**To complete this document please include:**

* Current Year Notice of Assessment
* Personal Alberta Health Care Card
* Medical Form (doctor may send separately)

|  |  |  |
| --- | --- | --- |
| **Applicant:** | **Last Name:** | **Given Name:** |
|  |  |
| **Street Address:** | (Municipal Address-Unit Number, Street, Avenue, Postal Code) |
| **Mailing Address:** | (Mailing Address & postal code, if different from above) |
| **Home Telephone:** |  | **Cellular Telephone:** |  |
| **Date of Birth: (mm/dd/yr)** |  | **Email Address:** |  |
| **Do you receive Alberta Seniors Cash Benefit?** | * Yes
* No
 | **Marital Status:** | * Married
* Single
* Widow/er
 |
| **Is there a co- applicant? (Please complete separate application)** | * Yes
* No
 | **If Yes; Provide****Co-Applicants Name:** |  |
| **Years of Residency in the County of Vulcan:** |  |
| **Years of Residency in Alberta:** |  |
| **Are you a Canadian Citizen?****If no, provide copies of immigration papers** | * Yes
* No
 |

**Current Housing:**

|  |  |  |
| --- | --- | --- |
| **I currently:** | * Live Alone
 | * Live with Others
 |
| **My Home:** | * Meets my needs
 | * Does not meet my needs and is a hardship for me
 |
| **Comments:** |  |
| **Special Hobbies and Interests:** |  | **Languages Spoken:** |  |
| **I currently receive Home Care Services:** | * Yes
* No
 | **If Yes; what services:** | * Medication assistance
* Bathing assistance
* Housekeeping
 | * Dressing assistance
* Wound dressing
* :
 |

**Self-Management**:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Level of Mobility (check all that apply):** | * Unaided
 | * Cane
 | Scooter | * Walker
 | * Wheelchair
 |
| **Personal Care and Hygiene (i.e. dressing, bathing):** | * Without Assistance
 | * Require Assistance
 |
| **Comments:** |  |
| **Medication:** | * able to manage on own
 | * difficulty remembering to take properly
 |
| **Comments:** |  |
| **Nutrition:** | * Feel needs are being met
 | * Feel needs are not being met
 |
| **Household Activities: (are you able to do unassisted)** | * Shopping
 | * Laundry
 | * Housekeeping
 |
| **Comments:** |  |
| **Social and Community** | * Prefer to be by myself most of the time
 | * Currently participate in outside activities and events
 |
| **Comments:** |  |

**Physician:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Last Name:** |  | **First Name:** |  |
| **Address:** |  | **Telephone Number:** |  |
| **Town / City:** |  | **Postal Code:** |  |
| **Date of last****Physical:** |  | **Length of Time as****family physician:** |  |

**Additional Contacts**: (Person to be notified in case of emergency and that you authorize to have access your personal, financial and medical information)

|  |  |  |
| --- | --- | --- |
| **Contact:** | **Last Name:** | **Given Name:** |
|  |  |
| **Relationship:** |  | **Email Address:** |  |
| **Street Address:** | (Municipal Address-Unit Number, Street, Avenue, Postal Code) |
| **Mailing Address:** | (Mailing Address & postal code, if different from above) |
| **Home Telephone:** |  | **Cellular Telephone:** |  |
| **Do you authorize Marquis Foundation to contact this person when a room is offered?** | * Yes
* No
 |

|  |  |  |
| --- | --- | --- |
| **Contact:** | **Last Name:** | **Given Name:** |
|  |  |
| **Relationship:** |  | **Email Address:** |  |
| **Home Telephone:** |  | **Cellular Telephone:** |  |
| **Do you authorize Marquis Foundation to contact this person when a room is offered?** | * Yes
* No
 |

**Other Information:**

|  |
| --- |
|  |
|  |

**Declaration:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| I | / We |  | , of | the |  |
| Of |  | In the Province of Alberta, to solemnly declare as follows: |
| 1. That I/We am/are the applicant(s) named in the said application; |
| 2. The I/We have resided in the Province of Alberta |  | years of my/our life / lives and in |
| the District for |  | Years; |
| 1. I/We understand that this application does not constitute an agreement on the part of Marquis Foundation, or its agents, to provide me with accommodation;
2. I/We further agree that I/We am/are obligated to advise Marquis Foundation, or its agents, in writing, or any changes in family composition, gross family income, assets, employment or change of address, should they occur; and
3. Pursuant to the Freedom of Information and Protection of Privacy Act, I/We give Marquis Foundation my/our consent to make inquiries that are necessary to verify the information given in this application including conducting a credit check, and I/we authorize any person, corporation or social agency to release to Marquis Foundation any information pertinent to the assessment of my/our application being fully aware that discovery of any false statements shall cancel any further consideration of my/our application.

