www.homelandhousing.ca

Confidential Application

Please review the below checklist and include all information/documentation to ensure we can process your application and if need be assign you to our wait list.

If applying as a couple, ensure that documentation for both parties are remitted.

Applicant	Co-Applicant	Please check :
☐	☐	**All sections of the application are complete**
☐	☐	**Application is signed and dated**
☐	☐	**Completed Medical Form by your physician for applicant and co-applicant is attached.**
☐	☐	**A copy of your current year's Notice of Assessment is included, applicant and co-applicant**

and

Applicant	Co-Applicant	Please check :
☐	☐	**Photocopy of your current year Income Tax Return along with all "T" slips, such as T3's, T4's and T5's (Self Contained)**

If you have any questions or require any assistance with completing this application, please contact our Corporate Office at (780) 939-5116

Completed Applications can be mailed, faxed, emailed or dropped off at:

Homeland Housing Corporate Office
PO Box #3096 9922 – 103 Street
Morinville, AB T8R 1R7
Fax: 780-939-2513
Email: info@homelandhousing.ca

Homeland Housing
Better Housing, Better Living

Confidential Application for Accommodation

Primary Applicant	Co-Applicant
☐Mr. ☐ Mrs.☐ Miss. ☐Ms.	☐Mr. ☐ Mrs.☐ Miss. ☐Ms.
Frist Name:	First Name:
Middle Name:	Middle Name:
Last Name:	Last Name:
Status in Canada: ☐ Canadian Citizen ☐ Landed Immigrant ☐ Independent Status ☐ Private sponsorship	Status in Canada: ☐ Canadian Citizen ☐ Landed Immigrant ☐ Independent Status ☐ Private sponsorship
Sex: Male ☐ Female ☐	Sex: Male ☐ Female ☐
Date of Birth: (MM/DD/YYYY)	Date of Birth: (MM/DD/YYYY)
Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced	Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced
Mailing Address & Email	**Address if Different from Primary Applicant**
Street No. and Name:	Street No. and Name:
Apt No.:	Apt No.:
City:: Prov. Postal Code	City: Prov. Postal Code:
Email Address:	Email Address:
Can we email you?: ☐ Yes ☐ No	**Alberta Health Card #**
Preferred Method of Communication: ☐ Phone ☐ Email ☐ Correspondence	Applicant: Co-applicant:

Current Address – (Leave Blank if same as Mailing Address)
Street No. and Name:
Apt No.:
City: Prov. Postal Code:
Is this a Subsidized Unit? ☐ Yes ☐ No
Arrears: ☐ Yes ☐ No

Contact Information
Home Phone Number:
Work Phone Number: Can you take personal calls? ☐ Yes ☐ No
Cell Phone Number:
Can we safely contact you at your mailing address and home phone number: ☐ Yes ☐ No If no, please provide a number where we can safely contact you:

Present Accommodation	
Home Information: ☐ Own ☐ Rent ☐ Share	If Share, # 0f
Monthly Housing Expenses: Mortgage $	Adults:
Rent $	Children:
Monthly Electricity: $	Bedrooms:
Average Monthly Water: $	Bathrooms:
Average Monthly Heating: $	
Monthly Taxes: $	

Current Landlord Information (Please leave this section blank if you own your home or you are homeless)
Name: ______
Address: ______
City: ______ Postal Code ______
Telephone Number: ______
Occupancy From (MM/YYYY) ______
Have you received an eviction notice? ☐ Yes ☐ No (if yes please provide a copy of the notice with your application)
Eviction Date: Reason:

Other Information: Applicant
Preferred Language: ☐ English ☐ Other (please specify) ______
(Non-English support may not be provided)

Other Information: Co-Applicant
Preferred Language: ☐ English ☐ Other (please specify) ______
(Non-English support may not be provided)

