THE BLOOM GROUP
Community. Services. Together.

Referral Requirements for Adult Guardianship Program

The application package contains all the forms necessary to open an account. Due to the number of forms required by Provincial and Federal agencies, **multiple originals are required**. Please print **single-sided** and **fill all documents in full**. Incomplete applications require additional follow up and will create unnecessary delays. **We can only accept original signed forms completed in full, returned by mail.** If you have any trouble with the application process, please contact our office at 604-606-0335 / tfan@thebloomgroup.org / acheng@thebloomgroup.org

CHECKLIST:

- ☐ **Client Profile and Application**
- ☐ **Fee Schedule**
- ☐ **Certificate of Incapability** - signed/completed by Physician, Nurse Practitioner, Psychologist or Psychiatrist (medical professional only)
  - Applicable if client is deemed incapable to manage own finances.
- ☐ **Referral Letter for Certified Incapable Client** (signed by referrer)
- ☐ **Pension Management Contracts**
  - 3 sets required (for OAS, CPP and The Bloom Group file), client signed, and someone witnessed the signatures.
  - Print additional set for each source of private pension income.
- ☐ **Private Pension Release** - If applicable, for any income other than OAS/CPP
  - Please attach recent pension statement or provide information
- ☐ **Consent to Communicate Information to an Authorized Person**
  - 2 sets required (for each of OAS and CPP)
- ☐ **Authorize a Representative For Access by Phone and Mail**
- ☐ **Redirect Deposit**
- ☐ **Direct Deposit Enrollment Form**
- ☐ **Release of Information** - 1 letter required for each service provider (i.e. utility, phone, cable, etc.), with recent statement or invoice

** Please print clearly and print on single-sided pages for all documents.
** All original signed forms must be mailed to The Bloom Group - Adult Guardianship Program.
** Processing time for new accounts can take up to 6 - 8 months based on application completeness, and Service Canada/Canada Revenue Agency servicing time for pension redirection.

THE BLOOM GROUP
Community. Services. Together.

Client Profile and Application

Client name: _____ Date of referral: _____

DOB: _____ (MM / DD / YYYY) Birth Place: _____ City / Province / Country SIN: _____

PHN: _____ Gender: _____ Marital Status: _____

Mother's Maiden Name: _____ please attach any certified copies of ID, if available.

RESIDENCE:

Current Address: _____

Previous Address (if known): _____

Phone: _____ Email: _____

Current per diem / rent rate: $ _____ Facility and Contact: _____

_____

Will the client be moving? Y / N If yes, please provide us the new address:

_____

FAMILY AND FRIENDS:

Name: _____ Relationship: _____ Phone: _____

Email: _____ Address: _____

Name: _____ Relationship: _____ Phone: _____

Email: _____ Address: _____

REFERRAL INFORMATION:

Agency: _____

Address: _____ Phone: _____

Name: _____ Title: _____

Email: _____

Adult Guardianship Program. 317 E. Hastings Street, Vancouver, BC, V6A 1P3. Phone: 604 606 0335. Fax: 604 606 0321. Web: www.thebloomgroup.org

THE BLOOM GROUP
Community. Services. Together.

REASON FOR REFERRAL: _____

_____

MEDICIAL INFORMATION:

Doctor: _____ Phone: _____

OTHER SUPPORT AGENCY:

Agency: _____ Contact: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

FINANCIAL INFORMATION:

OAS $ _____ CPP $ _____ GIS $ _____ OTHER $ _____

Please provide other details regarding income currently being received, both private pensions and other, if known.

_____

Bank / Credit Union: _____

Transit #: _____ Institution #: _____ Account #: _____

Please attach a void cheque and provide any statements where available.

Last year of income tax filed: _____ Has the client filed for the current tax year? Y / N

Please attach the most recent Notice of Assessment ('NOA') if available.

Is the client eligible for the Disability Tax Credit? Y / N

Adult Guardianship Program. 317 E. Hastings Street, Vancouver, BC, V6A 1P3. Phone: 604 606 0335. Fax: 604 606 0321. Web: www.thebloomgroup.org

UTILITIES / TELEPHONE / CABLE, ETC.:

Provider: _____ Account #: _____

Provider: _____ Account #: _____

Provider: _____ Account #: _____

Please attach statements/invoices, if available

OTHER ARRANGEMENTS:

Is there a Will? Y / N Location of the Will: _____

Name and contact of Executor: _____

Please attach a copy of the Will, if available

Have pre-arrangements been made? Y / N If yes, provide contract / details: _____

Please attach a copy of the contract, if available.

If no pre-arrangements have been made, what is the client's wish? Cremation / Burial / Other? _____

Is there a POA? Y / N

If yes, please provide name and contact: _____

Please attach a copy of the POA agreement, if available.

