

# *St. John's Centre*

## **Rent-Geared-to-Income Application Checklist**

***Please return all completed forms to St. John's Centre.***

### **Completed Financial Information Required:**

- Verification of Assets** (legal size coloured form)
  - Need one for each Financial Institution
- Copies of Bank Statements for the last three months** (You must provide bank statements for each account at each Financial Institution)
- Proof of investments i.e. GIC's, RRSP's etc.**
  - I have no investments
- Prior year Income Tax Return**
  - Back up T-slips
  - Notice of Assessment

### **Completed Non-Financial Information Forms Required:**

- Application for Rental Accommodation**
- Support Services Questionnaire**
- Medical Release Authorization**
- Medical Form (must be completed by family physician)**
- Consent to Disclose Income Verification**
- Canadian Birth Certificate or Proof of Canadian Citizenship or Landed Immigrant Status**

***Applications are processed and added to wait list when fully completed.***



**6. Previous Tenancy in any form of Subsidized Rental Accommodation in Ontario:**

Has the applicant or co-applicant lived in a housing project under any housing program administered by the Ministry of Municipal Affairs or a Central Service Manager ?  Y  N  
Housing Provider's Name \_\_\_\_\_ Address & Phone \_\_\_\_\_

Occupancy Dates  
(Month/Year)  
From: \_\_\_\_\_ To: \_\_\_\_\_

Housing Provider's Name \_\_\_\_\_ Address & Phone \_\_\_\_\_

Current Landlord's Name (not social housing) \_\_\_\_\_ Address & Phone \_\_\_\_\_

Previous Landlord's Name (not social housing) \_\_\_\_\_ Address & Phone \_\_\_\_\_

St. John's Centre is a SMOKE-FREE building. Are you currently a smoker? \_\_\_\_\_  
Only 1 pet is allowed per household. If you have a pet, please specify the kind. \_\_\_\_\_

**7. Comments: (Optional)**

**8. Declaration, Release and Consent to Information: Signature and Date Required**

I/We declare that all information contained in this application is correct and complete. I/We understand that this application does not constitute an agreement to provide me/us with rental accommodation. Information attached to or contained within this form is collected for St. John's Centre by St. John's Centre and will remain the confidential property of same.

Personal information contained in this form or in attachments is collected for St. John's Centre by St. John's Centre pursuant to the Housing Services Act 2011 O. Reg 367/11 S. 23 and will be used to determine suitability and eligibility for special needs housing and rent geared-to-income subsidy.

Personal information may be disclosed to the Ministry of Municipal Affairs and Housing and other municipal/provincial and federal departments and agencies who assist in the provision of affordable housing. Information provided by the household may be shared for the purposes of making decisions or verifying eligibility for assistance under the Housing Services Act 2011, the Ontario Disability Support Program Act, 1997, and the Ontario Works Act, 1997.

The applicant and/or co-applicant consents to the verification, disclosure and transfer of information given on this form and attachments by or to any of the above mentioned entities and will provide any required supporting material.

Questions regarding this collection should be directed to: St. John's Centre, 440 Water St., Peterborough, Ontario, K9H 7K6.

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

Co-Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Please return completed application and all required documentation to St. John's Centre. Applications can only be processed when fully complete.*

# St. John's Centre

## MEDICAL FORM

**This form must be fully completed by your Physician/Nurse Practitioner and returned to:  
St. John's Centre Telephone: (705) 749-0757 · Fax: (705) 749-5767**

*St. John's Centre is a non-smoking apartment building for seniors, 65 years and older, capable of independent living. The Centre is accessible and offers dining facilities and a range of in house services provided through it's Supportive Housing Program. Completion of this medical form is required to determine eligibility for tenancy.*

(PLEASE PRINT)

APPLICANT'S NAME: \_\_\_\_\_ D.O.B: \_\_\_\_\_

HEALTH CONDITIONS: (PLEASE PRINT) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Infectious Diseases: Yes  No  If yes, specify: \_\_\_\_\_

Evidence of Substance Abuse: Yes  No  If yes, specify: \_\_\_\_\_

**ST. JOHN'S CENTRE IS A SMOKE-FREE BUILDING** Smoker? Yes  No

**If the applicant/tenant has previously smoked, when did he/she quit?** \_\_\_\_\_

### COGNITIVE FUNCTION

Normal:  Impaired:  If impaired, specify: \_\_\_\_\_

### MOBILITY

Restrictions: \_\_\_\_\_

Assistive Devices Used: \_\_\_\_\_

**Please identify any difficulties with activities of daily living:** \_\_\_\_\_  
\_\_\_\_\_

**Date of last visit to Physician/Nurse Practitioner:** \_\_\_\_\_

Physician's/Nurse Practitioner's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Completed

# *St. John's Centre*

## **Medical Release Authorization**

I authorize my attending Physician/Nurse Practitioner and/or my caregiver to release any medical information to St. John's Centre.

I understand that:

1. This information is required to complete the application process for a unit at St. John's Centre.
2. This information will be kept in strict confidence.
3. This information will be retained on my file at St. John's Centre.

