Abbeyfield House Society of High River.
Box 12, 708-2ND Street SE., High River, Alberta. T1V 0C6
Charitable Registration # 89119 9028 RR0001

Date: _____

File # _____

APPLICATION FOR RESIDENCY

Please complete this form by typing or printing in block letters.

Surname (Mr., Mrs., Ms., Miss) _____

First Name (s) _____

I like to be known as _____

Date of Birth _____ Marital Status _____

Address _____

Postal Code _____ Telephone (____) _____

Email _____

Place of Birth _____ Social Insurance Number (SIN) _____

Alberta Health Care Number _____

If you do not have Alberta Health Care, how long have you been a resident of Alberta? _____

Have you applied for Alberta Health Care? Yes ☐ No ☐

Other Health Insurance Coverage _____

_____

Do you receive income from:

Old Age Security Pension	Yes ☐	No ☐
Canada Pension Plan	Yes ☐	No ☐
Guaranteed Income Supplement	Yes ☐	No ☐
Spouse's Allowance	Yes ☐	No ☐
Other Private Income	Yes ☐	No ☐

File # _____

Name of the nearest responsible relative or friend (local if possible) who would be prepared to take an interest in your well-being and who would accept certain responsibilities as Sponsor on your behalf, during your stay at Abbeyfield.

Name _____

Address _____

Telephone _____ Email _____

Relationship _____

Next-of-kin (if different than above) _____

Address _____

Telephone _____ Email _____

Relationship _____

DECLARATION:

I wish to apply to live in the Abbeyfield House of High River and I am able to provide the required furniture for my room. I understand that I am responsible for maintaining all my furnishings and medical devices (if any).

I authorize the Abbeyfield Society of High River to make enquiries of my doctor, and hereby consent to the findings of the medical examination being confidentially communicated to the Honorary Medical Consultant of the Society, so that he can make a recommendation as to my medical suitability to become a Resident.

I understand that charges may, from time to time, be increased as determined by the Society.

I understand that nursing care is NOT provided. In the event of serious illness, where it would be necessary for me to go to hospital or other facility, I would give my permission for an ambulance to be called at my expense.

I understand the House Manager's duties do not include overseeing my medications. I agree to prevent access to others by keeping them in a secure place in my room.

I understand that this is a non-smoking facility.

If I wish to leave, I would undertake to give Abbeyfield House Society one month's notice in writing or payment in lieu of such notice. I would also undertake to make arrangements to have my furniture and other belongings removed upon termination of my residency.

Upon being accepted in Abbeyfield House as a Resident, I understand that I will be expected to sign a resident's Agreement with the society.

Signature: _____ Date: _____

File # _____

Gender: Male ☐ Female ☐

Do you have any health problems? If so, please give details:

_____

_____

_____

_____

_____

_____

Please check answers to the following questions:		Yes	Sometimes	No
Do you drive a car?		☐	☐	☐
When you travel in your community do you need assistance?		☐	☐	☐
Are you in a bed or a chair most of the day?		☐	☐	☐
Do you have trouble bending, lifting or stooping?		☐	☐	☐
Do you have difficulty walking several blocks?		☐	☐	☐
Do you have difficulty climbing a few stairs?		☐	☐	☐
When walking:	Do you need assistance?	☐	☐	☐
	Do you need a cane?	☐	☐	☐
	Do you need a walker?	☐	☐	☐
	Do you need a wheelchair?	☐	☐	☐
	Do you need a scooter?	☐	☐	☐
Can you quite easily:	Open a can of food?	☐	☐	☐
	Button your clothes?	☐	☐	☐
	Tie your shoe laces?	☐	☐	☐
	Turn a key in a lock?	☐	☐	☐
	Write with a pen/pencil?	☐	☐	☐
	Complete your housework?	☐	☐	☐
Do you do your own shopping?		☐	☐	☐
Do you prepare your own meals?		☐	☐	☐
Do you feed yourself?		☐	☐	☐
Do you do your own laundry?		☐	☐	☐
Do you take a bath or shower without help?		☐	☐	☐
	How many times per week? _____			

Do you take medications on a regular basis? Yes ☐ No ☐ If YES, please list:

_____

_____

_____

_____

Pharmacy Name: _____ Telephone: _____

File # _____

Do you have difficulty speaking? Yes ☐ No ☐

Do you have difficulty swallowing? Yes ☐ No ☐

Do you have food allergies? Yes ☐ No ☐

If yes, please list them

_____

_____

Have you consulted a medical doctor in the last six (6) months? Yes ☐ No ☐

If YES, please give the reason for the consultation _____

_____

_____

The doctor's name _____ date of the visit _____

Are you currently being seen by a medical specialist? Yes ☐ No ☐

If YES, please give name, telephone number and specify the reason.

_____

_____

How often have you fallen in the last three months?

- Not at all ☐
- Once ☐
- 2 – 3 times ☐
- 4 or more times ☐

Are you worried about falling?

