Adult Guardianship Program Referral Requirements

Pension Trustee – Certified Incapable of Finances (CI)

- Client Profile – 3 pages
- Service Canada “Certificate of Incapability” - 2 pages (Complete/sign by Physician, Psychiatrist or Social worker)
- Referral Source Letter – 1 page (Complete/sign by referral party)
- Canada Revenue Agency “Authorizing or Cancelling a Representative - 2 pages (Client signs the 2nd page at the bottom)
- Letter to Canada Revenue Agency re: Stop direct deposit - 1 page (Client signs)
- Release of Information form and letter - 2 pages (1 form and1 letter, client signs one sets per service provider / bill)
- MSD Consent to Disclosure of information - 1 page (Client Signs)

Please mail all original signed forms to The Bloom Group Adult Guardianship Program for file opening.

315B Powell Street,
Vancouver, BC.
V6A 1G5
THE BLOOM GROUP COMMUNITY SERVICES SOCIETY
Adult Guardianship Program
CLIENT PROFILE

Client _____________________________ Date of referral _____________________________

TYPE OF AUTHORITY

☐ Pension Management Contract ☐ Penison Trustee ☐ Discretionary Trust

DOB _____/_____/_______ Place of Birth _____________________________
(month / day / year) (city / province / country)

SIN __________________________ Gender: ☐ Male ☐ Female ☐ Other __________________________

Living Status: Common-law / Single / Widowed / Divorced / Married

RESIDENCE

Current address: ________________________________________________________________

__________________________________________________________________________ Phone ___________

Current Per Diem / Rental Rate _____________________________
Facility/Landlord Name ________________________________________________________

__________________________________________________________________________ Phone ___________

Is address change necessary? Yes / No Will client be moving Yes / No

If Yes please outline moving arrangements ______________________________________

FAMILY AND FRIENDS (Contact information)

Name _____________________________ Name _____________________________
Relationship __________________________ Relationship ___________________________
Address ________________________________________________________________

__________________________________________________________________________ Address ___________________________________________

__________________________________________________________________________ Phone ________ Phone ________

REFFERAL INFORMATION

Referring Agency ______________________________________________________________
Name of person referring or contact _____________________________ Title ___________________________
Agency Address ______________________________________________________________

Phone _____________________________ Fax _____________________________

Email _____________________________
REASON FOR REFERRAL

MEDICAL INFORMATION
Doctor's Name
Phone

GOALS AND EXPECTATIONS/ (upcoming purchases):

OTHER SUPPORT AGENCY
Organization

Contact Name
Title
Address
Phone
Fax:

FINANCIAL INFORMATION - INCOME
OAS $
CPP $
GIS $
DVA $
R/K #: 
Gain / Other $

Do you have any instructions regarding the income?

INCOME TAX
Filed taxes current year: 
Last Year Income Tax filed 

Do you want to store financial documents in TBGCSS fire-safe vault? Yes / No

Do you want your money transferred from your bank account to AGP for easy access. Yes / No

Should you wish to transfer any money you're your account, you would need to arrange it.

BILL PAYMENTS

Charge accounts
Company 
Card# 
Amount owed $

Instructions:
UTILITIES
Hydro account #____________________

Cable account #_____________ Service provider____________________

Phone account # _______________ Service provider____________________

Other ________________________

DISABILITY TAX CREDIT
Would you qualify for a Disability Tax Credit? This refers to people who have disabilities where normal functions are impaired or movement and abilities are severely restricted.

Do you want the AGP to send a DTC application?  Yes _____  No _____

BUDGET PLAN

WILL: Do you have a Will? Yes / No  Is your Will current? Yes / No

If Yes, please state the location of the Will:

______________________________________________________________

Name & location of Executor/ix:

______________________________________________________________ Phone: __________________

If Will is outdated, do you want a codicil to your Will? Yes / No
If you have no Will, do you want a Will? Yes / No
Would you like a referral to a notary public to acquire a Will? Yes / No
Do you want a copy of your Will stored in TBGCSS fire-safe vault? Yes / No

