



**THE BLOOM GROUP**

Community. Services. Together.

## **Referral Requirements for Adult Guardianship Program Pension Management Contract Service**

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](mailto:tfan@thebloomgroup.org) / 778-945-3323 [acheng@thebloomgroup.org](mailto:acheng@thebloomgroup.org)

### **CHECKLIST:**

- Client Profile and Application**
- Fee Schedule**
- 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.
- Authorized to Communicate Information OAS**
- Authorized to Communicate Information CPP**
- Private Pension Release** - If applicable, for any income other than OAS/PP
  - Please attach recent pension statement or provide information
- Authorize a Representative for Offline Access**
- CRA Redirect Deposit Request**
- Direct Deposit Enrollment Form**

\*\* 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.



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## Client Profile and Application

Client name: \_\_\_\_\_ Date of referral: \_\_\_\_\_

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

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: \$ \_\_\_\_\_ Is the rent currently paying via EFT? Y / N

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: \_\_\_\_\_

Client Profile and Application v. Aug. 2025



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**REASON FOR REFERRAL:** \_\_\_\_\_

**MEDICAL 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.

Has the client received their pensions electronically to their bank account? Y / N

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.

Has the client received Tax Refund and GST Credit electronically to their bank account? Y / N

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



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## 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: \_\_\_\_\_

Is the POA authority registered with Service Canada and/or Canada Revenue Agency? Y / N

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

Is there a Representation Agreement? Y / N

If yes, please provide name and contact: \_\_\_\_\_

Is the Representation Agreement registered with Service Canada and/or Canada Revenue Agency? Y / N

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

Client Profile and Application v. Aug. 2025



## PENSION MANAGEMENT CONTRACT

I, \_\_\_\_\_ (name) , of \_\_\_\_\_ (address), 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 \$250 or 5% (whichever is greater) 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 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 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.



## Authorization to Communicate Information OLD AGE SECURITY

It is very important that you:

- use a pen and print as clearly as possible.

### SECTION A - ACCOUNT FROM WHICH THE INFORMATION IS TO BE COMMUNICATED

1. Social Insurance Number or Account Number (where applicable)	
2. <input type="radio"/> Mr. <input type="radio"/> Mrs.    Usual First Name and Initial	Last Name
<input type="radio"/> Ms. <input type="radio"/> Miss	

### SECTION B - PERSON WHO GIVES AUTHORIZATION TO COMMUNICATE THE INFORMATION

<b>Part 1:</b> Under the authority of the <i>Old Age Security Act</i> and Regulations, I hereby authorize the Minister of Human Resources and Social Development Canada to communicate, <b>on an annual basis and with the restrictions stated below</b> , the information checked in Part 2 of this section, to the person or body named in Section C.  This authorization remains in effect, unless I cancel it in writing. I have read the restrictions given on this form, and I understand the nature and effect of this authorization.  I am ( <i>check one</i> ): <input checked="" type="radio"/> the beneficiary <input type="radio"/> a legal representative			
<b>Signature of beneficiary or legal representative</b>	Year	Month	Day
<b>X</b>			

**This section to be completed by the legal Representative who signed above**

<input type="radio"/> Mr. <input type="radio"/> Mrs.    Usual First Name and Initial	Last Name	
<input type="radio"/> Ms. <input type="radio"/> Miss		
Home Address (No., Street, Apt., R.R.)	City	Area code and telephone number
Province or Territory	Country other than Canada	Postal Code

<b>Part 2: Information to be communicated</b>	
<input checked="" type="radio"/> <b>Any</b> information requested by the person or body named in Section C. <b>OR</b> <input type="radio"/> The following information (Please indicate below information to be disclosed)	
<b>TYPE OF BENEFIT</b>	
<input type="checkbox"/> Old Age Security	<input type="checkbox"/> Guaranteed Income Supplement
<input type="checkbox"/> Allowance	<input type="checkbox"/> Allowance for the Survivor
<input type="checkbox"/> <b>Monthly amount of benefit payable</b> - This is the current monthly amount of benefit that is payable.	
<input type="checkbox"/> <b>Month and year benefit commenced</b> - This is the first month for which there was eligibility to the benefit.	
<input type="checkbox"/> <b>Month and year benefit ceased</b> - This is the last month for which there was eligibility to the benefit.	

