Crystal Care Group

7815-160 street

Edmonton, Alberta, T5R2G6

Dear Potential Resident,
Thank-you for your interest in residences, owned and operated privately by Crystal Care Group Inc. We are a provider of personalized and exceptional supportive living services. In order to assess your suitability for residency in one of our homes, we ask potential residents to complete an Application for Residency.

This form is designed to help us begin to better understand you, your care needs and your preferences. We realize that many of the questions are of a personal nature. Your information will be regarded as privileged communication and will be treated with confidence, in accordance with all applicable legislation. Please ensure the information provided is complete and accurate so that we may make an informed decision about our ability to provide you with safe and quality care.

We look forward to reviewing your information and will be in contact with you to discuss our service philosophy and your application.

Kind regards,

Management

Crystal Care Group Inc.

Crystal Care Group
17215 77 Avenue, Edmonton, Alberta, T5T 0K1
Phone: 780-720-5541 *Fax:*780-669-4870
Email: crystalcaregroup@gmail.com

APPLICATION FOR RESIDENCY

I. GENERAL INFORMATION

Resident Name:_____

Birth date:_____

Address:_____

City:_____

Province:_____Postal Code:_____

Telephone: _____

Gender : Male Female

Current or Former Occupation:_____

Marital Status:_____Married___Single__Widow/er

Preferred Language:_____

Other languages:_____

Provincial Health Insurance #: _____

Provider:_____Policy #: _____

Supplemental Health Insurance:

Provider:_____Policy #: _____

Emergency Contact Information:

Name:_____

Phone #: _____

Address:_____

Relationship:_____

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II. CURRENT LIVING SITUATION

Please describe your current living situation:_____

_____

_____

Do you currently require someone to live with you or do you get help in your home?
If so, what type of help do you receive and how often?_____

_____

_____

I. MEDICAL INFORMATION

Family Doctor Name:_____
Phone #:_____

Do you regularly visit any specialist physicians? If so, please list them and the frequency of your appointments:_____

_____

Please list any medical conditions that you have:_____

_____

_____

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_____

Please list any surgeries you have had (including the year):_____

_____

_____

_____

Please list all medications (including over the counter medications) that you take on a regular basis:

_____

_____

_____

Do you regularly receive your seasonal influenza vaccination?_____Yes__No

Have you ever been told you have an Antibiotic Resistant Organism?____Yes__No

Do you require regular lab work?_____Yes__No

Height:_____ Weight:_____

Do you have any allergies: __YES __NO
If yes, please list them:_____

_____

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Are you on a special or restricted diet? ___YES____NO

If yes, please explain your dietary requirements:_____

II. ADDITIONAL SERVICES & ASSISTANCE WITH ACTIVITIES OF DAILY LIVING

Do you require any of the following services?

- CASE MANAGEMENT __ *Yes* /___ *No* *Provide Details* _____

  _____

- MENTAL HEALTH SUPPORT MANAGEMENT __ *Yes* /___ *No* *Provide Details*_____

  _____

- TRANSITION SUPPORT __ *Yes* /___ *No* *Provide Details*

  _____

  _____

- MEDICATION ASSISTANCE __ *Yes* /___ *No* *Provide Details* _____

  _____

  - _____D1: Medication administration daily
  - _____D2: Medication assistance daily
  - _____D3: Medication reminders daily
  - _____D4: Self-administration of meds daily

- HEALTH AND PERSONAL CARE __ *Yes* /___ *No* *Provide Details* _____

  _____

- SPECIAL DIET __ *Yes* /___ *No* *Provide Details* _____

  _____

- TRANSPORTATION __ *Yes* /___ *No* *Provide Details* _____

  _____

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- PROGRAMS __ *Yes* /___ *No* *Provide Details* _____

_____

- ASSISTANCE WITH ACTIVITIES OF DAILY LIVING __ *Yes* /___ *No* *Provide Details Below*

Please check the appropriate box, to indicate the level of assistance you require:

TASK	"I can do this independently"	"I require some assistance"	"I require total assistance"	Comments
Dressing				
Oral Care				
Bathing				
Eating				
Toileting				
Grooming				
Walking				
Transferring				
Medications				

III. ADDITIONAL INFORMATION

Are there any specific interests or hobbies you enjoy?

_____

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Do you have a Personal Directive?_____Yes___No

Is there anything else you would like us to know about your situation or your health care needs?

_____

_____

IV. FINANCIAL INFORMATION

Who will be responsible for the payment of bills? Self Someone else

If someone else will be responsible for your bills, please provide their contact information:

Name:_____Relationship:_____

Address:_____City:_____

Province:_____Postal Code:_____

Phone #: _____ e-mail: _____

I understand and agree that this application is neither a contract, nor a reservation for residence, but acknowledge and agree that the accuracy of the information contained herein is being relied on by Crystal Care Group Inc. to determine my suitability for residence in one of its facilities. Nothing contained in these documents is legally binding on me or the company to which I am applying for residency, until such time as a Residential Service Agreement has been approved and signed by all parties.

_____ _____

SIGNATURE OF APPLICANT (or Power of Attorney) DATE

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