MISSION ASSOCIATION FOR SENIORS HOUSING
7380 HURD STREET, MISSION, BC V2V 3H5

Assisted Living and Supportive Housing

TENANCY APPLICATION FORM **Date: _____**
Private rent suites

Name of Applicant: _____

Address: _____

Telephone: _____ **Birth date: _____**

Doctor: _____ **Phone Number: _____**

Please check one: ☐ One bedroom ☐Two bedroom ☐ Wheelchair Accessible Suite

General Information:
The information you are providing is your current status at the time of application. You will be asked to update this information when a suite becomes available and is being considered for you.

1. Current Living Arrangements:
☐ Own home ☐ Living with Family or Others ☐ Mobile Home
☐ Apartment or Condo ☐ Supportive Housing Facility
☐ Other: _____

2. Transportation (please check as many as apply):
☐ Drive Own Vehicle ☐ Use Scooter ☐ Public Transportation
☐ Rely on Others for Transportation

3. General Health and Assistance Needs:
From your perspective, your general health is now:
☐ Excellent ☐ Good ☐ Poor

Assistance Needed Now (please check one):

	NEVER	SOMETIMES	ALWAYS	**Assistance Provided by:**
Meal Preparation	☐	☐	☐	_____
Cleaning	☐	☐	☐	_____
Laundry	☐	☐	☐	_____
Shopping	☐	☐	☐	_____
Banking	☐	☐	☐	_____

Mobility (please check one): ☐Walking Independent ☐ Walking Independent with aids/assistance
Describe aids used if needed: _____
Are you able to manage stairs: ☐ Yes ☐ No

In the past six months have you experienced a fall: ☐ Yes ☐ No
In the past six months have you experienced confusion or become lost on a walk or outing:
☐ Yes ☐ No

Personal Care – Current (please check one):
Dressing: ☐ Independent ☐ Minimal Assistance
Assistance provided by whom: _____
Eating: ☐ Independent ☐ Minimal Assistance
Assistance provided by whom: _____
Bathing: ☐ Independent ☐ Minimal Assistance
Assistance provided by whom: _____
Medications: ☐ Independent ☐ Minimal Assistance
Assistance provided by whom: _____
Do you sometimes forget to take your medications: ☐Yes ☐ No
Compliance packaging (blister packaging): ☐Yes ☐ No
Notes: _____
_____
Name of your Pharmacy: _____
How do you receive your medications: _____

4. BC Health Care Services and Plan:
Has a Home Health Care Case Manager (Fraser Health Authority) completed a 'Needs Assessment': ☐ Yes ☐ No
If yes, do you receive services from Home Health Care now: ☐ Yes ☐ No
If yes, how many hours per week: _____
Are you on a waiting list for Assisted Living/Supportive Housing: ☐ Yes ☐ No

Please provide any additional information that should be known prior to further assessment and eligibility review:
_____
_____
_____

Are you moving from a residence or building that has been infested by bed bugs or silver fish:
☐ Yes ☐ No

It is understood and agreed that:
1. Mission Association for Seniors Housing considers all information that you provide as confidential and will use it only for purposes of this application.
2. This application does not obligate you or Mission Association for Seniors Housing in any way.
3. If you are being considered for tenancy and meet the eligibility criteria for one of the Society's private market rent suites, the Society will need to request medical and financial information for verification purposes.
4. A thorough review of information in this application along with updates in your health status and an interview will precede a final decision regarding tenancy.

5. When a final decision regarding eligibility has been made, the applicant and The Cedars Tenant Services Manager will meet to review and sign the Tenancy Agreement.
6. This information may be disqualified if it is found to contain inaccurate or false information.

Signed the _____ day of _____, 200__.

_____
Applicant

_____
Mission Association for Seniors Housing Representative

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PHYSICIAN INFORMATION REQUEST

Physician Name: _____

Phone Number: _____ **Fax Number: _____**

Address: _____

Patient's Name: _____

Current Address: _____

Diagnosis, current treatments, medical history: _____

_____

_____

Short-term memory: _____ Long-term memory: _____

Cognitive Skills for Daily Decision Making (independent, some impairment, severely impaired):

_____

Communication (making self understood – usually, sometimes, rarely/never): _____

_____

Coping Skills (ability to deal with emotional/physical stress or if depressed, agitated, anxious, etc.):

_____

Activities of Daily Living

Indoor Mobility: Uses cane ☐ Walker ☐ Wheelchair ☐ Outdoor Scooter ☐

Mobility issues day/night time (if different): _____

Transferring: Transfer into bed ☐ Transfer out of bed ☐ Other_____

Bed making ☐ Personal laundry ☐ Grocery Shopping ☐
Uses toilet ☐ Commode ☐ TED Stockings ☐
Uses incontinent products: _____

Incontinence awareness: _____

Special diet requirements: _____

Allergies: _____

_____

Medication Management

Current Medications: _____

_____

_____

Requires Assistance_____ Independent _____ Supervision_____

Notes: _____

Diabetic: Yes☐ No☐ Type: _____ Blood sugar check to be done: _____

Insulin: _____ Notes: _____

Oxygen: oxygen dependent ☐ portable oxygen tank ☐

Identified Risks (describe**)**

_____

_____

_____

_____

Physician Signature: _____ Date: _____