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

**SECTION C - PERSON OR BODY WHO WILL RECEIVE THE INFORMATION**

<b>1. Name of Person or Body</b> The Bloom Group CSS - Adult Guardianship Prgm		<b>2. Area code and telephone number</b> 604-606-0335	
<b>3. Address (No., Street, Apt., R.R.)</b> 391 Powell Street		<b>City</b> Vancouver	
<b>Province or Territory</b> BC	<b>Country other than Canada</b>	<b>Postal Code</b> V6A 1G5	
The information obtained pursuant to this request shall not be made available to any other person or body, unless specific authorization is given by the beneficiary or legal representative.			
<b>Signature of person or body</b> <b>X</b>		<b>Year</b>	<b>Month</b> <b>Day</b>

**RESTRICTIONS**

The regulations provide that the information cannot be communicated if:

1. the authorization is signed more than one year before the day on which it is received;
2. more than one request for information concerning the same beneficiary is made in the same year and is to be communicated to the same person or body;
3. this authorization is cancelled in writing.



# Authorization to Communicate Information Canada Pension Plan

**It is very important that you:**

use a **pen** and **print** as clearly as possible.

## SECTION A - PERSON OR AUTHORITY WHO WILL RECEIVE THE INFORMATION

1. Name of Person or Authority The Bloom Group CSS-Adult Guardianship Prgm		2. Area code and telephone number 604-606-0335	
3. Home Address (No., Street, Apt., R.R.) 391 Powell Street		City Vancouver	
Province or Territory BC	Country other than Canada		Postal Code V6A 1G5

## SECTION B - ACCOUNT FROM WHICH THE INFORMATION IS TO BE COMMUNICATED

4. Contributor's Social Insurance Number	
5. <input type="radio"/> Mr. <input type="radio"/> Mrs. <input type="radio"/> Ms. <input type="radio"/> Miss	Usual First Name and Initial Last Name
6. The information to be communicated relates to  <input checked="" type="radio"/> the contributor named above <input type="radio"/> the contributor's spouse or common-law partner <input type="radio"/> the contributor's child(ren)	
7. Unless I cancel this authorization in writing, I hereby authorize the Canada Pension Plan to communicate, within the restrictions stated on page 2, <b>on an annual basis</b> , the information checked below. <i>(please check only one option)</i> <input checked="" type="radio"/> Option 1 - Any information requested by the person or authority named in Section A. (including benefit information, medical information, etc.) <b>OR</b> <input type="radio"/> Option 2 - The following information only - check the appropriate boxes <input type="checkbox"/> a) <b>Type of benefit</b> - This identifies the benefit (i.e. Disability, Retirement, Survivor's). <input type="checkbox"/> b) <b>Monthly amount of benefit payable</b> - This is the current monthly amount of benefit that is payable. <input type="checkbox"/> c) <b>Month and year benefit commenced</b> - This is the first month for which there was eligibility to the benefit. <input type="checkbox"/> d) <b>Month and year benefit ceased</b> - This is the last month for which there was eligibility to the benefit. <input type="checkbox"/> e) <b>Amount of contributory salary and wages and self-employed earnings for each calendar year as shown in the records of earnings.</b>	
<p>One total amount of earnings is provided for each calendar year since the commencement of the Plan in January 1966, or since the calendar year in which the contributor reached the age of 18, if that occurred later. The amount for any year is the total contributory earnings which the contributor received from all employers and from self-employed earnings for that year. However, the total amount for any year does not include earnings from any one source that are in excess of the Year's Maximum Pensionable Earnings.</p>	

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

**SECTION C - AUTHORIZATION TO COMMUNICATE THE INFORMATION**

In accordance with the *Canada Pension Plan* and the regulations made thereunder, I hereby authorize the Canada Pension Plan to communicate the information checked in number 7, to the person or authority named in Section A. I have read the explanations and restrictions given on this form and I understand the nature and effect of this authorization.