Is there a Representation Agreement? Y / N

If yes, please provide name and contact: _____

Please attach a copy of the Representation Agreement, if available.

Adult Guardianship Program. 317 E. Hastings Street, Vancouver, BC, V6A 1P3. Phone: 604 606 0335. Fax: 604 606 0321. Web: www.thebloomgroup.org

THE BLOOM GROUP
Community. Services. Together.

Adult Guardianship Program Fee Schedule

(Fees in effect since May 1st 2021)

Pension Management Contract – Capable and Voluntary

Opening Fee: **$25** one-time fee
Program Fee: **$60** monthly fee
Investment Fee (pooled-accounts only): **0.25%** quarterly investment fee on assets managed (based on the average quarterly balance)
Closing Fee: **1%** on the closing balance of account at close

Pension Trustee – Certified Incapable of Managing Finances

Opening Fee: **$25** one-time fee
Program Fee: **$60** monthly fee
Investment Fee (pooled-accounts only): **0.25%** quarterly investment fee on assets managed (based on the average quarterly balance)
Closing Fee: **1%** on the closing balance of account at close

Discretionary Trust – Persons with Disabilities Designation or Income Assistance

Opening Fee: **2%** fee on funds deposited.
Program Fee: **1%** annually, charged monthly (based on the closing balance) **2%** fee on additional deposits.
Closing Fee: **2%** on the closing balance of account at close or transition into PMC or Pension Trustee.

Power of Attorney (no new accounts being accepted)

Opening Fee: **5%** fee on funds deposited
Program Fee: **0.4%** annually, charged monthly (based on the closing balance)
Closing Fee: **5%** on the closing balance of account at close

Adult Guardianship Program 317 E. Hastings Street, Vancouver, BC, V6A 1P3
Phone: 604 606 0335 Fax: 604 606 0321 Web: www.thebloomgroup.org

Service Canada

PROTECTED B (when completed)

Personal Information Banks
ESDC PPU 116, 146

Certificate of Incapability

Information about the Old Age Security and/or Canada Pension Plan beneficiary	Beneficiary's Social Insurance Number

◯ Mr. ◯ Mrs. ◯ Ms ◯ Miss Usual First Name and Initial	Last Name	
Address - No., Street, Apt., P.O. Box, R.R. and City	Province or Territory	
	Country - If other than Canada	Postal Code

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 incapability.

Does the person named above have:

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

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).

8. Diagnosis of impairment	Date impairment started
9. Comments	

Service Canada delivers Employment and Social Development Canada programs and services for the Government of Canada.

Beneficiary's Social Insurance Number

Complete questions 10 and 11 if you are a designated non-medical professional (social worker, lawyer or member of the clergy).

10. Description of impairment	Date impairment started
11. Comments	

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 member of the clergy) completing this form.

First Name and Initial	Last Name	Signature X	Date
Address - No., Street, Apt., P.O. Box, R.R. and City	Province or Territory		Telephone
	Country	Postal Code	Profession

FOR OFFICE USE ONLY

Approval ◯ Yes ◯ No	Reason for Disapproval	Reassessment Date	Signature	Date

This is a request for **The Bloom Group Community Services Society – Adult Guardianship Program** to act as the **Trustee of Pension Income,** and manage financial affairs for:

_____
(Please print client name)

Dr. _____ has seen this person on _____ (MM/DD/YYYY) and he/she was found to be incapable of managing his/her finances.

Regards,

_____
Name of Facility

_____ _____
Referrer Name Title

_____
Date

_____
Signature

THE BLOOM GROUP
Community. Services. Together.

PENSION MANAGEMENT CONTRACT

I, _____, of _____
_____, have asked The Bloom Group Community Services Society ("The Bloom Group") to assist me with the management of my income and expenses, which may include, without limitation, the receipt and management of my pension income from various sources (my "Pension Income") and my expenses and bills and any other services which may be required to facilitate the management of my income and expenses (the "Services").

Fees

I agree that the compensation to be paid to The Bloom Group for providing the Services will be as follows:

1. Opening Fee: an initial opening fee of $25.00 at the time that an account is established for me by The Bloom Group;

2. Monthly Program Fee: a monthly program fee of $60.00;

3. Closing Fee: a closing fee of 1.0% of the gross funds in my account with The Bloom Group at the time of the account closing;
(together, the "Fees").

Changes to Fees

I acknowledge and agree that the Fees will be reviewed by The Bloom Group annually and may be changed from time to time by The Bloom Group. The Bloom Group will use its reasonable efforts to advise me in advance of any fee changes.