And 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”. |
|  |  |  |
|  |  | Signature of Applicant |  |  | Signature of Applicant |  |  |  |  | Guardian/Witness |
| Declared before me at the |  | of |  | In the Province of Alberta |
| This |  | Day of |  | Year  |  |
|  |
| Marquis Foundation Representative: |  |

It is incumbent upon the applicant to notify Marquis Foundation of any changes in information provided in this application.



|  |  |  |
| --- | --- | --- |
| Applicant: | Last Name: | Given Name: |
|  |  |
| Date of Birth: (MM/DD/YY) |  | Alberta Health Care Number: |  |
| Date of Last Examination: |  | Last Annual Physical: |  |
|  |
| Physicians Name:(printed) |  |
| Address: |  |  |
| Street/Box |  | Town/City |  | Postal Code |
| Office Phone: |  | Date of Examination: |  |
| Hospital Affiliation: |  | Physician’s Signature: |  |

**Application for Seniors Lodge - Medical Report**

**Please return completed form to:**

 **Peter Dawson Lodge, 614 1st street N, Vulcan, AB T0L 2B0**

**P: 403-485-2422 F: 403-485-2393 E: drc@marquisfoundation.ca**

|  |
| --- |
| **Authorization For Release Of Medical Information**I hereby authorize the release of all information requested by Marquis Foundation and waive any and all claims against the person or organization releasing the report, or any of its of officers, servants, agents, staff members or employees for any purpose whatsoever in connection with the communication and disclosure of the said information.I understand that this personal information is being collected in accordance with the Freedom of Information and Protection of Privacy Act (FOIPP), and I consent to the said collection. For questions about the collection and use of your personal information, contact the Director of Resident Care at Marquis Foundation at 403-485-2422 |
| **Applicants Signature:** |  | **Date:** |  |
| **Witness:** |  | **Date:** |  |

|  |  |
| --- | --- |
| Is the Applicant’s current health stable? | * Yes
 |
| Has the Applicant had serious medical issues within the past year? | * Yes
 |
| If “yes” please provide details and current management: |
|  |
| Does the Applicant Have: | Yes | No | Applicant ability to manage without assistance: |
| Pacemaker |  |  |  |
| Colostomy Bag |  |  |  |
| Oxygen |  |  |  |
| Ileostomy Bag |  |  |  |
| Artificial Limb |  |  |  |
| Other Aids to Daily Living (specify) |  |  |  |

|  |  |
| --- | --- |
| Hearing | * Normal  Impaired  Absent  Hearing Aid
 |
| Visual | * Normal Impaired Absent  Good with Glasses
 |
| Mobility | * Excellent – no mobility aid  Good – minimal help with mobility aid
* Good – but dependent on mobility aid  Uses a wheelchair and can transfer in/out
* Confined to a wheelchair
 |
| Check any of the following mobility aids and frequency of use: |
| * Cane Regular Occasionally
 | * Walker Regular Occasionally
 |
| * Wheelchair  Electric or  Manual  Regular  Occasionally
 |
| * Scooter  Electric or  Manual  Regular  Occasionally
 |
| Special Diet | * Diabetic  Cut-up Food  Low Cholesterol  Gluten Free
 |
| * Low Fat  Minced Food  Pureed  Other:
 |
| Allergies | * Food  Medication  Environment Describe:
 |

# A picture containing plant  Description automatically generated

# Application for Seniors Lodge - Medical Report

 **Does the Applicant have any of the following disorders/conditions?**

|  |  |  |
| --- | --- | --- |
| Condition | Current | If “yes” please provide particulars (please attachaddition informal if required) |
| Yes | No |
| Heart Disease |  |  |  |
| High Blood Pressure |  |  |  |
| Stroke |  |  |  |
| Diabetes |  |  |  |
| Arthritis |  |  |  |
| Epilepsy |  |  | If yes, | * Mild
 | * Moderate
 | * Severe
 |
| Renal Failure |  |  | If yes, | * Mild
 | * Moderate
 | * Severe
 |
| Incontinence (bladder) |  |  | If yes, | * Mild
 | * Moderate
 | * Severe
 |
| Incontinence (bowel) |  |  | If yes, | * Mild
 | * Moderate
 | * Severe
 |
| Respiratory Deficiencies |  |  |  |
| Parkinson’s Disease |  |  | If yes, | * Mild
 | * Moderate
 | * Severe
 |
| Cognitive Impairment |  |  | If yes, | * Mild
 | * Moderate
 | * Severe
 |
| Alzheimer’s Disease |  |  | If yes, | * Mild
 | * Moderate
 | * Severe
 |
| Wandering |  |  |  |
| Mental Illness |  |  |  |
| Uncontrolled, Aggressive orViolent Behaviour |  |  |  |
| Socially inappropriate or Disruptive behaviour |  |  |  |
| Depression |  |  |  |
| Alcohol or Drug Abuse |  |  | If yes, | * Past
 | * Present
 | Details: |
| Infectious Diseases |  |  | If yes, | Type: |  |  |
| Smoking |  |  |  |
| Tuberculosis |  |  |  |
| Nutritional Deficiencies |  |  |  |
| Communication Difficulty? |  |  | Due to: Mental Causes Deafness* Speech Impediment Language Barrier

Details: |
| Marquis Foundation provides meals, Housekeeping Services and 24 Hour Non-Medical Supervision. Given this information is your patient, without assistance, able to: |
|  | **Yes** | **No** | **Comments** |
| Administer own medications |  |  |  |
| Physically manage care including dressing |  |  |  |
| Maintain appropriate level of personalhygiene |  |  |  |
| Is the Applicant able to independentlyambulate to and from the dining room in the lodge setting? |  |  |  |
| Live in a lodge setting without assistance such as reminders andprompting |  |  |  |
| Socially fit in and interact with other seniors |  |  |  |
| Does the Applicant require Home Care Services? |  |  |  |
| Is there any other support agencyinvolved? |  |  |  |

Any special concerns that have not been captured on the medical form, please attach explanation on a separate page.