



APPLICATION FOR LODGE ACCOMODATION  
GOLDEN HILLS LODGE

Box 370, 814 1st Street North, Three Hills Alberta T0M 2A0

Telephone: 403-443-5333 Fax: 403-443-5271 Email: operations@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** ( \$30.00 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:

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Incontinence</li> <li><input type="checkbox"/> Alcohol or other substance abuse</li> <li><input type="checkbox"/> Oxygen Therapy Required</li> <li><input type="checkbox"/> Hearing</li> <li><input type="checkbox"/> Vision</li> <li><input type="checkbox"/> Seizures</li> <li><input type="checkbox"/> Other: _____</li> <li>_____</li> <li>_____</li> <li>_____</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Depression/Mental Health Issues</li> <li><input type="checkbox"/> Cardiac/respiratory             <ul style="list-style-type: none"> <li><input type="checkbox"/> Allergies</li> <li><input type="checkbox"/> Diabetes</li> </ul> </li> <li><input type="checkbox"/> Mobility-use of cane</li> <li><input type="checkbox"/> Mobility-use of walker</li> <li><input type="checkbox"/> Dementia/Wandering Behavior</li> </ul> |
|--|---|

REASON FOR LODGE APPLICATION  
(Please check appropriate boxes)

- 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 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.

**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/GOLDEN HILLS LODGE 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/Golden Hills Lodge.**

**DATE:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **WITNESS:** \_\_\_\_\_



Box 370, 814 1<sup>st</sup> 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 Severe	Mild	Moderate	
Wandering	None Severe	Mild	Moderate	
Confusion	None Severe	Mild	Moderate	
Aggressive/violent behavior	None Severe	Mild	Moderate	
Depression/suicidal ideation or tendencies	None Severe	Mild	Moderate	
Alcoholism/substance abuse	None Severe	Mild	Moderate	
Incontinence	None Severe	Mild	Moderate	

<b>Cardiovascular Illness</b>	<b>None Severe</b>	<b>Mild</b>	<b>Moderate</b>		
<b>Respiratory Illness</b>	<b>None Severe</b>	<b>Mild</b>	<b>Moderate</b>		
<b>Liver Disease</b>	<b>None Severe</b>	<b>Mild</b>	<b>Moderate</b>		
<b>Epilepsy</b>	<b>None Severe</b>	<b>Mild</b>	<b>Moderate</b>		
<b>Diabetes</b>	<b>None Severe</b>	<b>Mild</b>	<b>Moderate</b>		
<b>Nutritional Deficiencies</b>	<b>None Severe</b>	<b>Mild</b>	<b>Moderate</b>		
<b>Allergies</b>	<b>None Severe</b>	<b>Mild</b>	<b>Moderate</b>		
<b>Visual</b>	<b>None Severe</b>	<b>Mild</b>	<b>Moderate</b>		
<b>Hearing</b>	<b>None Severe</b>	<b>Mild</b>	<b>Moderate</b>		
<b>Mental Illness (including personality disorders)</b>	<b>None Severe</b>	<b>Mild</b>	<b>Moderate</b>		
<b>Eating Disorder</b>	<b>None Severe</b>	<b>Mild</b>	<b>Moderate</b>		
<b>Arthritis</b>	<b>None Severe</b>	<b>Mild</b>	<b>Moderate</b>		
<b>HIV Positive</b>	<b>Yes</b>	<b>No</b>			
<b>Tuberculosis (If yes, attach chest X-Ray results)</b>	<b>Yes</b>	<b>No</b>			
<b>Smoker?</b>	<b>Yes</b>	<b>No</b>			
<b>Bariatric Patient? If yes, include BMI &amp; any special physical requirements</b>	<b>Yes</b>	<b>No</b>			
<b>Has this applicant been diagnosed with an MRSA infection?</b>	<b>Yes</b>	<b>No</b>			
<b>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)</b>	<b>Yes</b>	<b>No</b>			
<b>Does Applicant Have or Require</b>	<b>Yes</b>	<b>No</b>	<b>Does Applicant Have or Require</b>	<b>Yes</b>	<b>No</b>
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 via email to [operations@kneehillhousing.com](mailto:operations@kneehillhousing.com) or fax to 403-443-5271  
Attention: Operations Manager and mail original to Golden Hills Lodge Box 370, Three Hills AB, T0M  
2A0**