

The information on this form is collected under the authority of the Alberta Housing Act and is in accordance with Alberta's Freedom of Information and Protection of Privacy Act. This information will be used to determine and verify the client's eligibility under Social Housing Accommodation Regulations. If you have any questions, you may contact a Property Clerk or the FOIP Co-ordinator at Lethbridge Housing Authority's Business Office: 324-B, Mayor Magrath Drive South, Lethbridge, AB T1J 3L7 (403) 329-0556.



## **SENIOR CITIZEN HOUSING APPLICATION**

### **INSTRUCTIONS FOR COMPLETING APPLICATION**

#### **Please Read Carefully**

Complete **ALL** questions and supply **ALL** of the requested information. If a question does not apply to your situation, mark **N/A** in the section.

#### **YOU ARE REQUESTED TO PROVIDE:**

**1. A copy of your most recent Income Tax Return and/or Notice of Assessment.**

If you do not have an Income Tax return available, please provide:

A copy or stub of most recent paycheque, benefit cheque, pension cheque, etc., for **each member of your household receiving income from any source.**

Cheque stubs must provide complete information: company name, name of recipient, gross income amount and the period that the income covers.

**2. A Medical Form (as attached) completed by your Doctor.**

Your completed application must be signed and witnessed. Lethbridge Housing Authority provides the Commissioner for Oaths service free of charge.

**If your application is selected, a Placement Officer will notify you immediately.**

**324-B, Mayor Magrath Drive South  
Lethbridge, AB T1J 3L7**

**UPDATES are required if there are any changes with:**

- Your source of income,
- Family size,
- Address, phone number, etc.

**IF LETHBRIDGE HOUSING AUTHORITY HAS NOT CONTACTED YOU WITHIN 90 DAYS FOLLOWING YOUR INTERVIEW YOU MUST:**

Renew your application in person, by mail, by phone (329-0556) or by fax (327-3906); by providing your name, address, telephone number, and up to date statement(s).

**THIS APPLICATION CANNOT BE PROCESSED UNLESS ALL QUESTIONS ARE FULLY ANSWERED, ALL PROOF OF INCOME IS PROVIDED, AND VALID PICTURE IDENTIFICATION IS RECEIVED.**

**PLEASE KEEP THESE INSTRUCTIONS FOR YOUR  
INFORMATION**

**LETHBRIDGE HOUSING AUTHORITY – APPLICATION**

**1. NAME:** \_\_\_\_\_

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

Birthdate: \_\_\_\_\_

**2. SPOUSE/CO-APPLICANT NAME:** \_\_\_\_\_

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

Birthdate: \_\_\_\_\_

**3. Marital Status:**

Married  Divorced  Widowed  Single  Common-Law  Separated

If separated, divorced, common-law, state length of time \_\_\_\_\_

**4 Present Address:** \_\_\_\_\_ **Present Landlord's Name & Address:**

\_\_\_\_\_

\_\_\_\_\_

Postal Code: \_\_\_\_\_

Length of Tenancy \_\_\_\_\_ Landlord's Telephone: \_\_\_\_\_

Telephone: \_\_\_\_\_

**5. Have you ever received subsidized housing in the past? Circle one: YES or NO**

**If yes, where?** \_\_\_\_\_

**6. Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

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

Telephone: \_\_\_\_\_

**7. Family Doctor:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**8. Do you own a vehicle? Yes / No** Make/Year \_\_\_\_\_

License Plate # \_\_\_\_\_ Estimated Value \$ \_\_\_\_\_

Driver's License: \_\_\_\_\_

**9. Do you presently have a pet? Yes / No** What kind? \_\_\_\_\_

Are you willing to part with your pet(s)? \_\_\_\_\_

***Most animals are not permitted***

**10. DESCRIBE PRESENT ACCOMODATION:**

**Rent or Own  
(Circle one)**

Type of Dwelling: \_\_\_\_\_

Total # of Bedrooms: \_\_\_\_\_ # of Bathrooms: \_\_\_\_\_

Rental Payments \$ \_\_\_\_\_

Does this include: Heat **Yes / No** Electricity **Yes / No** Water **Yes / No**

Is the dwelling shared with another family? \_\_\_\_\_

**11. Is there any medical condition that could affect your housing needs that we should know about? YES or NO (For example, is wheelchair accommodation a requirement?) Note: MEDICAL INFORMATION for Physician to complete.**

If yes, who? \_\_\_\_\_

In what way? \_\_\_\_\_

**12. Why do you wish to move?** \_\_\_\_\_

\_\_\_\_\_

**13. Have you received an eviction notice?** \_\_\_\_\_

If yes, for what date? \_\_\_\_\_ **(Please submit copy)**

Have you **given** notice to vacate? \_\_\_\_\_

If yes, for what date? \_\_\_\_\_ **(Please submit copy)**

**14. DEBTS:** (List creditors, amounts owing & arrears, if any, including rent or utilities)

<i>Name of Creditor</i>	<i>Amount Presently Owing</i>	<i>Amount in Arrears</i>
1.		
2.		
3.		