FUNERAL ARRANGEMENTS Do you have pre-arrangements made: Yes / No

If Yes, name of funeral home: _____________________________ Phone: __________

Do you have any instructions that you want the AGP to carry out? _____________________________

OTHER RELEVANT INFORMATION
Certificate of Incapability

Information about the Old Age Security and/or Canada Pension Plan beneficiary

<table>
<thead>
<tr>
<th>Mr.</th>
<th>Mrs.</th>
<th>Usual First Name and Initial</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms</td>
<td>Miss</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address - No., Street, Apt., P.O. Box, R.R. and City</th>
<th>Province or Territory</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Country - If other than Canada</th>
<th>Postal Code</th>
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</table>

Note: If you are applying on behalf of an individual who is homeless or at imminent risk of being homeless please enter the community where the individual resides.

Please note that, to be considered incapable of managing his/her own affairs, a person must be suffering from severe mental impairment or a physical illness or impairment. (Please refer to the questions below.) If you are related by blood or marriage to the incapable individual or to the person applying to administer the benefits of the incapable individual, you cannot certify the individual's incapacity.

Does the person named above have:

<table>
<thead>
<tr>
<th>1. Good general knowledge of what is happening to his/her money or investments?</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Sufficient understanding of the concept of time, in order to pay bills promptly?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>3. Sufficient memory to keep track of financial transactions and decisions?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>4. Ability to balance accounts and bills?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>5. Significant impairment of judgement due to altered intellectual function?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
</tbody>
</table>

In addition:

6A. How long have you known this person? 6B. Please state this person's date of birth.

7. Do you consider this person capable of managing his/her own affairs? Yes No

If no, is improvement expected? (Provide date)

Complete questions 8 and 9 if you are a medical professional (Physician, Registered Nurse, Nurse Practitioner, Psychologist, or Psychiatrist).

<table>
<thead>
<tr>
<th>8. Diagnosis of Impairment</th>
<th>Date impairment started</th>
</tr>
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</table>

9. Comments

Service Canada delivers Employment and Social Development Canada programs and services for the Government of Canada.
Complete questions 10 and 11 if you are a designated non-medical professional (social worker, lawyer or clergyman).

<table>
<thead>
<tr>
<th>10. Description of impairment</th>
<th>Date impairment started</th>
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</table>

<table>
<thead>
<tr>
<th>11. Comments</th>
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</table>

To be completed by both medical and designated non-medical professionals, if certifying the incapability of a senior who is homeless or at imminent risk of being homeless.

12. Please complete the following certification:

I am a member in good standing of

(Name of Professional Association / Organization)

Membership/Registration Number:

Note: If you make a false or misleading statement, you may be subject to an administrative monetary penalty and interest, if any, under the Canada Pension Plan or the Old Age Security Act, or may be charged with an offence. Any benefits you received or obtained to which there was no entitlement would have to be repaid.

Name and signature of designated individual (medical professional, social worker, lawyer, or clergyman) completing this form.

<table>
<thead>
<tr>
<th>First Name and Initial</th>
<th>Last Name</th>
<th>Signature</th>
<th>Date</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>X</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Address - No., Street, Apt., P.O. Box, R.R. and City</th>
<th>Province or Territory</th>
<th>Telephone</th>
</tr>
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<tr>
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<table>
<thead>
<tr>
<th>Country</th>
<th>Postal Code</th>
<th>Profession</th>
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FOR OFFICE USE ONLY

<table>
<thead>
<tr>
<th>Approval</th>
<th>Reason for Disapproval</th>
<th>Reassessment Date</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
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</tbody>
</table>
This is a request for The Bloom Group Community Service Society - Adult Guardianship Program to act as the Trustee of Pension Income and manage the finances for:

__________________________________________
(Print of Client Name)

Dr.________________________________________ has seen this person on
__________________________ and he/she was found to be incapable of managing
(Date)
his/her finances.

Sincerely,

__________________________________________
Name of Facility

__________________________________________
Name of Referring Person and Title                     Date

__________________________________________
Signature

CI Referral Source Letter
Authorizing or Cancelling a Representative

Important – If you moved recently, update your address and contact information with the Canada Revenue Agency (CRA) online if you are registered with MyAccount at www.cra-arc.gc.ca/myaccount, by telephone at 1-800-959-8281, or in writing.

