Sylvan Lake Foundation

"The best place for your best days"

Application for Accommodations

Our Mission is to provide seniors of modest means with affordable, secure, home-like living through our wellness programs, enhanced through community partnerships.

Information provided with this application is collected under the authority of the Alberta Housing Act and is protected by the provisions of the Freedom of Information and Protection of Privacy Act.

FULL NAME	First Name	Last Name
ADDRESS	Street/Box	
	Town/City	Postal Code
PHONE #	Home	Cell
DATE OF BIRTH	Date/Month/Year	Current Age
PERSONAL HEALTH CARE NUMBER		

MARITAL STATUS (Please check the appropriate box)				
☐ Married	☐ Widow/Widower	☐ Separated	☐ Divorced	☐ Single

Have you ever been convicted or charged with a criminal offense?	Yes	No

Length of Residence in Alberta	Preferred Language

*Please attach a copy of your most recent **Notice of Assessment** from Revenue Canada for your application to be processed.

A personal interview with the Housing Coordinator will be part of the assessment/placement process. Priority for admission to the Lodge will be determined based on the information provided with this application. The applicant will be advised of their priority compared to other applicants and vacancies will be the basis of the highest priority rating.

Requested date of occupancy: ____

Any other information or comments that would assist us in processing your application:

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I ______________________________ certify that the foregoing information is correctly answered and I agree to abide by the regulations for living in the Lodge of the Sylvan Lake Foundation.

______________________________ ______________________________
DATE SIGNATURE OF APPLICANT

PLEASE RETURN THIS COMPLETED APPLICATION FORM TO:
SYLVAN LAKE FOUNDATION
100, 4620 – 47 AVENUE
SYLVAN LAKE, ALBERTA T4S 1N2

SYLVAN LAKE FOUNDATION

MEDICAL CERTIFICATE

APPLICANT NAME: ______________________ EXAMINATION DATE: ________________

ADDRESS:______________________________________TELEPHONE:_________________

BIRTHDAY:______________________HEIGHT:________________WEIGHT:_____________

APPLICATION AUTHORIZATION

I hereby, authorize any physician, medical clinic, hospital or other person that has any records or knowledge of my health to provide full information to the Sylvan Lake Foundation or any authority of their behalf.

DATE: ___________________________ SIGNATURE : ______________________________________

MENTAL CONDITION

- ☐ Approximately normal
- ☐ Period of confusion and or Forgetfulness
- ☐ Persistent confusion, disorientation
- ☐ Hallucinations
- ☐ Drug abuse
- ☐ Other:______________________

BEHAVIOUR

- ☐ Approximately normal
- ☐ Emotionally unstable
- ☐ Withdrawn, apathetic
- ☐ Wanders
- ☐ Noisy, disturbing to others
- ☐ Hoarding tendencies
- ☐ Other:_________________

PHYSICAL CONDITION

Speech	☐ Normal	☐ Impaired	☐ Absent
Vision	☐ Normal	☐ Impaired	☐ Absent
Hearing	☐ Normal	☐ Impaired	☐ Absent
Glasses	☐ Yes	☐ No	
Hearing Aid	☐ Yes	☐ No	

- ☐ Obesity
- ☐ Heart problem
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Lung condition
- ☐ Other, please explain: ____

MOBILITY

☐ Independent ☐ Walking Aid ☐ Wheelchair

DEFECTS

☐ Arms ☐ Hands ☐ Fingers ☐ Legs ☐ Feet ☐ Joints ☐ Body

CARE REQUIREMENTS

☐ Dresses self
☐ Does own grooming
☐ Bathes self
☐ Feeds self
☐ Manages own medications
☐ Continent of urine
☐ Continent of bowels

DIET

☐ Regular ☐ Low salt ☐ Low fat ☐ Diabetic

MEDICATIONS		**ALLERGIES**
______________	______________	______________
______________	______________	______________
______________	______________	______________

TB X-RAY: ______________ Results: ______________

Does the applicant require Home Care Services? ☐ Yes ☐ No
If yes, what services?: ______________

Is the applicant suffering from any chronic diseases, which requires:
Special care: ______________ Medical treatment: ______________
Remarks: ______________

Please comment on any idiosyncrasies, sleeping patterns, personal hygiene.
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Any further remarks that may be helpful in evaluating this applicant.
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PLEASE NOTE: THIS APPLICATION CANNOT BE ACCEPTED IF IT IS NOT COMPLETLY FILLED OUT.

SIGNATURE OF MEDICAL PHYSICIAN: ______________
PRINTED SIGNATURE: ______________
COMPLETE ADDRESS: ______________
TELEPHONE NUMBER: ______________
PLEASE MAIL OR FAX THIS COMPLETED MEDICAL EXAMINATION TO:

SYLVAN LAKE FOUNDATION/SYLVAN LAKE LODGE
100-4620-47 AVENUE
SYLVAN LAKE, ALBERTA T4S 1N2
FAX: 403-887-6039