**15. Employer:** \_\_\_\_\_

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

**Telephone:** \_\_\_\_\_ **Contact Person:** \_\_\_\_\_

**16. Assets:**

Real Estate Property Address (Property owned by yourself and/or spouse/co-applicant):

Present Value: \$ \_\_\_\_\_ Mortgage: \$ \_\_\_\_\_

Bonds & Securities: \$ \_\_\_\_\_ RRSP's: \$ \_\_\_\_\_

Total Cash & Bank Deposits: \$ \_\_\_\_\_

Name of Bank: \_\_\_\_\_ Branch: \_\_\_\_\_

**17. REFERENCES (not relatives):**

1. \_\_\_\_\_ 2. \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_

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I understand that this application does not constitute an agreement on the part of Lethbridge Housing Authority or its agents to provide me with rental accommodation.

I further acknowledge the right of the Housing Authority at anytime prior to the execution and delivery of a lease hereby applied for, to withdraw, revoke, or cancel without penalty or liability for damage or otherwise, any acceptance or approval of this application previously made or given. I hereby authorize you to make any inquiries you deem necessary to verify the facts contained herein by any method the Housing Authority deems necessary, being fully aware that discovery of any false statement shall cancel any further consideration of any application.

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

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Applicant**

\_\_\_\_\_  
**Co-Applicant**

<b>FOR OFFICE USE ONLY:</b>

**OTHER INCOME**

Provide the Gross Income (before deductions) from **ALL SOURCES** for **ALL PERSONS** listed on this application. This includes all income received from any type of pension, employment, bank savings, bonds, rental property, business investments, student loans, etc. as listed below:

TYPE OF INCOME	TENANT	CO-TENANT
Old Age Pension and Supplement		
Canadian Pension		
Alberta Government Supplement		
War Veterans Pension		
Social Assistance***		
Disability Pension		
Employment Insurance Benefits		
Worker's Compensation		
Company Pension/Superannuation		
Employment Income		
A.I.S.H. (Assured Income for Severely Handicapped)		
Income Derived from Assets		
Other Income (Please Specify)		

\*\*\*If applicable, SOCIAL WORKER'S NAME: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

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**Lethbridge Housing Authority provides the Commissioner for Oaths  
 service free of charge, during your interview.  
 \*Picture Identification Required\***

## **STATUTORY DECLARATION**

Dominion of Canada            )       In the matter of this application for dwelling  
 Province of Alberta           )       accommodation in the Housing Project.  
                   To Wit                    )

I/We \_\_\_\_\_ of the  
 city of \_\_\_\_\_ in the Province of \_\_\_\_\_, do solemnly  
 declare as follows:

1. That I/We am/are the applicant(s) named in the said application;
2. That any statements made by me/us in the said application are to the best of my/our knowledge, information and belief, full and true in all respects.
3. The I/We have resided in the Province of Alberta for \_\_\_\_\_ years of my/our life, and in the district for \_\_\_\_\_ years;

And I/We made 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                    )  
 \_\_\_\_\_ )  
 in the Province of Alberta                )  
   )  
 this \_\_\_\_\_ day of                        )  
   )  
 \_\_\_\_\_, 20\_\_\_\_ )

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

\_\_\_\_\_  
 A Commissioner for Oaths in and  
 for the Province of Alberta

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



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**AUTHORIZATION TO OBTAIN INFORMATION  
AND CONSENT TO DISCLOSE INFORMATION**

Eligibility for social housing accommodation and the calculation of rent throughout the tenancy is based upon information provided by Tenants and other members of the Tenant's household on the application and upon up-to-date information which is to be provided by the Tenant and members of the Tenant's household from time to time during the period of the tenancy. The information referred to in this authorization may be requested or disclosed for the purpose of assisting Lethbridge Housing Authority in verifying household and income information contained in an application for social housing accommodation, assessing and verifying initial and on-going eligibility for social housing accommodation, verifying initial and on-going household income and financial circumstances in order to calculate or recalculate rent payable for social housing accommodation pursuant to the **Social Housing Accommodation Regulations** under the **Alberta Housing Act**.