I am:  
 (check one)       the contributor       a beneficiary       a representative

<input type="radio"/> Mr.	<input type="radio"/> Mrs.	Usual First Name and Initial	Last Name
<input type="radio"/> Ms.	<input type="radio"/> Miss		
Home Address (No., Street, Apt., R.R.)		City	
Province or Territory		Country other than Canada	Postal Code
<b>Signature</b>			Year Month Day
<b>X</b>			

**SECTION D - DECLARATION** *(To be completed by the person or authority authorized to receive this information)*

The information obtained pursuant to this request shall not be made available to any other person or body unless specific authorization is given by the contributor or beneficiary.

<b>SIGNATURE OF PERSON OR AUTHORITY</b>	Year Month Day	Area code and telephone number
<b>X</b>		604-606-0335

**RESTRICTIONS**

The regulations provide that the information cannot be communicated:

1. if the authorization is signed more than one year before the day on which it is received;
2. if more than one request for information concerning the same contributor or beneficiary is made in the same year and is to be communicated to the same person or authority;
3. if I cancel this authorization in writing.

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 also request 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  
391 Powell Street  
Vancouver, BC V6A 1G5

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

Sincerely,

\_\_\_\_\_  
signature



**Step 3 – Level of access**

Choose **one** of the following levels:

**Level 1** – Allow access **to information only**

The CRA can disclose information about your account to your representative.

**Level 2** – Allow access **to information and to make certain account changes**

The CRA can disclose information about your account to your representative, and they can request to make certain changes on your account.

**Step 4 – Authorization expiry date**

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

Expiry date (YYYYMMDD):  (optional)

**Note:** If there is no expiry date, the authorization will remain until you or someone with signing authority changes or cancels it.

**Step 5 – Certification**

**You must have signing authority** for the accounts identified in **Step 1**. The CRA may contact you for more information.

Choose the appropriate option:

- I am the:**
- taxpayer
  - parent or legal guardian of a taxpayer under the age of 16
  - legal representative (such as the executor, power of attorney, or trustee)
  - owner (such as the sole proprietor, or a partner of a partnership)
  - officer of a non-profit organization
  - corporate director or corporate officer
  - individual with delegated authority for the business account

**The CRA will not process this form** if your name does not match the one in the CRA's records. To avoid processing delays, verify that the CRA has complete and valid information on file for you **before** signing this form.

First name \_\_\_\_\_ Last name \_\_\_\_\_ Telephone number \_\_\_\_\_

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

Signature: \_\_\_\_\_ Date (YYYYMMDD):

Once filled out, **send this form to your tax centre** within **six months** of the date you signed it or the CRA will not process it. For more information, see page 4.

Personal information (including the SIN) is collected and used to administer or enforce the Income Tax Act and related programs and activities including administering tax, benefits, audit, compliance, and collection. The information collected may be disclosed to other federal, provincial, territorial, aboriginal or foreign government institutions to the extent authorized by law. Failure to provide this information may result in paying interest or penalties, or in other actions. Under the Privacy Act, individuals have a right of protection, access to and correction of their personal information, and to file a complaint with the Privacy Commissioner of Canada regarding the handling of their 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 165, CRA PPU 178, CRA PPU 218, CRA PPU 223, CRA PPU 224, CRA PPU 231, CRA PPU 232, CRA PPU 233, CRA PPU 234 and CRA PPU 235 on Info Source at [canada.ca/cra-info-source](http://canada.ca/cra-info-source).



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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: \_\_\_\_\_

Please set up or update a Direct Deposit for tax refund and GST Credit 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)  
391 Powell Street  
Vancouver, BC V6A 1G5

Sincerely,

\_\_\_\_\_  
Client Signature

CRA Redirect Deposit Request v. Aug. 2025



# 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

City/Town  Province

Postal Code  Telephone No.

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

Income tax refund, Goods and Services Tax/Harmonized Sales Tax (GST/HST) credit, Canada Child Benefit (CCB) and any related provincial and territorial payments, Canada Workers Benefit (CWB) 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

Canada Pension Plan  Old Age Security  Canada Pension Plan Disability

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.  Financial Institution No.

Account No.

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

Given Name  Initial(s)

Role

Address

City/Town  Province

Postal Code  Telephone No.

**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](#). 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.

Should you refuse to provide your consent, we will be unable to process your direct deposit enrolment form; alternatively, you may contact the government department or agency responsible for issuing your payment(s) to explore other enrolment options.