Complete this form to authorize the CRA to deal with another person who would act as your representative for income tax matters or to cancel any existing representatives on your account. Only forms received with a valid account number will be processed.

By registering with MyAccount at www.cra.gc.ca/myaccount, you will be able to provide immediate access to your representative and cancel and manage your representatives through “Authorize my representative.” You can also authorize or cancel a representative by completing this form and mailing it to your tax centre. We aim to process this paper form in 20 business days or less from the date it is received at the tax centre. To immediately cancel a representative, call us at 1-800-959-8281.

Part 1 – Taxpayer information
You will need to complete a separate Form T1013 for each account and representative. Complete the line that applies:

**SIN, TTN or ITN**

First name: ______________________  Last name: ______________________

**Trust account number**

Trust name: ______________________

**T5 filer identification number**

Filer name: ______________________

Part 2 – Representative information and authorization

Name of your representative (individual or business): ______________________

Mailing address: ______________________

Do not complete a new form every year if there are no changes. Complete section A or B, as applicable.

A. Authorize online access (includes access by telephone, in person, and in writing)

To grant online access to your representative, your representative must register online through “Represent a Client” at www.cra.gc.ca/representatives and obtain a ReplID or GroupID or register their business number (BN). Our online services do not have a year-specific option. Therefore, your representative will have access to all tax years.

By completing this section to authorize a representative for a trust account, the representative will have access to all tax years with no online access.

**ReplID**

First name: ______________________  Last name: ______________________

**GroupID**

Name of group: ______________________

**Business number (BN)**

Name of business: ______________________

Enter the level of authorization (level 1 or 2): [ ] If you do not specify a level of authorization, we will assign a level 1.

If you authorize your representative for online access and have a “care of” address, you will receive a letter to confirm the authorization.

or

B. Authorize access by telephone, in person, and in writing (no online access)

Enter the full name of the individual or business you are authorizing. If you do not identify a specific representative from that business, you will be authorizing the CRA to deal with any representative from that business.

**Individual:**

First name: Adult Guardianship Workers

Last name: ______________________

**Name of business:** The Bloom Group Community Service Society - Adult Guardianship Program

**Telephone:** ______________________  **Ext:** ______________________  **Fax:** 604-606-0321

Tick the appropriate box and indicate the level of authorization:

[ ] All tax years (past, present, and future)  **Level of authorization (level 1 or 2)**  [ ] If you do not specify a level of authorization, we will assign a level 1.

or

[ ] Enter the applicable tax year or years (past and/or present), and specify the level of authorization (level 1 or 2) for each tax year.

**Tax year(s)**

**Level of authorization**

T1013 E (15)  (Vous pouvez obtenir ce formulaire en français à www.arc.gc.ca/formulaires ou en composant le 1-800-959-7383.)
Part 3 – Authorization expiry date

Enter an expiry date, if applicable, otherwise the authorization will stay in effect until you or your representative cancels it or we are notified of your death.

Year   Month   Day

Part 4 – Cancel one or more existing authorizations

Complete this section only to cancel an existing authorization. Tick the appropriate box.

☑ Cancel all authorizations

or

☐ Cancel the authorizations given for the individual, group, or business identified below:

ReplID

First name: ___________________ Last name: ___________________

GroupID  G

Name of group: ________________________________________________

Business number (BN)

Name of business: ____________________________________________

Part 5 – Signature and date

If you are the taxpayer, you must sign and date this form. If you are the legal representative, you must tick the box below, and sign and date this form.

☐ I am the legal representative for this taxpayer or estate/trust (executor/administrator, power of attorney, the legal guardian or the trustee or custodian of this trust account).

Important: You must send a complete copy of the legal document giving you the authority to act in this capacity to the taxpayer’s tax centre. Read the attached information sheet for tax centre addresses.

If two or more legal representatives are acting jointly on the taxpayer’s behalf, each legal representative must sign below.