Many employers or agencies who furnish assistance and/or benefits (Alberta Family and Social Services, Employment Insurance, etc.) or others with whom you might deal, will not release information without the written consent from the employee, the recipient or a person with whom they deal. We, therefore, request the following be signed by all persons listed on your Family Composition Form list who are 15 years of age or older.

**I/WE do hereby authorize for any one or more of the above stated purposes:**

1. The Lethbridge Housing Authority (LHA) or its designate to verify all information provided to LHA relating to this application for housing and any future information provided to LHA throughout the entire tenancy period. Such information may be verified by LHA or its designate making inquiries of and obtaining information (including personal information) from previous, current and future employers; credit bureaus; financial institutions; federal, provincial or municipal government departments, offices, agencies and boards; previous landlords; schools or educational institutions; and others from whom I receive income or benefits;
2. The LHA or its designate to disclose any information (including personal information) and to provide copies of documents in the possession of Lethbridge Housing Authority to all federal, provincial and municipal government departments, offices, agencies or boards; interpreters; credit bureaus; financial institutions; past or future landlords; past, current or future employers; schools or educational institutions; and others from whom I receive income or benefits;
3. All past, current and future employers or others from whom I receive income or benefits; credit bureaus; financial institutions; federal, provincial and municipal government departments, offices, agencies and boards; schools and educational institutions to release such information concerning myself, as may be requested by LHA (including personal information) to LHA;

Housing for Families, Seniors and Special Needs in our Community

**(See Over ⇒)**





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**MEDICAL INFORMATION for SOCIAL HOUSING**

**TO: ATTENDING PHYSICIAN**

A. This medical information form is required by Lethbridge Housing in regards to the Applicant/Tenant seeking or maintaining subsidized housing. All information must be current within a 6-month time frame.

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

C. Please **Mail or Fax this form directly to:**

**LETHBRIDGE HOUSING AUTHORITY**  
**324-B, Mayor Magrath Drive South**  
**LETHBRIDGE, AB T1J 3L7**  
**FAX: 403-327-3906**

**AUTHORIZATION FOR RELEASE OF INFORMATION FROM THE MEDICAL REPORT:**

I \_\_\_\_\_ hereby authorize any Physician, Medical Clinic, Hospital or other person that has any records or knowledge of my health to provide full information.

Date: \_\_\_\_\_

*Signature of Applicant / Tenant*

Witness: \_\_\_\_\_

**PLEASE PRINT**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Last Examination: \_\_\_\_\_

How long has applicant been your patient? \_\_\_\_\_

Our housing consists of self-contained apartments equipped with kitchen and bathroom facilities. The Applicant must be mentally and physically able to maintain him/her self, including cooking, cleaning, personal hygiene, etc. **Given this information, is your patient independent enough to:**

- 1. Physically manage all personal care? Yes No Unknown
- 2. Maintain an appropriate level of personal hygiene? Yes No Unknown
- 3. Socially fit in with other seniors? Yes No Unknown
- 4. Administer his/her own medication? Yes No Unknown

Is the Applicant currently receiving Home Care? Yes No Unknown

If YES, how many hours per week and for what types of service? \_\_\_\_\_

Are any other support agencies involved? \_\_\_\_\_



Is there any past or present evidence of:	NO	YES	If YES, please explain how this impacts the ability to live independently <i>(Please attach additional information if required)</i>
Depression			
Cognitive Impairment			If yes, <input type="checkbox"/> Mild <input type="checkbox"/> Medium <input type="checkbox"/> Severe
Alzheimer's Disease			If yes, <input type="checkbox"/> Mild <input type="checkbox"/> Medium <input type="checkbox"/> Severe
Mental Illness			
Uncontrolled Aggressive or Violent behavior			
Infectious Diseases			If yes, type:
Alcohol or Drug Abuse			If yes, <input type="checkbox"/> Past <input type="checkbox"/> Present Details:

Does the Applicant use any of the following?	Yes	No
Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>
Oxygen	<input type="checkbox"/>	<input type="checkbox"/>
Mobility Aids: _____	<input type="checkbox"/>	<input type="checkbox"/>

If there is impairment, please describe applicant's ability to live independently and interact with others:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Name and Address of Physician completing medical information:**

Name: \_\_\_\_\_ Clinic Address: \_\_\_\_\_

Clinic Phone No: \_\_\_\_\_

Clinic Fax No: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THIS MEDICAL REPORT IS VALID FOR 6 MONTHS**