



## **ROCKY SENIOR HOUSING COUNCIL**

5427- 52 AVENUE

ROCKY MOUNTAIN HOUSE, ALBERTA

T4T1S9

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

E-mail: [info@rockyseniors.com](mailto:info@rockyseniors.com)

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

The personal information in this form is being collected by Rocky Senior Housing under section 33(c) of the Freedom of Information and Protection of Privacy Act for the purpose of administering applications for subsidized housing or rental benefits. If you have questions regarding the collection of this information, please contact Westview Lodge at **403-845-3588** from **8:30am – 4:30pm**.

When you apply/and become a tenant of **Rocky Senior Housing**, 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.



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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

\_\_\_\_\_  
A Commissioner for Oaths in and for Alberta

\_\_\_\_\_  
Printed name of Commissioner for Oaths and Appointment Expiry Date



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**PLEASE PRINT  
PLEASE ANSWER ALL QUESTIONS OR YOUR APPLICATION WILL BE  
RETURNED**

APPLICATION FOR OCCUPANCY

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

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

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

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

Please check of your residency:

- Canadian Citizen
- Refugee
- Permanent Resident
- Sponsored by the Government of Canada
- Ukrainian Evacuee
- Applicant of Refugee or immigrant Status
- Landed Immigrant with private sponsorship
- Other

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CO- APPLICANT (IF APPLICABLE)

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

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

Please check of your residency:

- Canadian Citizen
- Refugee
- Permanent Resident
- Sponsored by the Government of Canada
- Ukrainian Evacuee
- Applicant of Refugee or immigrant Status
- Landed Immigrant with private sponsorship
- Other

**Please provide an alternate contact person that is not your spouse.**

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

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

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

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

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**You MUST provide your most recent Notice of Assessment (NOA) and proof of any other income not included in your NOA (Example: RRIF, Private Pension, out of country pension, investment income)**

**\*\* If your most current NOA is not indicative of your income, please also include three months of your most recent bank statements, with your name on them \*\***

1. Finances

- AISH \$\_\_\_\_\_ monthly / yearly
- Old Age Security \$\_\_\_\_\_ monthly / yearly
- Alberta Seniors Benefits \$\_\_\_\_\_ monthly / yearly
- Guaranteed Income Supplement \$\_\_\_\_\_ monthly / yearly
- Government Rebates \$\_\_\_\_\_ monthly / yearly
- Canada Pension Plan \$\_\_\_\_\_ monthly/yearly
- Other Pension \$\_\_\_\_\_ monthly/yearly
- Employment \$\_\_\_\_\_ monthly / yearly
- Other (RRSP, RRIF, etc.): \$\_\_\_\_\_ monthly / yearly

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

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

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

5. Do you pay utilities on top of your monthly rent?  Yes  No

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

7. Please Check off any of the Following population groups that apply to members of your household that are applying for tenancy:

- Indigenous peoples
- People with disability
- Individual fleeing violence or leaving a second stage Shelter
- At risk of or transitioning out of homelessness\*
- People dealing with mental health or recovering from addiction\*

- Veteran
- Recent Immigrant or Refugee (In Canada less than 5 years)
- Racialized group
- Identify with diverse concepts of gender identity and expression or sexual orientation

**\*Rocky Senior Housing Council is mandated through the Social Housing Accommodation Regulation to determine that the applicant(s) is/are able to safely live independently, including seeking verification from social or community services.**

The personal information collected through Rocky Senior Housing Council is for the purpose of application for subsidized housing or rental benefits. This collection is authorized by section 33(c) of the Freedom of Information and Protection of Privacy Act. For questions about the collection of personal information, contact the office at 403-845-3588 or mail to 5427 52 Ave, Rocky Mountain House, AB T4T 1S9

8. Do you smoke:     Yes             No

9. Do you currently live in:

Clearwater County            Yes/ No    How many years? \_\_\_\_\_

Village of Caroline            Yes/ No    How many years? \_\_\_\_\_

Rocky Mountain House    Yes/ No    How many years? \_\_\_\_\_

**Please note: Rocky Senior Housing Council determines housing accommodation eligibility based on residency requirements. Applicants must have lived in Clearwater County, the Town of Rocky Mountain House, or the Village of Caroline for a minimum of one year.**

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

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

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12. 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)

(Rent cap: \$800.00)

\_\_\_\_\_ **COLUMBUS PLACE**, ROCKY MOUNTAIN HOUSE

(THREE STOREY APARTMENT BUILDING- 36 UNITS)

(Rent cap: \$800.00)

\_\_\_\_\_ **DAY MANOR**, ROCKY MOUNTAIN HOUSE

(8 UNITS- SECURE BUILDING ENTRY ONLY BY KEY OR BUZZER SYSTEM)

(Rent cap: \$800.00)

\_\_\_\_\_ **MCLEOD MANOR**, LESLIEVILLE

(4 UNITS- ROW HOUSING)

(Rent cap: \$565.00)

\_\_\_\_\_ **MOUNTAIN SUNSET MANOR**, CAROLINE

(8 UNITS- SECURE BUILDING ENTRY ONLY BY KEY OR BUZZER SYSTEM)

(Rent cap: \$670.00)



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**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: [info@rockyseniors.com](mailto:info@rockyseniors.com)

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

\*\*\*\*\*

**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 \_\_\_\_\_

How long has the applicant been under your care: \_\_\_\_\_

Is the patient able to administer their own medication safely and accurately?  
 YES  NO

Is Applicant able to walk two blocks with ease?  YES  NO

What kind of walking aids does the Applicant use: \_\_\_\_\_

Does the Applicant require Home Care assistance?  YES  NO

If YES, please specify needs.

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

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

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

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

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

Does the Applicant show any sign of senility or memory loss?

YES  NO

If YES, to what degree and please provide a copy of MMSE or MOCA.

Has the patient been diagnosed with any mental health condition that may impair their ability to manage independently? \_\_\_\_\_ YES \_\_\_\_\_ NO

If YES, please explain:

How is the patient's sight?

Good  Impaired  Managed with vision aids

How is the patient's hearing?

Good  Impaired  Managed with hearing aids

How is the patient's speech?

Good  Impaired  Managed with supplementary aids

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: \_\_\_\_\_