- Very worried ☐
- Somewhat worried ☐
- Not worried ☐

How often do go to see your family doctor?

- More than once a week ☐
- Once a week ☐
- Once a month ☐
- Once every six months ☐
- Once a year ☐
- Less than once a year ☐

Family Doctor's Name: _____ Telephone: _____

Address: _____

File # _____

Current living arrangements:
Please provide the following information about your present living situation.

I own my own home ☐

I rent my home ☐

If you rent, are you on notice to leave? ☐

If on notice, please give details.

_____

_____

Do you live alone?	Yes ☐	No ☐
Do you live with your spouse?	Yes ☐	No ☐
Do you live with adult children/ relatives?	Yes ☐	No ☐
Do you live with a friend or friends?	Yes ☐	No ☐
Do you live in a care home?	Yes ☐	No ☐

Social contact:
During the last three (3) months, how often have you met socially with friends or relatives?

Every day ☐

Several days per week ☐

2 to 3 times per month ☐

Not at all ☐

Hobbies and interests:
We are interested in knowing about your hobbies and other interests. Please list these below:

_____

_____

Organizations:

Are you a member of a club, church or other organization?	Yes ☐	No ☐
Are you active in the club or organization?	Yes ☐	No ☐

Please give details:

_____

_____

Please remember to fill out the Medical Assessment Questionnaire and submit both forms to:

Abbeyfield House Society of High River
Box 12, 708-2nd Street SE
High River, Alberta. T1V 0C6

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Charitable Registration # 89119 9028 RR0001

Date: _____ RES 2008-2

File # _____

MEDICAL QUESTIONNAIRE - IN CONFIDENCE

Dear Applicant and Doctor:

The following information is requested so that the Residents' Selection Committee of the Abbeyfield House Society of High River may be informed as to the medical condition of the following person:

_____
who is applying for Residency in the Abbeyfield House High River.

The Abbeyfield House Society of High River and the Abbeyfield Concept

The House, with a maximum of ten residents, provides supportive assistance and companionship for lonely seniors who, although relatively fit for their years, are no longer willing or able to live in their own home and do not need institutional care. We offer a family-style setting and a balance between privacy and companionship; security and independence. Seniors who have Alzheimer disease are not suitable.

The four main criteria for residency are, in order of importance:

- Extent of loneliness
- Level of health
- Likely compatibility with other residents
- Income sensitivity

A current medical examination is requested at the time of application. It is therefore essential that the information given is factual and up-to-date. Incomplete information could result in embarrassment and impediment to the prospective resident, who might otherwise be considered suitable as a resident.

The pages following contain a simple questionnaire. Please contact your own medical doctor to make the necessary arrangements to have this medical questionnaire completed, ***as soon as possible***, and have it returned to you or to:

Chair, Resident Selection Committee,
Abbeyfield House Society of High River
Box 12, 708–2nd Street SE,
High River, Alberta. T1V 0C6

I agree to the release of the following confidential information to Abbeyfield and any related medical inquiries to that information requested by Abbeyfield.

_____ _____
Signature of Applicant *Date*

File # _____

MEDICAL QUESTIONNAIRE

Name of Applicant: _____ Date of Birth: _____

Questions:	Yes	No	If No, Please Specify
1. Is vision normal?	☐	☐	_____
2. Is hearing normal?	☐	☐	_____
3. Is urinary function normal?	☐	☐	_____
4. Is bowel function normal?	☐	☐	_____
5. Is there any history of heart or lung disease?	☐	☐	_____
6. Is there any history of allergy to food or drugs?	☐	☐	_____
7. Is there any digestive disorder?	☐	☐	_____
8. Are there any significant medical problems?	☐	☐	_____
9. Is there any skin condition or ulcers requiring treatment?	☐	☐	_____
10. Is there any mental or emotional problem?	☐	☐	_____
11. Can applicant climb stairs, walk, dress, bathe, and eat unaided?	☐	☐	_____
12. Does applicant need regular drug or nursing care?	☐	☐	_____

File # _____

	Yes	No	If No, Please Specify
13. Does applicant have a prosthesis, pacemaker, etc.?	☐	☐	_____
14. Does applicant have annual Influenza inoculations?	☐	☐	_____
15. Is there a history of drug or alcohol abuse?	☐	☐	_____
16. Is the applicant, in your opinion, suitable physically, mentally & emotionally for residency in Abbeyfield House?	☐	☐	_____

Physician's Name: _____

Address: _____

Telephone: _____

Signature: _____

Privacy and Confidentiality Policy:

All personal information given to Abbeyfield House Society of High River will remain completely confidential. This information may be disclosed only to appropriate third parties after consultation with, and, written authorization from, the provider of the information.

Information will not be collected or retained that is not necessary or otherwise required by law.

Personal information will be stored in a locked, secure location.

Please return this completed form to:

Chair, Resident Selection Committee
Abbeyfield House Society of High River
Box 12. 708–2nd Street. SE
High River, Alberta. T1V 0C6