**RENTAL APPLICATION FORM**

**285 PEMBINA INC.**

**285 Pembina Hwy, Wpg, MB, R3L 2E1**

APPLICANT CONTACT INFORMATION

Name:

Date of Birth:

Home Address:

(Street) (Town) (Province) (Postal Code)

Phone Number: Alt Phone Number:

Email Address:

Mailing Address:

(If different from home address)

If you want another person as the main contact for your application, please provide the following information:

Contact Name:

Phone Number: Alt Phone Number:

Email Address:

Organization:

INCOME

|  |  |
| --- | --- |
| **Income Source** | **Monthly** |
| Employment or Employment Insurance | $ |
| Worker’s Compensation | $ |
| Self Employment Income | $ |
| Retirement (CPP, OAS, Pension, RRSP) | $ |
| Alimony & Child Support | $ |
| Veterans Affairs | $ |
| Employment & Income Assistance | $ |
| Other Income | $ |
| Total Gross Monthly Income | = $ |

If you receive Employment & Income Assistance, please provide the following information:

Case #: Worker: Phone:

Do you have any assets?  Yes  No If yes, please list total net value below:

Property (land, residential, commercial) $ Savings (GIC’s deposits, etc.) $

AFFORDABILITLY

What is your monthly rent or mortgage payment: $ Electricity: $

Natural Gas: $ Water Quarterly: $

RENTAL HISTORY

Please provide at least one year of rental history for the applicant:

|  |  |  |  |
| --- | --- | --- | --- |
| Address | Contact person for Landlord | Phone | Dates of tenancy |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

If you have lived in Manitoba Housing before, please provide the following information:

Leaseholder: Address:

Move out date:

SUITABILITY

How many bedrooms are in the home where you currently live?  Studio  1  2  3  4  5

How many adults and children live in the home? Adults: Children:

ADEQUACY

Is your home in need of major repairs?  Yes  No

*If yes, please include an Order to Repair from the Residential Tenancies Branch (RTB) or a completed Housing details form. Contact the RTB at 204-945-2476 (Winnipeg) or 1-800-782-8403 to get more information on Orders to Repair*

Is your current home condemned?  Yes  No

*If yes, please include a copy of documents from Public Health or Fire Department that states the home is not habitable.*

EDUCATION AND TRAINING

Are you currently enrolled in a:

Degree or Diploma program or  Skills development course

College or University: Agency:

Program: Course:

*Please provide proof of enrolment from the institution or agency*

SPECIAL CIRCUMSTANCES

Please answer the following questions. If you check “Yes”, you will need to provide the required documents listed beside the question when you submit your application.

The medical Information and Housing Details form are located on page 4 & 5. You will need to have these forms completed only if any of the situations below apply to you.

Are you: Required Document

|  |  |  |
| --- | --- | --- |
| Homeless? (living in a shelter, on the street or in the hospital) | Yes  No | Housing Details Form |
| Temporarily sheltered and at risk of homelessness? (staying at family or friends, hotel, hostel or transitional immigration centre) | Yes  No | Housing Details Form |
| A single parent or individual with a disability who is being forced to leave their current home within the next three months? | Yes  No | Housing Details Form and Notice to Vacate from current landlord |
| Needing to move due to family separation, loss of a caregiver or unsafe housing conditions for your children? | Yes  No | Housing Details Form |
| Needing to move to be closer to work, school, child care or support services? | Yes  No | Housing Details Form |
| Needing to move due to your medical conditions? | Yes  No | Medical Information Form |
| Disabled and unable to work or take training for 12 months or longer? | Yes  No | Medical Information Form or Medical Assessment |
| Requiring accessible housing to accommodate household members with physical disabilities? | Yes  No | Medical Information Form |
| Needing better housing in order to retain or regain custody of your children? | Yes  No | Letter from your Child & Family Services worker |

PUBLIC TRUSTEE

If this application is being submitted on behalf of a person who is registered with the Public Trustee, the Trustee must complete the information below and stamp before submitting.

Name: Public Trustee Stamp

Phone:

COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Your personal information is collected under the authority of Manitoba Housing programs and used to determine you eligibility for rental housing and any tenancy which may result from this application. Your personal information is protected by *The Freedom of Information and Protection of Privacy Act* and, if applicable, *The Personal Health Information Act (PHIA).*

If you have any questions about the collection of personal information, please contact Manitoba Housing’s Access and Privacy Coordinator at 600- 352 Donald Street, Winnipeg or (204) 945-3025.

In this form, words in the singular include the plural and words in plural include the singular.

**CONSENT TO DISCLOSE AND SHARE INFORMATION**

I consent to Manitoba Housing sharing any personal information relating to me or my dependents with other government departments, external agencies or service providers to confirm eligibility for rental housing, determine my housing needs and rental charge. I understand that this information may be kept on file for the length of the tenancy. I understand that I may cancel this consent at any time in writing to Manitoba Housing.