Print name of taxpayer or each legal representative

X

Signature of taxpayer or each legal representative, a parent if taxpayer is under the age of 16, a witness when signed with a mark

Year   Month   Day

Date of signature

If your representative has not electronically submitted this form on your behalf then it must be submitted within six months of the date of signature. If not, it will not be processed.

Privacy Act, personal information bank number CRA PPU 175
Date: ______________________

Canada Customs and Revenue Agency
Surrey Taxation Centre
9755 King George Hwy
Surrey, BC
V3T 5E1

Dear Sir or Madam:

RE: __________________________

SIN: __________________________

If I have direct deposit to a bank account please discontinue and redirect cheques made payable to:

________________________________
(client name)

c/o The Bloom Group Community Services Society
Attention: Adult Guardianship Program (AGP)
315B Powell Street
Vancouver, BC V6A 1G5

Sincerely,

________________________________________________________________________

Client Signature

(Direct contact for CCRA 1-800-959-8281)

CCRA Stop Direct Deposit 2013
RELEASE OF INFORMATION

To: __________________________

I, ____________________________ do hereby give my permission to The Bloom Group Community Services Society, Adult Guardianship Workers (or representative) to discuss the account mentioned below with representatives of your company:

BC Hydro: [ ] Account #: ____________________________

Bell Canada: [ ] Account #: ____________________________

Rogers: [ ] Account #: ____________________________

Shaw: [ ] Account #: ____________________________

Telus: [ ] Account #: ____________________________

Terasen: [ ] Account #: ____________________________

Other: [ ] Account #: ____________________________

FOR PRIVACY REASONS, PLEASE ONLY GIVE INFORMATION ON 1 BILL PER FORM.

Client Signature: ____________________________ Date: ____________________________

Address: ____________________________ Phone: ____________________________

Witness: Print Name: ____________________________ Signature: ____________________________

Address: ____________________________ Phone: ____________________________

Adult Guardianship Worker mainly managing account at Adult Guardianship Program:

Worker #: __________ Name: ____________________________ Phone: ____________________________
Date:

Service Provider:

To Whom It May Concern:

RE:  Account Holder:

Account Number:

Address:

I, __________________, am writing to inform you that I have asked The Bloom Group Community Service Society Adult Guardianship Program to help me manage my finances. They are also assisting me with my day to day finances. I give my permission to The Bloom Group Community Services Society – AGP representatives to discuss the account mentioned with representatives from your company. In addition, I am requesting that my monthly bills be sent to The Bloom Group Adult Guardianship Program for payment.

Please change my mailing address and mail bills or statements and any correspondences to following address:

________________________
c/o The Bloom Group Community Services Society
Adult Guardianship Program
315B Powell Street
Vancouver, BC V6A 1G5

If you should have any questions please contact my adult guardianship worker
________________________________________ at The Bloom Group Community Services Society Adult Guardianship Program at 604-606-

Sincerely,

Signature: _______________________________
RELEASE OF INFORMATION

To: ____________________________

I, ____________________________, do hereby give my permission to The Bloom Group Community Services Society, Adult Guardianship Workers (or representative) to discuss the account mentioned below with representatives of your company:

- BC Hydro: [ ] Account #: ____________________________
- Bell Canada: [ ] Account #: ____________________________
- Rogers: [ ] Account #: ____________________________
- Shaw: [ ] Account #: ____________________________
- Telus: [ ] Account #: ____________________________
- Terasen: [ ] Account #: ____________________________
- Other: [ ] Account #: ____________________________

FOR PRIVACY REASONS, PLEASE ONLY GIVE INFORMATION ON 1 BILL PER FORM.

