSICIAN: _____

EXAMINATION DATE: _____ PHYSICIAN PHONE #: _____

LENGTH OF TIME APPLICANT HAS BEEN YOUR PATIENT: _____

PHYSICAL CONDITION:

SIGHT: _____ good _____ impaired _____

HEARING: _____ good _____ impaired _____

MOBILITY: _____ walks without help, _____ walker/cane, _____ wheelchair

TRANSFERS: _____ on their own, _____ with assistance (one or two person assist) _____

Is client able to communicate coherently? Explain _____

CONTINENT OF URINE: _____ CONTINENT OF FECES: _____

Method of control: _____

Does the client need assistance with any of the following:

Dressing/undressing: _____ Cueing/Prompting: _____

Bathing: _____ Eating: _____

Grooming/personal hygiene: _____ Home Care: _____

Does the client require assistance with medications? _____

Does the client suffer from a chronic disorder that would affect others living in the facility? _____

Or that would require any special type of service/care/attention: _____

Does the client suffer from any communicable disease? _____

Is your client physically able to manage in a communal/apartment setting without personal/nursing care? _____

Note: The buildings are not staffed – they are for independent seniors who can manage meals, housekeeping and laundry on their own, or with independently-contracted Home Care services.

Mental capacity to live in a communal setting: _____

MEDICAL HISTORY: _____

Drug intolerance and allergies: _____

PHYSICIAN SIGNATURE and OFFICE STAMP

Date