



The Cove Retirement Living

Carl E.

Archie S.

Rideout House & Williston House

Waiting List Application Form

Name: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Phone: _____

Contacts:

(1) Name: _____

(2) Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Email: _____

Email: _____

Requested date of occupancy:

Soon as possible 3 - 6 months time 6 months - 1 year 1 - 2 years 2 - 5 years

Requested Apartment Size:

Studio 1 Bedroom 2 Bedroom

Present Living Arrangements:

Self contained apartment Bording House/Home
 With family With Non-Family
 Own home (____ one level living – or ____ two level) Other _____

Income Information: (Please submit all income as reported in your last income tax Notice of Assessment. Please note all information is kept confidential)

Monthly Income:

• Old Age Security	\$ _____	
• Provincial Assistance	\$ _____	
• War Veterans	\$ _____	
• Disability Pension	\$ _____	
• Canada Pension Plan	\$ _____	
• Other Pensions	\$ _____	Total Monthly Income \$ _____

Name, address and telephone of present Landlord:

Name, address and telephone of a character reference: (not family)

- YES, I agree to the above statements and will make a deposit of \$750.00 made out to Williston House, to hold an apartment when one becomes available, and is fully refundable. The deposit can then be transferred to a security deposit when I occupy the residence.

- Please provide a brief medical history from your Physician attached to this application.

I declare this information to be correct. I understand that this application does not constitute an agreement on the part of Williston House to provide me with rental accommodations, and I further acknowledge that this application is the property of Williston House. I hereby authorize you or your agent to make any inquiries you deem necessary to verify the above statements.

Signature: _____

Date: _____

Tenant Needs Assessment Form

Name: _____

Date of Birth: ___/___/_____
(dd)(mm)(y y y y)

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ email: _____

Health Card # (MSI) _____ Private Health Insurance: _____

Supporting Network (List of children, family, or friends involved)

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Emergency Contact: _____

Family Physician: _____ Phone: _____

List of Current Medication or Treatment:	Dosage or Procedure	Date Ordered
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Any Drug Allergies? Yes ___ No ___

If yes, what allergies? _____

Any Hospitalizations in past year? Yes ___ No ___

If yes, for what? _____

Any recent Surgeries? Yes ___ No ___

If yes, for what? _____

	Yes	No	Comment
f. Do you wear Hearing Aids?	<input type="checkbox"/>	<input type="checkbox"/>	_____
g. Any dietary Allergies?	<input type="checkbox"/>	<input type="checkbox"/>	_____
h. Any difficulty chewing/swallowing?	<input type="checkbox"/>	<input type="checkbox"/>	_____
i. Dentures? Upper	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lower	<input type="checkbox"/>	<input type="checkbox"/>	_____
Partial plate	<input type="checkbox"/>	<input type="checkbox"/>	_____
j. Do you have a good appetite?	<input type="checkbox"/>	<input type="checkbox"/>	_____

6) Personal Care:

a. Able to dress self?	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. Able to look after own medication?	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. Able to walk without assistance?	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. Able to use shower without help?	<input type="checkbox"/>	<input type="checkbox"/>	_____
e. Able to make your own bed?	<input type="checkbox"/>	<input type="checkbox"/>	_____
f. Do you look after your own foot care?	<input type="checkbox"/>	<input type="checkbox"/>	_____

7) Personal Finances/Banking:

a. Do you handle you own financial affairs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. Do you have a Power of Attorney?	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. Are you still living in own home?	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. Do you have an Advanced Directive?	<input type="checkbox"/>	<input type="checkbox"/>	_____
e. Do you have a Do Not Resuscitate Order?	<input type="checkbox"/>	<input type="checkbox"/>	_____
f. Do you own your own vehicle?	<input type="checkbox"/>	<input type="checkbox"/>	_____

8) Memory / Orientation:

a. Has there been signs of memory loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
- poor short term memory?	<input type="checkbox"/>	<input type="checkbox"/>	_____
- poor long term memory?	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. Safety concerns with stoves?	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. Falls in the last 5 months?	<input type="checkbox"/>	<input type="checkbox"/>	_____