Name of Physician/Nurse Practitioner: \_\_\_\_\_

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

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

\_\_\_\_\_

The applicant is responsible for any fees incurred for the completion of any medical forms.

\_\_\_\_\_  
Applicant Name (Please Print)

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

Dated on this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

# St. John's Centre

## SUPPORT SERVICES QUESTIONNAIRE - Return to St. John's Centre

*St. John's Centre is not a nursing home. It is a retirement home consisting of self contained apartments. Tenants must be able to live independently with or without the help of support services. The Centre is neither equipped nor appropriate for individuals dependant on continuous care or supervision. In considering your application, it is important that we fully understand your needs. The following information is necessary to assess your needs and complete the application process. To be eligible for a special needs unit at St. John's Centre you must require on a regular basis one or more of the support services:*

**PLEASE CHECK  AND COMPLETE EACH OF THE FOLLOWING QUESTIONS.**

**I/We currently receive the following services:**

	Yes	No
Personal Care:		
Homemaking		
Meal Service		

# of visits  
per week

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Applicants are required to purchase (1) meal per day

**Who provides this service for you?**

Name of Agency: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of Family: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of Friend: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Is the support you are presently receiving enough to accommodate your needs?**

Yes	No

If not, please state what services you would require from St. John's Centre.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please circle all that apply.**

I use a:

Walker                      Wheelchair                      Bath Seat                      Raised Toilet Seat                      Not Applicable

**Additional Information:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I/We \_\_\_\_\_ authorize the public agency or the individual providing my care to release any medical or service information to St. John's Centre.

\_\_\_\_\_  
Applicants Signature

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

\_\_\_\_\_  
Power of Attorney Signature (if applicable)

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

# St. John's Centre

## Consent to Disclose Income Verification Information (to be used at time of initial occupancy and every annual review)

1. I/we, \_\_\_\_\_ consent to the acquisition and release of information verifying my/our income to an authorized representative of St. John's Centre by:

\_\_\_\_\_  
(name of financial institution, organization)

\_\_\_\_\_  
(name of financial institution, organization)

\_\_\_\_\_  
(name of financial institution, organization)

for the sole purpose of determining or verifying my initial or ongoing eligibility for subsidized housing.

2. This Consent is effective from the date of signing for **twelve months**.
3. I/we fully understand the nature and purpose of this consent and have given my/our consent and authorization voluntarily.

\_\_\_\_\_  
Applicant Name (Please Print)

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

\_\_\_\_\_  
Applicant Name (Please Print)

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

Dated on this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.



440 Water Street, Peterborough, ON K9H 7K6  
 Phone #705-749-0757 Fax#705-749-5767

**VERIFICATION OF ASSETS**

It is the responsibility of the tenant or applicant to have this form completed. One copy of the form must be provided for each financial institution.

**PLEASE PRINT OR TYPE**

<b>PART 1: TO BE COMPLETED BY THE TENANT OR APPLICANT WITH ASSETS:</b>				
Family Name:		Given Name:		
Address:				
I authorize the release of the information below to St. John's Retirement Homes Inc. as required under the terms and conditions of my lease agreement. I authorize St. John's Retirement Homes Inc. to contact any organization mentioned on this form to confirm the information provided.				
Signature:		Date:		
<b>PART 2: TO BE COMPLETED BY THE FINANCIAL INSTITUTION: PLEASE PRINT OR TYPE</b>				
The rent charged to the person named above is in part based on gross income. Please provide the information requested for all accounts or other assets held with your organization by the person named above.				
Financial Institution's Name and address (banks stamp/seal)		Name of person completing this form:		
		Position:		
		Signature:		
ACCOUNT #	BALANCE	INTEREST RATE	INTEREST EARNED (in last 12 months)	
		%		
		%		
		%		
Direct Deposits Made to Above Account(s) (List Details Below)				
Source		Amount	Monthly/Weekly	
BONDS, DEBENTURES, TERM DEPOSITS, SAVINGS CERTIFICATES, RSPs, ETC.				
SECURITY	MATURITY DATE	VALUE	INTEREST RATE	INTEREST EARNED (in last 12 months)
			%	
			%	
			%	
Signature (on behalf of financial institution):				Date:
<b>PART 3: DECLARATION AND CONSENT TO DISCLOSE INCOME VERIFICATION. TO BE COMPLETED BY APPLICANT OR TENANT, PERSON NAMED IN PART 1.</b>				
Have you recently transferred or given away any property, real estate, investments or other funds to relatives or friends? Yes or No? If yes, when? Please provide details:				
I/We have read and fully understand that all information given in this report is complete and accurate.				
I/We consent to the acquisition and release of information verifying my/our income to an authorized representative of St. John's Retirement Homes Inc. by my named Financial Institution(s) for the sole purpose of determining or verifying my initial and ongoing eligibility for subsidized housing.				
I/We fully understand the nature and purpose of this consent and have given my/our consent and authorization voluntarily. This consent is effective from date of signing for twelve months.				
Signature :		Date:		
Signature:		Date:		