M.D. OF ST PAUL FOUNDATION

APPLICATION FOR SENIORS SELF- CONTAINED APARTMENTS

- ☐ Ashmont Aspen Grove Apartments
- ☐ Buckingham House
- ☐ Fort George Manor
- ☐ Heritage Homes I
- ☐ Heritage Homes II
- ☐ Mallaig Golden Lodge Homes

Please return Application to:

4440-50th Avenue
St. Paul, Alberta
T0A 3A2
Tel: 780-645-5366
Fax: 780-645-5733
l.starnault@stpaulfoundation.ca

1. **Applicant's Name:** _____
(Last Name) (First Name)

2. **Present Address:** Box or Street Address: _____

City, Town, Village: _____Postal Code_____

Telephone No: _____

Length of Tenancy: _____

Date of Birth: _____(mm/dd/yyyy)

Alberta Health Care No: _____

Social Insurance No: _____

3. **Co-Applicant's Name:** _____
(Last Name) (First Name)

Present Address: Box or Street Address: _____

City, Town, Village: _____Postal Code:_____

Telephone No: _____

Length of Tenancy: _____

Date of Birth: _____

Alberta Health Care No: _____

Social Insurance No: _____

4. **Present Landlord's Name and Address:** _____

_____

Landlords Telephone No: _____ Rental Payments _____

5. **Marital Status:** _____

6. **Are you a Canadian Citizen:** Yes _____ No _____

7. **Please List all assets:** Own Home: Value: $_____

Investments: Value: $ _____

Own Vehicle: Value: $ _____

Other: Value: $ _____

8. **Please Provide: Yearly Income Tax Return or Notice of Assessment Approved by The Canada Customs And Revenue Agency.**

9. **Reason for wanting to move:** _____

_____

10. **When are you prepared to move?** _____

11. **Next of Kin:** _____ **Next of Kin**_____

Relationship: _____ Relationship:_____

Phone No: _____ Phone No:_____

12. **Will you require a parking stall?** Yes No_____

The Information supplied in this application is to the best of my/our knowledge and belief, complete and accurate.

I/We authorize the MD of St. Paul Foundation to obtain such information as it may require regarding my/our affairs and agree that it may be retained by the MD of St. Paul Foundation.

I/We agree that upon acceptance of this application I/We shall enter into as Residential Tenancy Agreement with the MD of St. Paul Foundation prior to taking possession.

I/We have read and understood and agree with the foregoing terms.

Applicant Signature _____ Date _____

Co-Applicant Signature _____ Date _____

(Acceptance MD OF ST. PAUL Foundation)

Accepted this _____ Day of _____, 20_____.
MD OF ST. PAUL FOUNDATION

PER: _____ (Property Manager)

SENIOR CITIZENS HOUSING MEDICAL INFORMATION

To: ATTENDING PHYSICIAN

a. This Medical Information form required by the M.D. of St. Paul Foundation in regards to all Applicants seeking admission into self-contained Senior Citizens Apartments. All information must be current within a six-month time frame.

b. The form is to supplement other information to determine if the Applicant is physically able to look after himself/herself in a self contained apartment-type complex

c. Any charge for the completion of this form is the responsibility of the Applicant

d. Once the Applicant has signed the Authorization, please do not return the form to the Applicant but mail it directly to: M.D. of St. Paul Foundation
4440-50 Ave.
St. Paul, Alberta
T0A 3A2
or Fax: 780 645 5733 email: l.starnault@stpaulfoundation.ca

AUTHORIZATION

I hereby authorize any Physician, Medical Clinic, Hospital or other person that has any knowledge of my health to provide full information to the M.D. of St. Paul Foundation or any authority acting on their behalf.

DATE: _____ Signature of Applicant: _____

Witness: _____

1. Name of Applicant: _____

   Address: _____

   Birthdate: _____
2. Date of last contact with the patient to substantiate this information: _____
3. Can the Applicant physically maintain himself/herself in a private self-contained apartment?
   YES: _____ NO: _____
4. Please detail any medical information which you feel would be important to the Applicant's application for Senior Citizens Housing:

   _____

   _____

   _____

   DATE: _____ Attending Physician's Signature_____

   Name (Please Print) _____