I authorize any person, agency or organization to release or exchange information for that purpose. I understand this consent includes requests pertaining to my marital status, employment, income, assets and liabilities, medical condition, family status, benefits received under other programs or any other relevant personal information. I understand this includes Manitoba Housing conducting a personal investigation including past and present landlord reference checks, income verification and utility checks.

A copy or facsimile of this signed Consent to Disclose has the same effect as the original and is sufficient to authorize the disclosure or exchange of information.

**DECLARATION**

I understand that this application is not an agreement on the part of Manitoba Housing to provide me with housing. I acknowledge that, once submitted, this application becomes property of Manitoba Housing.

I certify that the information given in this statement is true, correct, and complete in every respect. It fully discloses my income from all sources. If something is incorrect or not true, I understand that Manitoba Housing may cancel my application or take any other measures deemed appropriate.

**CONSENT TO RELEASE INCOME INFORMATION**

I consent to the release of income, expense and dependents’ information from my income tax records by the Canada Revenue Agency (CRA) to Manitoba Housing under the authority of the Renewal Corporation Act of Manitoba. The information will be relevant to, and solely for, verifying eligibility, determining need and setting rental charges for government-subsidized rental housing.

This consent is valid for the previous two tax years, the current year and each year after if I am a tenant with Manitoba Housing. I understand that, if I wish to withdraw this consent, I may do so at any time in writing to Manitoba Housing.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Last Name | First name | Date of Birth (dd/mm/yyyy) | Social Insurance Number | Signature | Date (dd/mm/yyyy) |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Applicants signing with an “X” must have a witness:

Witness name (please print) Witness signature Date

MANITOBA HOUSING- MEDICAL INFORMATION FORM

**Medical professionals must complete this form**

Patients name (please print):

This patient has expressed a need for social housing or a transfer to a new rental suite due to a medical condition or disability. In order to assist Manitoba Housing in determining eligibility and establishing appropriate housing, please answer the questions below, where applicable.

***CERTIFIED MEDICAL PROFESSIONAL SECTION***

The following professions are qualified to complete this form. Please check yours:

Medical doctor or Nurse Practitioner: all conditions  Optometrist: vision  Audiologist: hearing

Psychologist: cognition, memory  Occupational or Physiotherapist: mobility, agility, endurance

Does the patient have a disability that prevents them from working and taking part in training for 12 months or more?  Yes  No

Does the patient need to move out of their current home for medical reasons?  Yes  No

If yes, please explain (e.g. proximity to support services, mobility issues, mental health limitations).

|  |
| --- |
|  |
|  |
|  |

Does the patient require any physical enhancements in their housing for medical reasons?  Yes  No

If yes, please describe the enhancements required (e.g. accessibility, elevator, extra space for medical equipment).

|  |
| --- |
|  |
|  |
|  |

Does the patient require any support services to live independently?  Yes  No

If yes, please describe the services:

|  |
| --- |
|  |
|  |
|  |

**Medical Professional Information:**

Name:

Address: Phone:

Signature: Date:

MANITOBA HOUSING- HOUSING DETAILS FORM

**Support workers must complete this form**

Client’s name (please print):

This form must be completed by a support worker who holds a position of responsibility in their profession or in their community and is not related to the applicant. Supports workers include housing advocates, religious leaders, social workers and other professionals who can verify the housing needs of the applicants.

**ADEQUACY**

I have visited the applicant’s home and can personally verify that the following issues must be addressed in their current home in order to make it healthy and safe:

|  |
| --- |
|  |
|  |
|  |

I verify that the landlord has been contacted regarding these problems  Yes  No

If yes, the issues have been unresolved for months.

**OR**

I have knowledge of the landlord and expect retribution from said landlord if the applicant takes action through the Residential Tenancies Branch.  Yes  No

**HOMELESSNESS**

Based on my direct observation of the applicant’s circumstances, I can confirm that the applicant is:

1. Homeless (living in a shelter, on the street or in the hospital)  Yes  No
2. Temporarily sheltered and at risk of homelessness  Yes  No

(living at a friends or family, hotel, hostel, or transitional immigration centre)

1. A single parent or individual with a disability who is being forced to leave their current home within the next three months. Please explain:  Yes  No

**PROXIMITY**

I confirm that the applicant is experiencing hardship due to the time the spend travelling daily to work, school, childcare or needed services. If yes, please describe (e.g. time, distance, etc.)  Yes  No

**DECLARATION**

I certify that the information provided here is true, correct and complete to the best of my knowledge.

