Capital Region Housing Corporation

10232 – 112 STREET NW
EDMONTON, ALBERTA, T5K 1M4

Phone (780) 420-6161
Fax (780) 426-6854

TO: **INCOME SECURITY** Fax: 495-2263
P.O. Box 2710, Main Station
Edmonton, Alberta T5J 2G4

To have this form completed or to book an appointment, please call 1–800–277–9914 (English) or 1–800–277–9915 (French)

RE:

____
NAME

____
SOCIAL INSURANCE NUMBER

____
ADDRESS

____
LEASE IDENTIFICATION NUMBER

____
TELEPHONE NUMBER

Dear Sir/Madam:
Management Bodies are required under the ***Alberta Housing Act*** to verify income for clients (including applicants, tenants and subsidy recipient) for the purpose of establishing eligibility and determining the basic rent. Information is protected by the privacy provisions of the ***Freedom of Information and Protection of Privacy Act***. Questions regarding the collection of personal information may be directed to an Applications, Community Housing, Affordable Housing or Subsidy Clerk III at the address and telephone number listed above.
The client has indicated that he/she is presently receiving a pension. Your assistance is requested in completing the information section of this form and returning it to our office.
The client has authorized the release of this information as indicated below.

CAPITAL REGION HOUSING CORPORATION

I, ____________________________________, the undersigned hereby authorize your agency to release any information requested by the Capital Region Housing Corporation. I give permission for you to send this completed form directly to Capital Region Housing Corporation.

____
SIGNATURE

____
DATE

Canada Pension Plan

Retirement Benefits $______________________________
Disability Benefits $______________________________
Disability Child Benefits $______________________________
Survivors Benefits $______________________________
Orphans Benefits $______________________________
Effective ____
____
Benefits Effective ____
____

Old Age Security

Basic Old Age Security $______________________
Guaranteed Income Supplement $______________________
Spouses Allowance $______________________
Widowed Spouses/Allowance $______________________
Effective ____
____
Benefits Effective ____
____

____
SIGNATURE OF AUTHORIZED REPRESENTATIVE

____
POSITION HELD

____
NAME (PLEASE PRINT)

____
NAME OF COMPANY

____
DATE COMPLETED

____
TELEPHONE NUMBER

____
FAX NUMBER

PLEASE HAVE THIS FORM SIGNED BY AN OFFICIAL OF THIS AGENCY OR COMPANY