

Market Rent Application Checklist

Please return all completed forms to St. John's Centre.

Non Financial Information:

- Completed Application**
- Support Services Questionnaire**
- Medical Release Authorization**
- Medical Form (Completed solely by Physician/Nurse Practitioner)**
- Market Rent Acknowledgement**
- Copy of Canadian Birth Certificate, proof of Canadian Citizenship or proof of Landed Immigrant or Refugee Status**

Applications can only be processed when fully completed.

6. Previous Tenancy in any form of Subsidized Rental Accommodation in Ontario:

Has the applicant or co-applicant lived in a housing project under any housing program administered by the Ministry of Municipal Affairs or a Central Service Manager ? Y N
Housing Provider's Name _____ Address & Phone _____

Occupancy Dates
(Month/Year)
From: _____ To: _____

Housing Provider's Name _____ Address & Phone _____

Current Landlord's Name (not social housing) _____ Address & Phone _____

Previous Landlord's Name (not social housing) _____ Address & Phone _____

St. John's Centre is a SMOKE-FREE building. Are you currently a smoker? _____
Only 1 pet is allowed per household. If you have a pet, please specify the kind. _____

7. Comments: (Optional)

8. Declaration, Release and Consent to Information: Signature and Date Required

I/We declare that all information contained in this application is correct and complete. I/We understand that this application does not constitute an agreement to provide me/us with rental accommodation. Information attached to or contained within this form is collected for St. John's Centre by St. John's Centre and will remain the confidential property of same.

Personal information contained in this form or in attachments is collected for St. John's Centre by St. John's Centre pursuant to the Housing Services Act 2011 O. Reg 367/11 S. 23 and will be used to determine suitability and eligibility for special needs housing and rent geared-to-income subsidy.

Personal information may be disclosed to the Ministry of Municipal Affairs and Housing and other municipal/provincial and federal departments and agencies who assist in the provision of affordable housing. Information provided by the household may be shared for the purposes of making decisions or verifying eligibility for assistance under the Housing Services Act 2011, the Ontario Disability Support Program Act, 1997, and the Ontario Works Act, 1997.

The applicant and/or co-applicant consents to the verification, disclosure and transfer of information given on this form and attachments by or to any of the above mentioned entities and will provide any required supporting material.

Questions regarding this collection should be directed to: St. John's Centre, 440 Water St., Peterborough, Ontario, K9H 7K6.

Applicant Signature: _____ Date: _____

Co-Applicant Signature: _____ Date: _____

Please return completed application and all required documentation to St. John's Centre. Applications can only be processed when fully complete.

St. John's Centre

MEDICAL FORM

**This form must be fully completed by your Physician/Nurse Practitioner and returned to:
St. John's Centre Telephone: (705) 749-0757 · Fax: (705) 749-5767**

St. John's Centre is a non-smoking apartment building for seniors, 65 years and older, capable of independent living. The Centre is accessible and offers dining facilities and a range of in house services provided through it's Supportive Housing Program. Completion of this medical form is required to determine eligibility for tenancy.

(PLEASE PRINT)

APPLICANT'S NAME: _____ D.O.B: _____

HEALTH CONDITIONS: (PLEASE PRINT) _____

Infectious Diseases: Yes No If yes, specify: _____

Evidence of Substance Abuse: Yes No If yes, specify: _____

ST. JOHN'S CENTRE IS A SMOKE-FREE BUILDING Smoker? Yes No

If the applicant/tenant has previously smoked, when did he/she quit? _____

COGNITIVE FUNCTION

Normal: Impaired: If impaired, specify: _____

MOBILITY

Restrictions: _____

Assistive Devices Used: _____

Please identify any difficulties with activities of daily living: _____

Date of last visit to Physician/Nurse Practitioner: _____

Physician's/Nurse Practitioner's Name: _____ Phone: _____

Signature

Date Completed

St. John's Centre

Medical Release Authorization

I authorize my attending Physician/Nurse Practitioner and/or my caregiver to release any medical information to St. John's Centre.

I understand that:

1. This information is required to complete the application process for a unit at St. John's Centre.
2. This information will be kept in strict confidence.
3. This information will be retained on my file at St. John's Centre.

Name of Physician/Nurse Practitioner: _____

Telephone Number: _____

Address: _____

The applicant is responsible for any fees incurred for the completion of any medical forms.

Applicant Name (Please Print)

Applicant Signature

Dated on this _____ day of _____, _____.

St. John's Centre

SUPPORT SERVICES QUESTIONNAIRE - Return to St. John's Centre

St. John's Centre is not a nursing home. It is a retirement home consisting of self contained apartments. Tenants must be able to live independently with or without the help of support services. The Centre is neither equipped nor appropriate for individuals dependant on continuous care or supervision. In considering your application, it is important that we fully understand your needs. The following information is necessary to assess your needs and complete the application process. To be eligible for a special needs unit at St. John's Centre you must require on a regular basis one or more of the support services:

PLEASE CHECK AND COMPLETE EACH OF THE FOLLOWING QUESTIONS.

I/We currently receive the following services:

	Yes	No
Personal Care:		
Homemaking		
Meal Service		

of visits
per week

Applicants are required to purchase (1) meal per day

Who provides this service for you?

Name of Agency: _____ Phone #: _____

Name of Family: _____ Phone #: _____

Name of Friend: _____ Phone #: _____

Is the support you are presently receiving enough to accommodate your needs?

Yes	No

If not, please state what services you would require from St. John's Centre.

Please circle all that apply.

I use a:

Walker Wheelchair Bath Seat Raised Toilet Seat Not Applicable

Additional Information:

I/We _____ authorize the public agency or the individual providing my care to release any medical or service information to St. John's Centre.

Applicants Signature

Date:

Power of Attorney Signature (if applicable)

Date:

St. John's Centre

Market Rent Acknowledgement

I have waived my option of income assessment and I agree to pay the full market value for the unit stipulated in the Leasing Agreement with St. John's Retirement Homes Inc. I understand that I will not be able to apply for Rent-Geared-To-Income (RGI) subsidy for a minimum of two years from the commencement of my Lease Agreement.

I _____ have requested to be designated as a Market
Please Print
Rent tenant at St. John's Centre.

Signature _____ Date: _____