Trust Funds

I acknowledge and agree that The Bloom Group will keep a separate record of any funds and assets received by and/or held by The Bloom Group on my behalf (my "Trust Fund") but for the purposes of investment and administration, The Bloom Group may hold my Trust Fund and other trust funds for The Bloom Group's other clients in one or more combined accounts and The Bloom Group will allocate all trust receipts and disbursements among the combined trust accounts proportionately. I acknowledge and agree that I will need to report any trust income receipts that I may receive from The Bloom Group on my personal income tax return for the appropriate tax year.

Out-of-Pocket Expenses

In addition to the compensation The Bloom Group will receive for providing the Services, I agree that The Bloom Group will be entitled to be reimbursed by me for all the reasonable out-of-pocket expenses that may be incurred by The Bloom Group in the provision of its Services to me (the "Expenses"), including, without limitation, courier expenses and long-distance telephone call charges.

Payment of Fees and Expenses

I agree that the Fees and Expenses are payable from the date of this Contract and will be payable to The Bloom Group monthly or at such other frequencies as The Bloom Group, in its sole discretion, considers reasonable. Unless otherwise agreed to between myself and The Bloom Group, all of The Bloom Group's Fees and Expenses shall be charged to and paid out of the my Trust Fund. If my Trust Fund is insufficient to pay the Fees and Expenses, I agree that I will be responsible for promptly paying to The Bloom Group any shortfall in the Fees and/or Expenses. Upon request, The Bloom Group will provide me with a printed record of my Trust Fund including a record of any payment of Fees and/or Expenses to The Bloom Group or any distributions to myself.

THE BLOOM GROUP
Community. Services. Together.

Personal Information & Authorization

I hereby authorize and agree:

1. to the release of my personal information to The Bloom Group to allow The Bloom Group to provide the Services to me (my Social Insurance Number is _____);

2. to give The Bloom Group **signing authority** with my Pension Income providers;

3. to have any Pension Income cheques payable to me prepared in the name of myself, _____ c/o The Bloom Group Community Services Society (TBGCSS) Adult Guardianship Program (AGP); and

4. to have all correspondence sent to The Bloom Group Adult Guardianship Program at 317 E. Hastings Street, Vancouver, BC V6A 1P3.

I agree to sign any authorization forms or other documents or take any actions that may be required to provide The Bloom Group with the above authorizations and to allow The Bloom Group to provide the Services to me.

Termination of Contract

This Contract may be terminated by either me or The Bloom Group by written notice to the other party, such termination to be effective upon the receipt of the written notice of termination by the other party.

Dated this _____ day of _____, 20____

_____)
Witness Signature)

Witness Print name: _____)

_____)
Address)
_____)
_____)
Occupation)
_____)
Phone Number

_____
Client Signature

The Bloom Group Community Services Society by its authorized signatory:)

_____

Print Name:_____)

Title: _____

Adult Guardianship Program 317 E. Hastings Street, Vancouver, BC, V6A 1P3 Phone: 604 606 0335 Fax: 604 606 0321 www.thebloomgroup.org

THE BLOOM GROUP
Community. Services. Together.

PENSION MANAGEMENT CONTRACT

I, _____, of _____
_____, have asked The Bloom Group Community Services Society ("The Bloom Group") to assist me with the management of my income and expenses, which may include, without limitation, the receipt and management of my pension income from various sources (my "Pension Income") and my expenses and bills and any other services which may be required to facilitate the management of my income and expenses (the "Services").

Fees

I agree that the compensation to be paid to The Bloom Group for providing the Services will be as follows:

1. Opening Fee: an initial opening fee of $25.00 at the time that an account is established for me by The Bloom Group;

2. Monthly Program Fee: a monthly program fee of $60.00;

3. Closing Fee: a closing fee of 1.0% of the gross funds in my account with The Bloom Group at the time of the account closing;
(together, the "Fees").

Changes to Fees

I acknowledge and agree that the Fees will be reviewed by The Bloom Group annually and may be changed from time to time by The Bloom Group. The Bloom Group will use its reasonable efforts to advise me in advance of any fee changes.

Trust Funds

I acknowledge and agree that The Bloom Group will keep a separate record of any funds and assets received by and/or held by The Bloom Group on my behalf (my "Trust Fund") but for the purposes of investment and administration, The Bloom Group may hold my Trust Fund and other trust funds for The Bloom Group's other clients in one or more combined accounts and The Bloom Group will allocate all trust receipts and disbursements among the combined trust accounts proportionately. I acknowledge and agree that I will need to report any trust income receipts that I may receive from The Bloom Group on my personal income tax return for the appropriate tax year.

