MATHESON

Affordable Seniors Living

APPLICATION FORM

Name: _____ Personal Health Number: _____

Spouse/Partner: _____ Personal Health Number: _____

Address _____ City: _____ Postal Code: _____

Phone # _____ Marital Status: _____

Date of Birth: Applicant _____ Spouse/Partner: _____

☐ **Smoker?** ☐ **Do you require a non-smoking suite for health reasons?**

☐ **Are you wanting a parking spot in our garage? (There is a waiting period)**

Please provide us with the following information about your <u>current</u> and <u>previous</u> landlords:

Name _____

Address _____ How long at this address? _____

Phone Number _____

Name _____

Address _____ How long at this address? _____

Phone Number _____

Matheson Seniors Residence is an independent living building, not an assisted living building. All tenants must be capable of caring for their own needs. To ensure that this is possible, all applicants must complete a medical assessment form, which can be found online or picked up at the Main Office.

☐ **I have completed and included this form.**

Matheson is a member of the "Crime Free Multi-Housing" programme. To meet the requirements of this programme, all applicants must obtain a Police Information Check and submit the document to Matheson before a lease can be offered.

☐ **I have included this form.**

Matheson is a not-for-profit organization serving low income seniors. To qualify for housing here, all applicants must submit copies of their Revenue Canada Tax Assessment forms for the past 3 years.

☐ **I have included these forms.**

I understand that Matheson guarantees shelter only. I am aware that Matheson falls under the Alberta Residential Tenancies Act and has no responsibilities to me beyond that Act.

I understand and agree that providing incorrect information in connection with the application will be cause for application refusal or eviction.

Signature_____**Date**_____

Signature_____**Date**_____

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Confidential Medical Report

This form is to be completed by your family doctor using information that is no older than 6 months. Please visit your family doctor for a complete physical to provide the information required.

Please return the form to:

Matheson Seniors Residence
11445 - 135 St
EDMONTON AB T5M 3M6
FAX: 780-454-6045

If you or your Physician have questions about the information required, please feel free to call us during office hours (M-F; 8 am-4:30 pm) at 780-454-5505. Please note that the applicant is responsible for any charges associated with completion of this form.

Authorization

I _____ hereby authorize and instruct

my doctor _____

to release to Matheson Seniors Residence the information in this form.
I hereby waive any and all of its officers, agents, staff or employees for any purpose whatsoever in connection with the communication and disclosure of said information.

_____ _____

Signature of Applicant Date

Patient Information

Surname, First name, Initial

Address

Date of Birth

Phone Number

Physician Information

Full Name

Address

Phone Number

Date of Examination

Medical Assessment Form

Height: **Weight:**

Blood Pressure: **Pulse:**

Allergies

Current Medical Diagnoses (in order of significance)

Past Medical History

Hospital Visits in the past 2 years

Current Medications (or attach a print-out)

LAB WORK

Chest X-Ray	**_____**	**_____**
	Date	**Result**
HGB	**_____**	**_____**
	Date	**Result**
Urinalysis	**_____**	**_____**
	Date	**Result**

Care Information

If the patient has a serious medical condition, are they aware of it? _____

Is the patient's family aware of his or her medical needs? _____

Does the patient receive Home-Care services? _____

Does the patient require nursing services? _____

Does the patient require special dietary services? _____

Will the patient be safe in a suite with a stove? _____

Does the patient require a unit with wheelchair accessibility? _____

Is the patient able to walk 75 metres daily? _____

Does the patient have completed personal directive? _____

If yes, does the directive include "NO CPR?" _____

How long has the applicant been your patient? _____

_____

Physician's Signature **Physician's Stamp**