Person to Contact in your Absence - Applicant

Name	Relationship	Telephone #	Cell #

Person to Contact in your Absence – Co-Applicant (if different than Primary

Name	Relationship	Telephone #	Cell #

Additional Requirements
I/We have no permanent address (eg. Live in hostel, hotel, on the street, etc.) ☐
If so please specify: ______
The applicant or a co-applicant is either 16 or 17 years of age. ☐
I/We have applied for housing within one year of entering Canada ☐
Please specify date of entry: ______
Do you or any member of your family have a life threatening medical condition? ☐ Yes ☐ No
If yes please specify the details: ______

Income	**Current Tax Year**			
	Applicant		**Co-Applicant**	
Total Income – Line 150 of Notice of Assessment	$		$	
Other Income	**PRINCIPLE $**		**INTEREST $**	
	Applicant	**Co-Applicant**	**Applicant**	**Co-Applicant**
Chequing/Savings Accounts				
R.R.S.P./R.R.I.F.				
Term Deposits/GIC's				
Stocks				
Bonds (Canada Savings Bonds/Alberta Bonds)				
Annuities				
Company Pensions (Annuities)				
Rental Property				
Other Investment Income				

Assets	Value	Value
	Applicant	**Co-Applicant**
House		
Cottage		
Recreational Vehicles		
Other (specify)		
TOTAL ASSET VALUE:	**$**	**$**

Type of subsidized housing applying for:

Lodges
Only Bachelor Suites Available

- ☐ Chateau Mission Court, St. Albert
- ☐ North Ridge Lodge, St. Albert
- ☐ Heritage Place Lodge, Morinville
- ☐ Chateau Sturgeon, Legal
- ☐ Spruce View Manor, Gibbons
- ☐ Diamond Spring Lodge, Redwater
- ☐ Pembina Lodge, Westlock
- ☐ Smithfield, DSL 3-4, Westlock

Affordable Housing
1 & 2 Bedroom Suites

- ☐ North Ridge Place, St. Albert

Self-Contained Apartments
1 Bedroom Suites

- ☐ Chateau Mission Court, St. Albert
- ☐ Heritage Place 6-Plex, Morinville
- ☐ Lions Manor, Morinville
- ☐ Sunset Villa, Legal
- ☐ Sunrise Villa, Legal
- ☐ Pinecrest Gardens, Gibbons
- ☐ Golden Villa, Redwater
- ☐ Sunridge Manor, Bon Accord
- ☐ Sunset Manor, Bon Accord
- ☐ Pembina Supportive Housing, Westlock
- ☐ Smithfield Supportive Housing, Westlock
- ☐ Parkview Place, Westlock
- ☐ Parkview Plaza, Westlock
- ☐ Legion Villa, Westlock
- ☐ East View Manor, Clyde
- ☐ Spruceview Manor, Jarvie

FACILITY PREFERENCE:

First Choice: ______________________________

Second Choice: ______________________________

Third Choice: ______________________________

Type of Suite Requesting ☐ **Bachelor** ☐ **One Bedroom** ☐ **Two Bedroom**

If applying as a couple are you looking for: ☐ **One Bedroom** ☐ **Two Bedroom**

Have you ever had accommodations with Sturgeon Foundation, Westlock Foundation or Homeland Housing?

☐ Yes ☐ No

If yes, reason for leaving: ______________________________

	Applicant		Co-Applicant	
Are you able to prepare your meals?	Yes ☐	No ☐	Yes ☐	No ☐
Are you able to do your own housekeeping?	Yes ☐	No ☐	Yes ☐	No ☐
Are you able to look after your personal needs?	Yes ☐	No ☐	Yes ☐	No ☐
Do you require parking?	Yes ☐	No ☐	Yes ☐	No ☐

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

Applicant	Co-Applicant		Applicant	Co-Applicant	
☐	☐	D.A.T.S.	☐	☐	Day Program
☐	☐	Medical Alert Sy stem	☐	☐	Bathing
☐	☐	Occupational Therapy	☐	☐	Physio Therapy
☐	☐	Socializing	☐	☐	DVA Assistance
☐	☐	Meals on Wheels			

☐ ☐ Private Care (give contact name) ____________________

☐ ☐ Mental Health Services (give contact name) ____________________

☐ ☐ Home Care (give Home Care Co-coordinator's name) ____________________

☐ ☐ Social Assistance / A.I.S.H. Worker (give contact name) ____________________

☐ ☐ Other (specify) ____________________

HEALTH INFORMATION:

____

____

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

App	CoApp		App	CoApp		App	CoApp	
☐	☐	Incontinence	☐	☐	Diabetes	☐	☐	Mobility – Use of Cane
☐	☐	Alcohol/Substance Abuse	☐	☐	Hearing	☐	☐	Mobility – Use of Scooter
☐	☐	Oxygen	☐	☐	Vision/Sight	☐	☐	Mobility – Use of Walker
☐	☐	Allergies	☐	☐	Seizures	☐	☐	Mobility – Use of Wheelchair
☐	☐	Other:						

____________________ ____________________

Signature - Applicant Date (dd/mm/yyyy)

____________________ ____________________

Signature – Co-applicant Date (dd/mm/yyyy)

Office Use Only

Date Application Received		Application Reviewed By	
Copy Given		Received by	☐ Fax ☐ Email ☐ Mail ☐ Drop Off
Date Entered in Yardi		Yardi mCode	

Medical Form

Must be completed by your physician

Medical Form is to be completed by applicant’s physician

Co-applicant is required to have Medical Form completed by physician (if applicable)

Patient's Name ______________________ ______________________
Surname First Name

Address ____
Street

______________________ ____________ ____________
City/Town Province Postal Code

Date examined ________ ________ ______________________
Day Month Year

Attending Physician: ____
Please Print or Type

Mailing Address: ____
Street

______________________ ____________ ____________
City/Town Province Postal Code

Telephone Number: ____

Facsimile Number: ____

AUTHORIZATION FOR RELEASE OF INFORMATION FROM THE MEDICAL REPORT

I ______________________ hereby authorize and instruct ______________________
(Applicant) **(Physician)**

to release to Homeland Housing the information requested by Homeland Housing, and I hereby waive any and all claims against the person or organization releasing the report, or any of its officers, servants, agents, staff members or employees for any purpose whatsoever in connection with the communication and disclosure of the said information.

DATE: ________ ________ ________
Day **Month** **Year**

SIGNED: ____

WITNESSED: ____

MEDICAL DIAGNOSIS (In order of significance):

____

____

____

____

____

____

____

HEAD AND NECK:

RESPIRATORY:

OXYGEN REQUIRED: Yes ☐ No ☐ Intermittent ☐ Continuous ☐

CARDIOVASCULAR: Blood Pressure: ______________________

Pacemaker: Yes ☐ No ☐

GASTROINTESTINAL: Continent: Yes ☐ No ☐

GENITO - URINARY: Continent: ☐ Incontinent ☐ Intermittent ☐

MUSCULOSKELETAL:

MENTAL HEALTH/MEMORY & ORIENTATION:

____

____

____

PSYCHO - SOCIAL/SPECIFIC BEHAVIOUR DISTURBANCE:

____

____

____

Any Alcohol or Other Substance Abuse: Yes ☐ No ☐

____

____

____

Vision/Sight Good ☐ Impaired ☐

____

____

____

Hearing Good ☐ Impaired ☐

____

____

____

Hospitalized in the last 12 Months? Yes ☐ No ☐

If yes, Where: ____

Why ____

How Often, ____

Length of Stay: ____

List of Current Medication(s):

____

____

____

Chest x-ray report: ______________________ **Date:** ______________

Activities of Daily Living: Is the Client:

- ☐ Able to Prepare Meals
- ☐ Able to do Own Housekeeping
- ☐ Able to Look After Personal Needs

Aids to Daily Living:

Cane ☐ Walker ☐ Wheelchair ☐ Scooter ☐

Do you consider this Applicant to be suitable mentally and physically to enter a lodge where: No Special Care, Nursing Care or Special Diets are available?

Yes ☐ No ☐

COMMENTS:

____

____

____

How long has the applicant been your patient?

____

Will you be the attending physician if/when the applicant moves to Homeland Housing?

Yes ☐ No ☐

Admitting Privileges To: ____

Accepting Physician: ____

________________________________ ______________________

Physician's Signature **Date**