Out-of-Pocket Expenses

In addition to the compensation The Bloom Group will receive for providing the Services, I agree that The Bloom Group will be entitled to be reimbursed by me for all the reasonable out-of-pocket expenses that may be incurred by The Bloom Group in the provision of its Services to me (the "Expenses"), including, without limitation, courier expenses and long-distance telephone call charges.

Payment of Fees and Expenses

I agree that the Fees and Expenses are payable from the date of this Contract and will be payable to The Bloom Group monthly or at such other frequencies as The Bloom Group, in its sole discretion, considers reasonable. Unless otherwise agreed to between myself and The Bloom Group, all of The Bloom Group's Fees and Expenses shall be charged to and paid out of the my Trust Fund. If my Trust Fund is insufficient to pay the Fees and Expenses, I agree that I will be responsible for promptly paying to The Bloom Group any shortfall in the Fees and/or Expenses. Upon request, The Bloom Group will provide me with a printed record of my Trust Fund including a record of any payment of Fees and/or Expenses to The Bloom Group or any distributions to myself.

THE BLOOM GROUP
Community. Services. Together.

Personal Information & Authorization

I hereby authorize and agree:

1. to the release of my personal information to The Bloom Group to allow The Bloom Group to provide the Services to me (my Social Insurance Number is _____);

2. to give The Bloom Group **signing authority** with my Pension Income providers;

3. to have any Pension Income cheques payable to me prepared in the name of myself, _____ c/o The Bloom Group Community Services Society (TBGCSS) Adult Guardianship Program (AGP); and

4. to have all correspondence sent to The Bloom Group Adult Guardianship Program at 317 E. Hastings Street, Vancouver, BC V6A 1P3.

I agree to sign any authorization forms or other documents or take any actions that may be required to provide The Bloom Group with the above authorizations and to allow The Bloom Group to provide the Services to me.

Termination of Contract

This Contract may be terminated by either me or The Bloom Group by written notice to the other party, such termination to be effective upon the receipt of the written notice of termination by the other party.

Dated this _____ day of _____, 20____

_____	)	_____
Witness Signature	)	Client Signature
	)	
	)	
Witness Print name: _____	)	
	)	
_____	)	
Address	)	
_____	)	
	)	
_____	)	
Occupation	)	
_____	)	
Phone Number		
The Bloom Group Community Services Society by its authorized signatory:	)	
	)	
	)	
	)	
_____	)	
Print Name:_____	)	
Title: _____		

Adult Guardianship Program 317 E. Hastings Street, Vancouver, BC, V6A 1P3 Phone: 604 606 0335 Fax: 604 606 0321 www.thebloomgroup.org

THE BLOOM GROUP
Community. Services. Together.

PENSION MANAGEMENT CONTRACT

I, _____ , of _____
_____ , have asked The Bloom Group Community Services Society ("The Bloom Group") to assist me with the management of my income and expenses, which may include, without limitation, the receipt and management of my pension income from various sources (my "Pension Income") and my expenses and bills and any other services which may be required to facilitate the management of my income and expenses (the "Services").

Fees

I agree that the compensation to be paid to The Bloom Group for providing the Services will be as follows:

1. Opening Fee: an initial opening fee of $25.00 at the time that an account is established for me by The Bloom Group;

2. Monthly Program Fee: a monthly program fee of $60.00;

3. Closing Fee: a closing fee of 1.0% of the gross funds in my account with The Bloom Group at the time of the account closing;
(together, the "Fees").

Changes to Fees

I acknowledge and agree that the Fees will be reviewed by The Bloom Group annually and may be changed from time to time by The Bloom Group. The Bloom Group will use its reasonable efforts to advise me in advance of any fee changes.

Trust Funds

I acknowledge and agree that The Bloom Group will keep a separate record of any funds and assets received by and/or held by The Bloom Group on my behalf (my "Trust Fund") but for the purposes of investment and administration, The Bloom Group may hold my Trust Fund and other trust funds for The Bloom Group's other clients in one or more combined accounts and The Bloom Group will allocate all trust receipts and disbursements among the combined trust accounts proportionately. I acknowledge and agree that I will need to report any trust income receipts that I may receive from The Bloom Group on my personal income tax return for the appropriate tax year.

Out-of-Pocket Expenses

In addition to the compensation The Bloom Group will receive for providing the Services, I agree that The Bloom Group will be entitled to be reimbursed by me for all the reasonable out-of-pocket expenses that may be incurred by The Bloom Group in the provision of its Services to me (the "Expenses"), including, without limitation, courier expenses and long-distance telephone call charges.

