

ITALIAN CANADIAN BENEVOLENT SENIORS APARTMENT CORPORATION (ICBSAC)

CASA ABRUZZO BENEVOLENT CORPORATION (CABC)

RENTAL APPLICATION

- CABOTO TERRACE, 3050 Dufferin St., North York, Ontario M6B 4G3
- CASA DEL ZOTTO, 3010 Dufferin St., North York, Ontario M6B 4J5
- CASA ABRUZZO, 338 Falstaff Ave., North York, Ontario M6L 3E7

DATE _____

1. Applicant

Name		Last Name			First Name		
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.		<input type="checkbox"/> Miss <input type="checkbox"/> Ms					
Street No.	Street Name		Apt. No.	City	Province	Postal Code	
Area Code/ Home Phone No.		Area Code/ Work Phone No.		<input type="checkbox"/> Single (1) <input type="checkbox"/> Widowed (3) <input type="checkbox"/> Divorced (5) <input type="checkbox"/> Married (2) <input type="checkbox"/> Separated (4) <input type="checkbox"/> Common-Law (6)			
Social Insurance #		Date of Birth			Sex		
Give Name of a Person we may contact if we cannot reach you or the co-applicant (and that can act as interpreter if required)		Name			Telephone No.		

2. Spouse/Co-Applicant

Name		Last Name			First Name		
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.		<input type="checkbox"/> Miss <input type="checkbox"/> Ms					
Street No.	Street Name		Apt. No.	City	Province	Postal Code	
Area Code/ Home Phone No.		Area Code/ Work Phone No.		<input type="checkbox"/> Single (1) <input type="checkbox"/> Widowed (3) <input type="checkbox"/> Divorced (5) <input type="checkbox"/> Married (2) <input type="checkbox"/> Separated (4) <input type="checkbox"/> Common-Law (6)			
Social Insurance #		Date of Birth			Sex		

3. Present Accommodation

Which of the Accommodation stated below, do you have now?		
<input type="checkbox"/> Room (1) <input type="checkbox"/> Condo (2) <input type="checkbox"/> Apartment (3) <input type="checkbox"/> House (4) <input type="checkbox"/> Staying with Friends or Relatives (5) <input type="checkbox"/> Other (O) Explain > _____		
Are you or any person who lives with you:	Do you have a lease? If yes,	If yes, Expiry Date
<input type="checkbox"/> Visually Impaired <input type="checkbox"/> Wheelchair User <input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	Y M D
Present Landlord's Name	Address	Telephone No
How long have you lived at present address _____ Year(s) _____ Month(s)		

4. Present Employment of Applicant/Co-Applicant (Also complete if self-employed)

Present Employer's Name		Telephone No.		
Address Where Employed?		Municipality		
Occupation	Name of Department	Telephone No.	Extension	Are you allowed to take personal calls? <input type="checkbox"/> Yes <input type="checkbox"/> No
Length of employment with present employer _____ year(s) _____ month(s)	Do you work <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Full and Part Time <input type="checkbox"/> Shift	If "part time", state days of the week. If "full and part time", give name of part time employer. If "shift", state hours.		

5. Statement of Gross Monthly Income and Assets (Attach written Proof of all Household Income)

List all Monthly Income and Assets for you and all other persons who will live with you in the Rental Unit.				
Income Source	Applicant	Co-Applicant	Assets Source	Assets Value
Employment (from all Sources)			Bank Account 1	
Canada Pension			Bank Account 2	
Family Benefits			Bonds	
Old Age Security			Securities/Stocks	
Supplements			Mortgages held	
Foreign Pension			Interest	
Worker's Compensation			Other Assets	
General Welfare				
Unemployment Insurance				
Other Income				
Total Incomes	\$	\$	Total Assets	
Do you or other persons who will live with you own property now? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, please advise what type (i.e. winterized home, cottage or land) and give Address/Location and approximate value.		

Subject to the other terms of this Application, the above information is strictly confidential and will not be released by us except where such information is to be relied upon by us in any legal proceedings, or must otherwise be produced in accordance with relevant law.

APPLICANT'S ACKNOWLEDGEMENT

The undersigned acknowledges that I.C.B.S.A.C. – C.A.B.C. is not a nursing home and that to be accepted as a tenant and to remain a tenant the undersigned must be able to either: (i) manage on her/his own and be in good health or (ii) make arrangements satisfactory to I.C.B.S.A.C. – C.A.B.C. to receive all appropriate support services from a service agency in the community. Tenants are responsible to care for their personal needs and if the time should come that any resident: (i) is not able to care for her/his personal needs, or (ii) has not made arrangements satisfactory to I.C.B.S.A.C. – C.A.B.C. to receive all appropriate support services from a service agency in the community, then it shall be necessary for such resident to find accommodation elsewhere and vacate the premises.

INFORMATION CONSENT

The undersigned consents to I.C.B.S.A.C. – C.A.B.C. obtaining such information as may be deemed necessary at any time in connection with the undersigned in respect of her/his application for the above premises being applied for herein and for any renewal or extension thereof. The undersigned also consents to the disclosure of any information concerning the undersigned and the sharing or exchange of information concerning the undersigned, with and to: (i) any credit reporting agency or to any person to whom the undersigned has or proposed to have financial relations and to I.C.B.S.A.C. – C.A.B.C. obtaining a credit report concerning the undersigned and/or (ii) any physician or other health care professional. The undersigned agrees to provide to I.C.B.S.A.C. – C.A.B.C. satisfactory evidence of age, health, income and Canadian Residency. The undersigned further agrees to submit to I.C.B.S.A.C. – C.A.B.C. forthwith, a **certificate of health** executed by his/her **doctor** in the form required by I.C.B.S.A.C. – C.A.B.C.

Attached

DATED AT CITY OF TORONTO this _____ day of _____ 20____

Witness:	Applicant:
Witness:	Co-Applicant:

7. To Be Completed by the Physician (Please print or type):**Medical Report**

Applicant's Name

Date of Birth

Your patient is applying with the VILLA CHARITIES NON-PROFIT Housing Project Caboto Terrace/Casa Del Zotto/Casa Abruzzo. The information you provide below will assist in assessing your patient's housing unit. It is essential that you are as specific as possible in your evaluation so that we can make a correct decision as to whether our accommodation meets your patient's current needs.

Thank you for your assistance.

Diagnosis and Prognosis

How are the above health problems aggravated by your patient's present accommodation?

In your opinion, why will your patient's medical status be improved by alternate accommodation?

Will your patient need any special structures, (i.e elevator, grab bars, wheelchair access)?

I can verify that he/she/they is/are able to carry out the following essential activities of day-to-day living either independently or with some assistance

Essential Day-to-Day Activities:**Independently****With Assistance**

Dressing/bathing

Preparing meals

Taking medication

Doing Laundry

Shopping for basic needs; food, clothing etc.

Tenant Obligations:

Comprehending the obligations of the lease

Cleaning the unit: removing garbage

Operating the stove safely

Paying monthly rent on time

Maintaining reasonably quiet in the unit

Physician's Certification:

I certify that this information represents my best judgment and is accurate to the best of my knowledge.

Signature

Date

Physician's Name

Telephone Number

Release from Patient

I hereby authorize and direct you to release any medical information pertaining to my health as and when requested to: Caboto Terrace/Casa Del Zotto/Casa Abruzzo.

Patient's Signature

Date