MENTAL HEALTH & ADDICTIONS PROGRAM

FINANCIAL SELF DECLARATION

FINANCIAL PACKAGE PROVIDED BY: _____

NAME

_____

PHONE

Eastern Health

REQUIRED DOCUMENTS FOR SELF DECLARATION

All information provided will remain confidential and in accordance with your signed consent forms. The following information is **required** to process your application:
Please note: Items 1 -3 apply to new applicants only:

1. **Verification of Birth** of Applicant and spouse/common law spouse (if applicable)

2. **MCP Number** for applicant and spouse

3. **Social Insurance Number** of applicant and spouse

4. **Income of Client and Spouse**. Please provide:

    A. Copy of your **Notice of Assessment** from Canada Revenue Agency for the most recent taxation year. If necessary, contact CRA at 1-800-959-8281 and request a copy of your latest "Option C" printout
    B. Verification of **Veteran's Allowance (DVA)** if applicable, in form of cheque stub or direct deposit

    **Please note: Income must be less than $150,000 annually to be considered eligible for services*

5. A completed Eastern Health's **Consent to Obtain/Share Client Information from/with The Department of Children, Seniors and Social Development form.**

NOTE: Clients 65 years of age and older are not required to submit verification of expenses. Please disregard Expenses section, as well as access forms on pages 6 & 7.

Eastern Health

MENTAL HEALTH & ADDICTIONS PROGRAM

FINANCIAL ASSESSMENT / SELF DECLARATION

APPLICANT	SPOUSE
Name: _____ ☐ Male ☐ Female Date of Birth: _____ Social Insurance #: _____ MCP #: _____ Mailing Address: _____ _____ Community of Residence if different from mailing address: _____ _____ Telephone #: _____	Name: _____ ☐ Male ☐ Female Date of Birth: _____ Social Insurance #: _____ MCP #: _____ Mailing Address: _____ _____ Community of Residence if different from mailing address: _____ _____ Telephone #: _____

FAMILY STATUS	RESIDENTIAL OPTION
☐ Single ☐ Married / Common Law ☐ Separated ☐ Divorced ☐ Widowed	☐ Own House / Apartment ☐ Board & Lodging with Relative ☐ Board & Lodging with Non Relative
Do you have medical insurance? ☐ Yes ☐ No *If yes, indicate Company and Percentage of Coverage:* _____ Do you have any dependents under the age of 18? ☐ Yes ☐ No *If yes, how many?* _____	

Eastern Health

FINANCIAL INFORMATION	
INCOME: *Please include a copy of the* ***Income Tax Notice of Assessment*** *from Canada Revenue Agency for the most recent taxation year. For* ***DVA****, please provide copy of cheque or direct deposit*	
Applicant's Income (per month)	**Spouse's Income (per month)**
OAS:	OAS:
CPP:	CPP:
Veteran's Allowance (DVA):	Veteran's Allowance (DVA):
Employment Earnings:	Employment Earnings:
E.I. Benefits:	E.I. Benefits:
Worker's Compensation:	Worker's Compensation:
Income from Rental Property:	Income from Rental Property:
Pensions:	Pensions:
Other:	Other:

EXPENSES

(Clients 65 years of age and older, disregard this section as well as access forms on pages 6 & 7)

Expenses: Please provide written verification of the following expenses.

Accommodations: ☐ Mortgage ☐ Rent

Utilities: ☐ Newfoundland Power ☐ Oil ☐ Wood ☐ Propane

Please provide statement of usage for past 12 months for all utilities used.

Eastern Health

I declare that the enclosed information is true to the best of my knowledge. I have not concealed or omitted any information concerning my financial condition or the financial condition of my spouse, if applicable. Changes in these circumstances or conditions will be reported to the Financial Assessment Officer / Social Worker before or as they occur to avoid overpayment. I understand I will be required to apply for any allowance for which I may become eligible.

Signature of Applicant: _____ Date: _____

Signature of Spouse: _____ Date: _____

Signature of Guardian (if applicable): _____ Date: _____

Contact person if other than Applicant or Spouse.

Please note that the signature below will provide Eastern Health consent to discuss the application and all future financial matters concerning the applicant with the contact person(s).

Name: _____ Phone: _____

Forward the completed application and all supporting documentation to the address below. **Your request cannot be considered until all financial information is received**. If you require additional assistance, please contact address below.

Housing Division
Mental Health & Addictions Program
Email: MHAHousingSUbsidy@easternhealth.ca
Telephone: (709) 777-3919

Eastern Health

ACCESS TO OIL ACCOUNT

This consent form authorizes Eastern Health to request financial information on my behalf.

I,_____of_____

Your Name Community

Hereby authorize and request_____

Name of Oil/Propane Company, Address, Phone and/or Fax number

to provide Eastern Health with a statement showing my oil/propane usage for the past twelve months.

Dated at _____ this _____ day of _____, 20____

_____

Signature of Applicant

_____

Witness

Please forward completed form to the Company you receive your oil from.

OIL/PROPANE COMPANY: Please forward twelve month oil usage statement to:

Housing Division
Mental Health & Addictions Program
Email: MHAHousingSUbsidy@easternhealth.ca
Telephone: (709) 777-3919

ACCESS TO NEWFOUNDLAND POWER STATEMENT

This consent form authorizes Eastern Health to request financial information on my behalf.

I,_____of_____
Your Name Community

Hereby authorize Eastern Health to access my Newfoundland Power account to obtain a 12 month summary.

_____ _____
Account Number Meter Number

Dated at _____ this _____ day of _____, 20____

_____
Signature of Applicant

_____
Witness

Newfoundland Power: Please forward the completed form to:

Housing Division
Mental Health & Addictions Program
Email: MHAHousingSUbsidy@easternhealth.ca
Telephone: (709) 777-3919

Eastern Health

CONSENT TO OBTAIN/SHARE CLIENT INFORMATION from/with THE DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT

File Number: _____ Program: _____

Client/Applicant		Spouse/Co-Applicant (if applicable)	
Date of Birth	Social Insurance Number	Date of Birth	Social Insurance Number
MCP Number		MCP Number	

Eastern Health may need to obtain client personal information from, or share client personal information with, the Department of Children, Seniors and Social Development to determine client eligibility for financial support and related services, and to process payments for services for which a client is eligible.

By personal information we mean:

- Client name, age, marital, family and aboriginal status, and education
- Client financial status
- Client identifying numbers such as SIN, MCP or other file numbers assigned to the client
- Information related to the supports and services required.

The information obtained under this consent will be used solely for the purposes listed above and will not be shared with any other person or organization without consent, except as required or permitted by law. **Note: Service may be delayed if this consent is not signed.**

CONSENT

In signing this form I agree that Eastern Health has my consent to obtain personal information about me and my spouse/co-applicant from and/or share personal information about me and my spouse/co-applicant with the Department of Children, Seniors and Social Development for the purposes of determining eligibility for financial benefits and other services or to process payments for services for which I am eligible.

This authorization is valid for as long as I am receiving financial services from Eastern Health.
I understand that I may withdraw this consent at any time by notifying Eastern Health in writing.

_____ _____

Signature of Client/Applicant *Signature of Spouse/Co-Applicant (if applicable)*

_____ _____

Date *Name of Spouse/Co-Applicant (please print)*

Substitute Decision Maker (if applicable):

I confirm that I have the authority to act for the client in decisions pertaining to the client's care and services.

_____

Name of Authorized Person (please print)

_____ _____

Signature of Authorized Person *Date*