Payment of Fees and Expenses

I agree that the Fees and Expenses are payable from the date of this Contract and will be payable to The Bloom Group monthly or at such other frequencies as The Bloom Group, in its sole discretion, considers reasonable. Unless otherwise agreed to between myself and The Bloom Group, all of The Bloom Group's Fees and Expenses shall be charged to and paid out of the my Trust Fund. If my Trust Fund is insufficient to pay the Fees and Expenses, I agree that I will be responsible for promptly paying to The Bloom Group any shortfall in the Fees and/or Expenses. Upon request, The Bloom Group will provide me with a printed record of my Trust Fund including a record of any payment of Fees and/or Expenses to The Bloom Group or any distributions to myself.

THE BLOOM GROUP
Community. Services. Together.

Personal Information & Authorization

I hereby authorize and agree:

1. to the release of my personal information to The Bloom Group to allow The Bloom Group to provide the Services to me (my Social Insurance Number is _____);

2. to give The Bloom Group **signing authority** with my Pension Income providers;

3. to have any Pension Income cheques payable to me prepared in the name of myself, _____ c/o The Bloom Group Community Services Society (TBGCSS) Adult Guardianship Program (AGP); and

4. to have all correspondence sent to The Bloom Group Adult Guardianship Program at 317 E. Hastings Street, Vancouver, BC V6A 1P3.

I agree to sign any authorization forms or other documents or take any actions that may be required to provide The Bloom Group with the above authorizations and to allow The Bloom Group to provide the Services to me.

Termination of Contract

This Contract may be terminated by either me or The Bloom Group by written notice to the other party, such termination to be effective upon the receipt of the written notice of termination by the other party.

Dated this _____ day of _____, 20____

_____)
Witness Signature)

Witness Print name: _____)

_____)
Address)
_____)
_____)
Occupation)
_____)
Phone Number

_____
Client Signature

The Bloom Group Community Services Society by its authorized signatory:)

_____

Print Name:_____)

Title: _____

Adult Guardianship Program 317 E. Hastings Street, Vancouver, BC, V6A 1P3 Phone: 604 606 0335 Fax: 604 606 0321 www.thebloomgroup.org

Date: _____

RE: PRIVATE PENSION or Subsidy payment HELD WITH

_____ **(File #** _____ **)**

To Whom It May Concern:

I, _____ (SIN _____, DOB _____), have requested The Bloom Group Community Services Society - Adult Guardianship Program to assist me with financial management. I give consent to the Adult Guardianship workers at The Bloom Group AG Program, to access all information in my file at your office.

Please immediately redirect my monthly payments to my trust account at The Bloom Group Adult Guardianship Program for management.

I am also requesting that you forward all correspondence including tax slips to The Bloom Group Community Service Society Adult Guardianship Program, so matters could be dealt with promptly with their assistance.

Please change my mailing address to the following address:

_____ (client name)
c/o The Bloom Group Community Service Society
Attn: Adult Guardianship Program
317 E. Hastings Street
Vancouver, BC V6A 1P3

Thank you for your prompt attention and assistance in this matter.

Sincerely,

_____
X signature

Service Canada

PROTECTED B (when completed)
Personal Information Bank
HRSDC PPU 031, 116, 140, 146, 175, 649

Consent to Communicate Information to an Authorized Person

This form allows you to name a person (such as your spouse, partner, other family member or friend) to communicate on your behalf with Service Canada regarding your Canada Pension Plan (CPP) and Old Age Security (OAS) benefits. It allows Service Canada to communicate to this authorized person your personal information concerning CPP/OAS benefits, payments, income, contributions and changes to your address (excluding the address where your cheque is mailed or the bank account where the payment is deposited). It **does not provide authority** for the person to apply for benefits for you, change your payment address or request/change voluntary tax withhold. If our records indicate that a legal representative, such as a Power of Attorney or Trustee, is authorized to act on your behalf, all communications will be made through that legal representative.

Note: Third Parties are not currently authorized to use the CPP/OAS On-line Services.

Section 1 : Your Consent *(you must complete and sign this section)*

First Name _____ Initial _____ Family Name _____ Social Insurance Number _____

I hereby give my consent for Service Canada to communicate **personal information on my behalf** and to act on information received from **the authorized person, named in Section 2, concerning CPP/OAS benefits, payments, income, contributions and changes to my address** (excluding the address where my cheque is mailed or the bank account where the payment is deposited) **on the programs below:**

Check applicable box(es): ☐ Canada Pension Plan ☐ Old Age Security

This consent form **does not provide authority** to the person to apply for benefits on my behalf or to change my payment address (the address where my cheque is mailed or the bank account where the payment is deposited) or request/change voluntary tax withhold. I understand that this consent remains valid unless I cancel it in writing and that it is only valid if Service Canada receives this form within one year from the date I sign it. I also understand that this consent is revoked in the event of my death.