If you require clarification about this privacy notice, you may contact the Public Services and Procurement Canada's Access to Information and Privacy Directorate by email at [TPSGC.ViePrivee-Privacy.PWGSC@tpsgc-pwgsc.gc.ca](mailto:TPSGC.ViePrivee-Privacy.PWGSC@tpsgc-pwgsc.gc.ca). If you are not satisfied with the response to your privacy concern or if you want to file a complaint about the handling of your personal information, you may wish to contact [the Office of the Privacy Commissioner of Canada](#).

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

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.canada.ca/direct-deposit](http://www.canada.ca/direct-deposit) 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.

### Part A - Applicant's Identification Information

Fill in the surname (last name), given name (first name) and any middle name initials, as well as the full address, telephone number, date of birth and Social Insurance Number (SIN) of the applicant in the fields provided. All fields are mandatory.

### Part B - Payment Information

Indicate the payment(s) the applicant currently receives by cheque and wishes to receive by direct deposit. If the applicant is already receiving payments by direct deposit and wants to change the banking details on file, indicate the payment(s) for which the change should be applied. The payment(s) indicated here will be deposited into the bank account indicated in Part C.

### Part C - Banking Information

This form can only be used for direct deposit payments destined for domestic (Canadian) bank accounts that use standard routing information, i.e., a Branch Number, Institution Number and Account Number. For direct deposit payments into foreign bank accounts, please consult the *Foreign Direct Deposit Enrolment Form* found at [www.canada.ca/direct-deposit](http://www.canada.ca/direct-deposit).

Instead of filling in Part C, a blank cheque with the word "VOID" written across the front can be attached to this form - see example below. This cheque must be associated with the Canadian bank account into which the payments indicated in Part B are to be deposited. Do not enclose anything other than a void cheque with this form.

If completing Part C of this form, account routing information can be obtained from the financial institution into which direct deposit payments are to be made. These details can also be found on a cheque associated with that bank account. Your financial institution must stamp this section to verify that the correct banking details have been entered if no void cheque is attached.

Name / Nom P.O. Box / C.P. 000 City / Ville, Canada H0H 0H0	<b>Example / Exemple</b>	Cheque No. N° de chèque	0000000
Pay to the order of Payez à l'ordre de	"Void" «Nul»	\$	_____ Dollars
_____		Signature	
⑈ 9999 ⑈	⑈ 999999 ⑈ 9999 ⑈	9999 ⑈ 9999 ⑈ 9999 ⑈	
1	2	3	4

1. Cheque number - not required.
2. Branch number - 5 digits.

3. Institution number - 3 digits.
4. Account number - as shown on your cheque.

### Part D - Legal Representative

If the applicant is signing Part E of this form on their own behalf, Part D does not need to be completed. If you are signing the form on the applicant's behalf, as the applicant's legal representative, indicate your name, role, address and telephone number. Examples of 'Role' can include Power of Attorney, Executor, Legal Guardian, Public Trustee, etc.

### Part E - Consent

Date and sign the form in order for it to be processed. By signing, you confirm that you have read and agreed with the consent statement on the form.



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## Adult Guardianship Program Fee Schedule

Fees effective : March 1 2024

### Pension Management Contract – Capable and Voluntary

Opening Fee: <b>\$25</b> one-time fee
Program Fee: <b>\$60</b> monthly fee
Investment Fee (pooled-accounts only): <b>0.25%</b> quarterly investment fee on assets managed (based on the average quarterly balance)
Closing Fee: \$250.00 or 5% on the closing balance of the client account whichever is greater.

### Pension Trustee – Certified Incapable of Managing Finances

Opening Fee: <b>\$25</b> one-time fee
Program Fee: <b>\$60</b> monthly fee
Investment Fee (pooled-accounts only): <b>0.25%</b> quarterly investment fee on assets managed (based on the average quarterly balance)
Closing Fee: \$250.00 or 5% on the closing balance of the client account whichever is greater.

### Discretionary Trust – Persons with Disabilities Designation or Income Assistance

Opening Fee: <b>2%</b> fee on funds deposited.
Program Fee: <b>1%</b> annually, charged monthly (based on the closing balance) <b>2%</b> fee on additional deposits.
Closing Fee: \$250.00 or 5% on the closing balance of the client account whichever is greater.