Client Signature: ____________________________ Date: ____________________________
Address: ____________________________ Phone: ____________________________

Witness: Print Name: ____________________________ Signature: ____________________________
Address: ____________________________ Phone: ____________________________

Adult Guardianship Worker mainly managing account at Adult Guardianship Program:
Worker #: ____________ Name: ____________________________ Phone: ____________________________
To Whom It May Concern:

RE: Account Holder:

Account Number:

Address:

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c/o The Bloom Group Community Services Society
Adult Guardianship Program
315B Powell Street
Vancouver, BC V6A 1G5

If you should have any questions please contact my adult guardianship worker ______________________ at The Bloom Group Community Services Society Adult Guardianship Program at 604-606-

Sincerely,

Signature: ______________________
RELEASE OF INFORMATION

To:  __________________________________________

I,  ________________________________ do hereby give my permission to The Bloom Group Community Services Society, Adult Guardianship Workers (or representative) to discuss the account mentioned below with representatives of your company:

BC Hydro:  [ ] Account #:  ________________________________

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Rogers:  [ ] Account #:  ________________________________

Shaw:  [ ] Account #:  ________________________________

Telus:  [ ] Account #:  ________________________________

Terasen:  [ ] Account #:  ________________________________

Other:  [ ] Account #:  ________________________________

FOR PRIVACY REASONS, PLEASE ONLY GIVE INFORMATION ON 1 BILL PER FORM.

Client Signature:  ________________________________ Date:  ________________________________

Address:  ________________________________ Phone:  ________________________________

Witness:  Print Name:  ________________________________ Signature:  ________________________________

Address:  ________________________________ Phone:  ________________________________

Adult Guardianship Worker mainly managing account at Adult Guardianship Program:

Worker #:  ___________ Name:  ________________________________ Phone:  ________________________________
Date:

Service Provider:

To Whom It May Concern:

RE: Account Holder:

Account Number:

Address:

I, ____________________________, am writing to inform you that I have asked The Bloom Group Community Service Society Adult Guardianship Program to help me manage my finances. They are also assisting me with my day to day finances. I give my permission to The Bloom Group Community Services Society – AGP representatives to discuss the account mentioned with representatives from your company. In addition, I am requesting that my monthly bills be sent to The Bloom Group Adult Guardianship Program for payment.

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c/o The Bloom Group Community Services Society
Adult Guardianship Program
315B Powell Street
Vancouver, BC V6A 1G5

If you should have any questions please contact my adult guardianship worker ____________________________ at The Bloom Group Community Services Society Adult Guardianship Program at 604-606-

Sincerely,

Signature: ____________________________
CONSENT TO DISCLOSURE
OF INFORMATION

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the Employment and Assistance Act and the Employment and Assistance for Persons with Disabilities Act. The collection, use and disclosure of personal information is subject to the provisions of the Freedom of Information and Protection of Privacy Act. You have the right to revoke this consent at any time. Any questions regarding this form should be directed to your local Employment and Assistance office.

<table>
<thead>
<tr>
<th>CLIENT NAME</th>
<th>BIRTH DATE</th>
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<tbody>
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<thead>
<tr>
<th>SR NUMBER (IF APPLICABLE)</th>
<th>CASE NUMBER (IF APPLICABLE)</th>
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</table>

I consent to the disclosure of any personal information currently held under the custody and control of the Ministry of Social Development and Social Innovation subject to the following limitations:

☐ 1. The following specific information only. (If more space is required, please attach an additional page)

☐ 2. All information relevant to the determination of eligibility for:
   - ☐ Income Assistance
   - ☐ Hardship Assistance
   - ☑ Bus Pass Program
   - ☐ Disability Assistance
   - ☐ Supplements

This information may be disclosed to an agency and/or an individual:

<table>
<thead>
<tr>
<th>AGENCY NAME</th>
<th>INDIVIDUAL NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Bloom Group Community Service Society - Adult Guardianship Pgrm</td>
<td>Adult Guardianship Workers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADDRESS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>315B Powell Street</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CITY / TOWN</th>
<th>POSTAL CODE</th>
<th>TELEPHONE NUMBER</th>
<th>FAX NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vancouver, BC</td>
<td>V6A 1G5</td>
<td>604-606-0321</td>
<td></td>
</tr>
</tbody>
</table>

This consent is effective on the date it is signed and will remain valid until I request that it be cancelled.

<table>
<thead>
<tr>
<th>SIGNATURE OF PERSON GIVING CONSENT</th>
<th>DATE (YYYY MMM DD)</th>
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NOTE: If you are signing on behalf of the Ministry Client, you must attach proof of that legal authority (for example, a copy of the court order naming you as Committee) to this Consent.