Your Signature: X _____ Date: _____ Year Month Day

Section 2 : The person you would like us to communicate with must complete and sign this section

Relationship to client: Pension Trustee

The Bloom Group Society (First Name) _____ Initial Adult Guardianship Program (Family Name)

Telephone numbers: Home 604-606-0335 Work _____ Other Fax: 604-606-0321

Complete mailing address: 317 E. Hastings Street (No., Street, Apt., P.O. Box, R.R.) Vancouver (City) BC (Province) _____ (Country) V6A 1P3 (Postal Code)

I understand that I can communicate with Service Canada on the program(s) checked off above to give and receive personal information on behalf of the person named in Section 1. I also understand that **I do not have the authority** to apply for a benefit or to change the payment address (the address where the cheque is mailed or the bank account where the payment is deposited) or request/change voluntary tax withhold on this person's behalf.

Signature: X _____ Date: _____ Year Month Day

Protection of your personal information

CPP and OAS cannot give your personal information to any person or organization without your written consent, except where authorized by CPP or OAS legislation. You (or your authorized legal representative) have the right to request a copy of the information in your file.

How to reach CPP and OAS: In Canada and the United States, call

- English: 1-800-277-9914
- French: 1-800-277-9915
- TTY users: 1-800-255-4786

To learn more about this form, Canada Pension Plan, Old Age Security Program and Service Canada on-line services, please visit our Internet site at: **servicecanada.gc.ca**

Service Canada delivers Human Resources and Skills Development Canada programs and services for the Government of Canada.

Service Canada

PROTECTED B (when completed)
Personal Information Bank
HRSDC PPU 031, 116, 140, 146, 175, 649

Consent to Communicate Information to an Authorized Person

This form allows you to name a person (such as your spouse, partner, other family member or friend) to communicate on your behalf with Service Canada regarding your Canada Pension Plan (CPP) and Old Age Security (OAS) benefits. It allows Service Canada to communicate to this authorized person your personal information concerning CPP/OAS benefits, payments, income, contributions and changes to your address (excluding the address where your cheque is mailed or the bank account where the payment is deposited). It **does not provide authority** for the person to apply for benefits for you, change your payment address or request/change voluntary tax withhold. If our records indicate that a legal representative, such as a Power of Attorney or Trustee, is authorized to act on your behalf, all communications will be made through that legal representative.

Note: Third Parties are not currently authorized to use the CPP/OAS On-line Services.

Section 1 : Your Consent *(you must complete and sign this section)*

First Name | Initial | Family Name | Social Insurance Number

I hereby give my consent for Service Canada to communicate **personal information on my behalf** and to act on information received from **the authorized person, named in Section 2, concerning CPP/OAS benefits, payments, income, contributions and changes to my address** (excluding the address where my cheque is mailed or the bank account where the payment is deposited) **on the programs below**:

Check applicable box(es): ☐ Canada Pension Plan ☐ Old Age Security

This consent form **does not provide authority** to the person to apply for benefits on my behalf or to change my payment address (the address where my cheque is mailed or the bank account where the payment is deposited) or request/change voluntary tax withhold. I understand that this consent remains valid unless I cancel it in writing and that it is only valid if Service Canada receives this form within one year from the date I sign it. I also understand that this consent is revoked in the event of my death.

Your Signature: X _____ Date: _____ (Year Month Day)

Section 2 : The person you would like us to communicate with must complete and sign this section

Relationship to client: Pension Trustee

The Bloom Group Society | | Adult Guardianship Program
First Name | Initial | Family Name

Telephone numbers: Home 604-606-0335 Work _____ Other Fax: 604-606-0321

Complete mailing address: 317 E. Hastings Street (No., Street, Apt., P.O. Box, R.R.) | Vancouver (City) | BC (Province) | _____ (Country) | V6A 1P3 (Postal Code)

I understand that I can communicate with Service Canada on the program(s) checked off above to give and receive personal information on behalf of the person named in Section 1. I also understand that **I do not have the authority** to apply for a benefit or to change the payment address (the address where the cheque is mailed or the bank account where the payment is deposited) or request/change voluntary tax withhold on this person's behalf.

Signature: X _____ Date: _____ (Year Month Day)

Protection of your personal information

CPP and OAS cannot give your personal information to any person or organization without your written consent, except where authorized by CPP or OAS legislation. You (or your authorized legal representative) have the right to request a copy of the information in your file.

How to reach CPP and OAS: In Canada and the United States, call

- English: 1-800-277-9914
- French: 1-800-277-9915
- TTY users: 1-800-255-4786

To learn more about this form, Canada Pension Plan, Old Age Security Program and Service Canada on-line services, please visit our Internet site at: **servicecanada.gc.ca**

Service Canada delivers Human Resources and Skills Development Canada programs and services for the Government of Canada.

