



**ROCKY SENIOR HOUSING COUNCIL**

5427- 52 AVENUE

ROCKY MOUNTAIN HOUSE, ALBERTA

T4T1S9

Telephone: (403) 845-3588 Fax: (403) 845-2228

E-mail: [wvlodge@telusplanet.net](mailto:wvlodge@telusplanet.net)

Visit our website: [www.rockyseniors.com](http://www.rockyseniors.com)

**APPLICATION FOR ACCOMMODATION – SENIOR CITIZENS**

**(CONFIDENTIAL)**

**PLEASE READ CAREFULLY**

I understand that this is just an application and that it is not an agreement on the part of Rocky Senior Housing Council, or its agents, to provide me with rental accommodation.

I further acknowledge the right of Rocky Senior Housing Council, or its agents, at any time prior to the execution and delivery to me of a lease, to withdraw, or cancel, without penalty or liability for damages or otherwise, any prior approval of this application.

I authorize Rocky Senior Housing Council, or its agents to investigate any or all of the statements made by me in this application, being fully aware that discovery of any false statement shall cancel any further consideration of my application.

I further agree that I am obligated to advise Rocky Senior Housing Council, or its agents, in writing, of any changes in family composition, gross family income, assets, employment or change of address, should they occur.

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Signature of Witness

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Signature of Applicant

## Information Collection Notice

When you become a resident of **Westview Lodge/ Rocky Senior Housing**, or when you apply for tenancy with us, we will collect your contact information and other necessary personal information. It will be used to:

- Determine if you are eligible for housing with us
- Confirm: your identity, health and/ or eligibility for the service we provide
- Provide ongoing service to meet your needs

We may disclose your personal information:

- When there is proper documentation to confirm that the information is being requested on your behalf
- To medical caregivers to help them provide the service you need
- When permitted or required by law; or
- To a public authority if, in our reasonable judgment, there appears to be an imminent danger which could be avoided by disclosing the information.

If you have any questions about the collection of your personal information, call us at **403-845-3588** from **8:30am- 3:30pm**.



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I, \_\_\_\_\_, of the \_\_\_\_\_ of \_\_\_\_\_, in the Province of Alberta, do solemnly declare as follows:

1. That I am the applicant named in this application;
2. That the statements made by me in this application are to the best of knowledge, information and belief, full and true in all respects;
3. That I have resided in the Province of Alberta for \_\_\_\_\_ years of my life and in the district for \_\_\_\_\_ years;

And I 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."

Declared before me

at the \_\_\_\_\_ of \_\_\_\_\_  
(town or city) (name of city or town)

in the province of Alberta,

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Commission for Oaths

My appointment expires on \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Commission for Oath



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**PLEASE PRINT**

PLEASE ANSWER ALL QUESTIONS

APPLICATION FOR OCCUPANCY

Full Name: \_\_\_\_\_  
Surname (Please Print) First Name

Present Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone No. (Including Area Code): \_\_\_\_\_

Date of Birth (Month- Day- Year): \_\_\_\_\_

Social Insurance Number: \_\_\_\_\_

Alberta Health Care Number: \_\_\_\_\_

\*\*\*\*\*

CO- APPLICANT (IF APPLICABLE)

Full Name: \_\_\_\_\_  
Surname (Please Print) First Name

Date of Birth (Month- Day- Year): \_\_\_\_\_

Social Insurance Number: \_\_\_\_\_

Alberta Health Care Number: \_\_\_\_\_

ROCKY SENIOR HOUSING COUNCIL

Please provide an alternate contact person.

Person to Contact: \_\_\_\_\_

Relationship to Applicants: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone No. (Including Area Code): \_\_\_\_\_

\*\*\*\*\*

1. Total from Line 150 of your income tax return: \$\_\_\_\_\_

2. Do you own or rent your present accommodation:  Own  Rent

3. Present rent or house payment: \$\_\_\_\_\_/ month

4. On average, how much do you pay for utilities: \$\_\_\_\_\_/ month

5. Is your present accommodation a:  House  Rooming House  
 Apartment  Motel/ Hotel  
 Other \_\_\_\_\_

6. Number of person(s) sharing your present accommodation:  
\_\_\_\_ Adults \_\_\_\_\_ Children

7. Reasons for wanting to move to a Senior's Self Contained apartment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Is there any other information you wish to provide:

\_\_\_\_\_  
\_\_\_\_\_

ROCKY SENIOR HOUSING COUNCIL

9. PLEASE LIST YOUR 1<sup>ST</sup>, 2<sup>ND</sup>, AND 3<sup>RD</sup> CHOICES:

***ALL OF OUR PROJECTS ARE NON SMOKING AND NO PETS!***

\_\_\_\_\_ **ACTON HOUSE, ROCKY MOUNTAIN HOUSE**  
(20 UNITS- ROW HOUSING)

\_\_\_\_\_ **COLUMBUS PLACE, ROCKY MOUNTAIN HOUSE**  
(THREE STOREY APARTMENT BUILDING- 36 UNITS)

\_\_\_\_\_ **DAY MANOR, ROCKY MOUNTAIN HOUSE**  
(8 UNITS- SECURE BUILDING ENTRY ONLY BY KEY OR BUZZER SYSTEM)

\_\_\_\_\_ **MCLEOD MANOR, LESLIEVILLE**  
(4 UNITS- ROW HOUSING)

\_\_\_\_\_ **MOUNTAIN SUNSET MANOR, CAROLINE**  
(8 UNITS- SECURE BUILDING ENTRY ONLY BY KEY OR BUZZER SYSTEM)

**\*\* All of our facilities are strictly no smoking and do NOT  
allow pets of any kind!\*\***

\*\*\*\*\*

**WHEN YOU BOOK THE  
APPOINTMENT  
PLEASE LET THEM KNOW  
THAT IT IS FOR A  
“MEDICAL”.**

**This makes sure that enough time is booked for  
the appointment with your Doctor.**

\*\*\*\*\*

TO: ATTENDING PHYSICIAN

Do not return this medical certificate to the applicant. Please complete and return directly to:

ADMINISTRATOR- [ROCKY SENIOR HOUSING](#)  
5427 – 52 Avenue, ROCKY MOUNTAIN HOUSE, AB T4T 1S9  
Telephone: 403-845-3588 Fax: 403-845-2228  
Email: [wvlodge@telusplanet.net](mailto:wvlodge@telusplanet.net)

I, \_\_\_\_\_ HEREBY CONSENT TO THE RELEASE OF THIS INFORMATION TO ROCKY SENIOR HOUSING COUNCIL AS PART OF MY APPLICATION TO WESTVIEW LODGE/SELF CONTAINED UNITS (SCU).

\_\_\_\_\_  
Signature of Applicant Date

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**NOTE TO EXAMINING PHYSICIAN:**

If this is an Apartment (Self Contained) applicant; they MUST be able to manage ALL day to day living needs on their own including scheduling home care and medical appointments.

Name of Applicant \_\_\_\_\_ Age \_\_\_\_\_

Date of Examination \_\_\_\_\_

Is Applicant able to walk two blocks with ease? \_\_\_\_YES \_\_\_\_NO

Does the Applicant require Home Care assistance? If yes, please specify needs.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the Applicant suffering from any chronic disease? If answer is yes, please explain in detail. \_\_\_\_\_

\_\_\_\_\_

Past or present medical illness. \_\_\_\_\_



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Past or present surgery. \_\_\_\_\_

\_\_\_\_\_

Habits: Smokes \_\_\_\_\_ Drinks \_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_

Does the Applicant show any sign of senility? If yes, to what degree? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Walking Aids \_\_\_\_\_ Vision \_\_\_\_\_ Hearing \_\_\_\_\_

Other remarks: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you consider your patient to be suitable mentally and physically to enter an APARTMENT where they are responsible for their own daily living needs:

\_\_\_\_\_YES \_\_\_\_\_NO

RATING OF ACCEPTABILITY: A) \_\_\_\_\_, B) \_\_\_\_\_, C) \_\_\_\_\_, D) \_\_\_\_\_

- A) Totally
- B) Defects present, but controlled medically or surgically
- C) Doubtful, because of senile changes, unclean habits
- D) Unacceptable, chronic invalid, etc.

SIGNATURE OF PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE  
INCLUDE AREA CODE: \_\_\_\_\_