Name: Phone:

Job Title: Organization:

Mailing Address:

Signature: Date:

**285 PEMBINA INC- INDEPENDENT LIVING APPLICATION**

PART A: GENERAL DATA

1. **Primary Language:** Other languages spoken:
2. **Applicant Gender:**

Male  Female  Prefer not to say

1. **Marital Status:**

Married  Separated  Not answered or unknown

Divorced  Single  Widowed (Year & adjustment)

1. **Occupation:**
2. **Age at Retirement:**

Adjustment to retirement  Good adjustment  Hard adjustment

1. **Status of License:**

Never had one  Active  Inactive

Date of Loss:  Good adjustment  Hard adjustment

1. **Veteran:**

Yes  No

1. **Living Arrangements of Applicant:**

Lives alone  With hired caregiver

Lives with spouse  Other

1. **Primary Caregiver:**

Spouse  Child  Other

1. **Does Primary Caregiver Live with Applicant?**

Yes  No

1. **Pattern of Relating to Others**:

Extroverted  Introverted  Initiates  Observes  Withdraws

1. **How Long Has Applicant Lived in Current Residence:** Years
2. **Primary Contact:**

Name: Phone:

Relationship: Email:

1. **Secondary Contact:**

Name: Phone:

Relationship: Email:

1. **Family Support Systems:**

|  |  |  |
| --- | --- | --- |
|  | **First & Last Name** (Printed) | **Location** |
| Spouse |  |  |
| Children |  |  |
| Sibling(s) |  |  |
| Nieces/Nephews |  |  |
| Grandchildren |  |  |
| Other |  |  |

1. **Does Applicant Suffer from Dementia:**

Yes  No

1. **Current Home Care Services:**

Provincial Home Care Program  Private  None

Hours per day/week:

Name of Case Coordinator:

Services Provided:

1. **Who Provides Transportation to Doctor/Medical Appointments:**

Family  Friend  Other

1. **Names of Physicians Involved:**

Name: Phone:

Type of Physician:

Name: Phone:

Type of Physician:

PART B: ACTIVITIES OF DAILY LIVING SKILLS

**DESCRIBE FUNCTIONING LEVEL WITH REGARD TO: (check all that apply)**

1. **Walking:**  Unassisted  Short distances  Long distances

Steady on feet  Risk for falls  Needs standby assistance

1. **Walking Aides:**  None  Cane/quad cane  Crutches

Wheelchair  Walker  Power chair

1. **Visual:**  No Impairment

Wears glasses

For reading  For distance  Bi-focal

Legally blind

Requires environmental land marking/cues to assist with way finding

Needs suite near common room

Needs table setting and meal plated in specific/consistent way

Cataracts  L  R

1. **Hearing**   No impairment

Wears hearing aid(s)

Right  Left  Both

Difficulty with hearing, has hearing aid but seldom uses it

Difficulty with hearing, no hearing aid

Deaf

1. **Eating:**  Independent

Needs some assistance (cutting, pouring sugar, etc.)

Difficulty using/confusion with utensils

Needs reminders and cueing to focus on eating

**6.** **Swallowing Problems:**  Yes  No

**7. Diet:**  Regular  Diabetic  Low Sodium  Minced

**8.** **Allergies to Food:**  None known

**9.** **Diabetic:**  Yes  No

**10.** **Other Medical Diagnosis:**

**11.** **Mental Health Diagnosis:**

**12.** **Toileting/Elimination:**  Independent

Needs assistance

**13. Dressing:**  Independent

Needs assistance

**14.** **Bathing:**  Independent

Needs assistance

**15.** **Grooming:**  Independent

Needs assistance

**16. Laundry:**  Independent

Needs assistance

PART C: BEHAVIOUR (EXHIBITED DURING THE PAST TWELVE MONTHS)

**1.** Communication barriers:

Passive

Anxious

Substitutes words that sound like other words

Difficulty word finding

Hearing Impaired

Other

**2.** Has difficulty concentrating on a task or activity

**3.** Does not initiate activities

**4.** Needs lots of encouragement to attend activities

**5.** Frequently loses or misplaces things

**6.** Collects/hoards items

**7.** Reluctant to care/assistance

**8.** Wanders away from home

**9.** Prefers to be alone rather than with others

**10.** Believes others are stealing from them  Sometimes  Often

**11.** Believes someone is coming into suite/home when they are not there

**12.** Has become verbally aggressive towards caregivers (such as yelling, swearing)

**13.** Visual Hallucinations

**14.** Auditory Hallucinations

**15.** Easily becomes anxious

Describe:

**16.** Easily becomes agitated

Describe:

**17.** Do you smoke  Yes  No

*Have you quit smoking in*  last six months  last year  more than a year ago

**18.** Currently how does applicant spend the day?

**19.** Does applicant attend any day program/support services outside the home?

Yes  No

**21.** Power of Attorney  Yes  No

**22.** Other support services that are in place/will be in place:

PART E: SUITE PREFERENCE

Do you require parking?  Yes  No

Which type of suite are you looking for?

Hostel Bachelor 1 Bedroom

Will you be joining the meal program?  Yes  No

Lunch program  $193 a month (plus rent)

Supper Program  $248 a month (plus rent)

Both Meals  $440 a month (plus rent)

*Please send completed applications along with most recent Notice of Assessment or EIA Budget letter*

***OFFICE USE ONLY***

**Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Application #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Interview: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Application Prioritized for Residency:  Yes  No Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Application Recommended for Residency:  Yes  No**

**Meal Program:  Yes  No**

**Suite Recommended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**