Authorize a Representative for Access by Phone and Mail

Representatives

Get access to your client's information **faster** online using "Represent a Client."
Go to **canada.ca/cra-login-services** and log in.

Individuals and Business owners

If you are a Canadian individual or business, **you can view, add, or modify an authorized representative online** using our online services at **canada.ca/cra-login-services**.

Use this form to authorize a representative to communicate on your behalf with the CRA **only** by phone, fax, and mail.
For more information, see **page 3**.

Part 1 – Identification

Complete all lines that apply.

I am giving my representative access to my accounts filled in below.

SIN, TTN, or ITN | First name | Last name

Trust account number (T) | Trust name

Non-resident account number (NR) | Non-resident account name

Business number | Business name

Choose **only one** of the following **business** options:

☐ **Option 1** – Give access to **all** my business number program accounts.

☐ **Option 2** – Give access to **specific** business number program accounts.

For a **list of supported program identifiers**, see page 3.

Program identifier (two letters)	**All reference numbers**		**A specific reference number** (four digits)
	☐	**or**	
	☐	**or**	

Part 2 – Representative information

Choose **one** of the following options and fill in the required information:

☐ **Option 1** – I am authorizing an **individual**:

Individual's first name | Last name | Telephone number | Extension

☑ **Option 2** – I am authorizing a **firm**:

Firm name: **THE BLOOM GROUP ADULT GUARDIANSHIP PROGRAM** | Telephone number: **604-606-0335** | Extension

Part 3 – Type of access

Check only **one** of the following options:

☐ **Option 1** – Allow **view only** access.

We can disclose information on your account to your representative. Your representative can also make payment arrangements for you.

☑ **Option 2** – Allow **update and view** access.

We can disclose information on your account to your representative. Your representative can also request to make some changes on your account. For a list of things your representative will **not** be able to update, see page 3.

Part 4 – Authorization expiry date

If you want this authorization to expire, enter an expiry date.

Expiry date (YYYYMMDD): |_|_|_|_|_|_|_|_|

Part 5 – Certification

You must have signing authority for the individual, trust, or business in order to sign this form. Forms that cannot be processed will be returned to the individual or business. We may contact you to confirm the information you have given.

Choose the appropriate option (for an **individual** or **trust**):

I am the: ☑ taxpayer

☐ administrator, executor, liquidator, power of attorney, trustee, or legal guardian or parent of a taxpayer under the age of 16

Choose the appropriate option (for a **business**):

I am the: ☐ owner

☐ corporate director, corporate officer, individual with delegated authority, officer of a non-profit organization, partner of a partnership, or trustee of a trust

This form will not be processed if your name does not match the one in our records. To avoid processing delays, verify **before** signing this form that we have complete and valid information on file for you.

First name _____ Last name _____ Telephone number _____

I certify that the information given on this form is correct and complete.

Signature: _____ Date (YYYYMMDD): |_|_|_|_|_|_|_|_|

Mailing address (if you are signing this form on behalf of an individual or trust) _____ City _____

Province, territory, or state _____ Country _____ Postal or ZIP code _____

Once completed, **send this form to your tax centre** within **six months** of the date it was signed or it will not be processed. For more information, see page 4.

Personal information (including the SIN) is collected for the purposes of the administration or enforcement of the Income Tax Act, the Excise Tax Act, the Tax Administration Act, and related programs and activities including administering tax, benefits, audit, compliance, and collection. The information collected may be used or disclosed for purposes of other federal acts that provide for the imposition and collection of a tax or duty. It may also be disclosed to other federal, provincial, territorial or foreign government institutions to the extent authorized by law. Failure to provide this information may result in interest payable, penalties or other actions. Under the Privacy Act, individuals have the right to access their personal information, request correction, or file a complaint to the Privacy Commissioner of Canada regarding the handling of the individual's personal information. Refer to Personal Information Bank CRA PPU 005, CRA PPU 015, CRA PPU 047, CRA PPU 063, CRA PPU 094, CRA PPU 140, CRA PPU 178 and CRA PPU 218 on Info Source at **canada.ca/cra-info-source**.

Date: _____

Canada Revenue Agency
Surrey Taxation Centre
9755 King George Hwy
Surrey, BC V3T 5E1
1-800-959-8281

Dear Sir or Madam:

RE: _____

SIN: _____

If I currently have a direct deposit to a bank account, please update and redirect payments to my Vancity bank account (enclosed).

Kindly mail all future correspondence to me at:

c/o The Bloom Group Community Services Society
Attention: Adult Guardianship Program (AGP)
317 E. Hasting Street
Vancouver, BC V6A 1P3

Sincerely,

_____
Client Signature

Public Works and Government Services Canada | Travaux publics et Services gouvernementaux Canada

PROTECTED "B" when completed

DIRECT DEPOSIT ENROLMENT FORM

Please print clearly and in block letters. Do not use this form to provide change of address information. Do not enclose anything other than your void cheque with this form.

PART A - Applicant's Identification Information

Surname

Given Name Initial(s)

Address 3 1 7 E H A S T I N G S S T R E E T

City/Town V A N C O U V E R Province B C

Postal Code V 6 A 1 P 3 Telephone No. 6 0 4 6 0 6 0 3 3 5

Date of Birth (YYYYMMDD) Social Insurance No.

PART B - Payment Information (Indicate the payment(s) to which you would like this change applied.)

Canada Revenue Agency

X Income tax refund, Goods and Services Tax/Harmonized Sales Tax (GST/HST) credit, Canada Child Benefit (CCB) and any related provincial and territorial payments, Working Income Tax Benefit (WITB) advance payments, any other deemed overpayment of tax, and any applicable benefit payments for previous years. I understand that providing new banking information replaces any banking information on file with CRA, and it will stay in effect until changed by me.

Service Canada

X Canada Pension Plan X Old Age Security

I understand that providing new banking information replaces any banking information on file with the Service Canada program(s) I am selecting, and it will stay in effect until changed by me.

PART C - Banking Information (Canadian financial institutions only)

IMPORTANT: Complete Part C or attach a blank cheque with "VOID" written on it.

Branch No. 1 6 4 8 0 Financial Institution No. 8 0 9

Account No. 1 0 0 0

Name(s) of Account Holder(s)

Financial Institution Stamp
(required if no void cheque attached)

PART D - Legal Representative

IMPORTANT: Only complete Part D if you are signing on the applicant's behalf.

A legal representative is an individual or organization authorized by virtue of a legal document, such as a Power of Attorney, to act on behalf of the client as though they were the client themselves. A legal representative includes, but is not limited to, Power of Attorney, Executor, Legal Guardian and Public Trustee.

Surname T H E B L O O M G R O U P C S S

Given Name A D U L T G U A R D I A N S H I P Initial(s)

Role P E N S I O N T R U S T E E

Address 3 1 7 E H A S T I N G S S T R E E T

City/Town V A N C O U V E R Province B C

Postal Code V 6 A 1 P 3 Telephone No. 6 0 4 6 0 6 0 3 3 5

PART E - Consent

Provision of the personal information, including your Social Insurance Number (SIN), is pursuant to *Department of Public Works and Government Services Act*, s. 5, s.11 and the *Financial Administration Act*, ss. 35(2). The Receiver General will use and disclose information to the federal institutions identified in Part B and to your financial institution in order to issue direct deposit payments, but will not disclose your SIN to your financial institution. Your personal information will be protected, used and disclosed in accordance with the *Privacy Act*, and as described in Personal Information Bank PWGSC PSU 712, Receiver General Payments. Under the Act, you have the right to access and correct your personal information, if erroneous or incomplete.

I, the undersigned, have read the Privacy Notice and consent to the collection, use and disclosure of my personal information as described therein.

2 0 2 X

Date (YYYYMMDD) Signature of Applicant or Legal Representative

Mail the completed form to the following address:

RECEIVER GENERAL FOR CANADA
PO BOX 5000
MATANE QC G4W 4R6

Need help with this form? Call 1-800-593-1666 (toll-free) Monday, Tuesday, Wednesday and Saturday from 7 a.m. to 7 p.m. or Thursday and Friday from 7 a.m. to 10 p.m., Eastern Standard Time (TDD/TTY: 1-844-524-5286), visit www.directdeposit.gc.ca or consult with your financial institution.

Until your direct deposit information has been updated, you will continue to be paid by cheque or direct deposit to the bank account currently on file.

To update your banking information in the future, please complete a new direct deposit enrolment form.

Please do not use this form to provide change of address information. To change your address information, please contact the department or agency that issues your payments.

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.

I give my permission to The Bloom Group Community Services Society – AGP representatives to access and act on my behalf for my account held with you.

In addition, I am requesting that all invoices and correspondence be redirected to The Bloom Group Adult Guardianship Program for payment.

The mailing address is:

_____(Client's Name)
c/o The Bloom Group Community Services Society
Adult Guardianship Program
317 E. Hastings Street
Vancouver, BC V6A 1P3

Should you have any questions, please contact my adult guardianship worker _____ at The Bloom Group Community Services Society Adult Guardianship Program at phone #

Sincerely,

_____

X signature