Niagara Regional Housing

APPENDIX I

CAREGIVER INFORMATION

Return this form to: *HOUSING PROVIDER*
Fax 905-
In Person *insert office hours*

The personal information disclosed on this form will be used for the purpose of evaluating your eligibility for an additional bedroom to accommodate a caregiver under Niagara Regional Housing's local **Occupancy Standards** under the *Housing Services Act, 2011*.

On an annual basis thereafter, the housing provider may ask for new information to verify that you still qualify for the extra bedroom to accommodate a caregiver.

Overnight care is provided to the person listed below, who is unable to live independently without care, to continue to live independently in their current residence.

Please note: A letter from your doctor must be provided outlining your requirement for a caregiver.

CAREGIVERS ARE REQUIRED TO COMPLETE SECTION 1 OR SECTION 2 BELOW

1. CARE AGENCY INFORMATION	
Name of Client Receiving Care	Client's Address
Name of Care Agency	Care Agency Representative Name
Care Agency Representative Title	Care Agency Representative Phone
2. CAREGIVER INFORMATION *The caregiver cannot be a member of the household (i.e. spouse, dependent children, etc).*	
Name of Client Receiving Care	Client's Address
Name Of Caregiver	
Are you currently required by Citizenship & Immigration Canada to live with a person requiring care? (circle one) YES NO	

3. CARE AGENCY / CAREGIVER DETAILS

I provide overnight care to the above named person for _____ nights per week, for the purpose of: (*please explain*)

Please check and complete one of the following:

☐ The client's address above is my permanent address and I live in this household solely for the purpose of providing care to the person named above.

☐ The client's address is not my permanent address. My permanent address is:

_____

4. CARE AGENCY / CAREGIVER DECLARATION

I declare that the information I have provided is true and correct to the best of my knowledge.

_____ _____

Care Agency/Caregiver Signature Date

CONSENT & RELEASE FROM TENANT/MEMBER

I understand that *PROVIDER NAME* requires the requested personal health information to determine my continued eligibility for an additional bedroom to accommodate a caregiver.

I authorize my physician and care agency or caregiver to release the information requested on this form to *PROVIDER NAME*, and I consent to *PROVIDER NAME* using, verifying and retaining this information in my housing file.

_____ _____

Tenant/Member Name (printed) Tenant/Member Signature

_____

Date

Office Use Only

☐ Approved ☐ Denied Date: _____ By: _____

*Personal information contained on this form is collected under the authority of the Housing Services Act, 2011 and subject to the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA), 1991 and the Personal Health Information Protection Act (PHIPA), 2004. The information will be used only for the purposes of determining continued eligibility for an additional bedroom. In requesting an additional bedroom, the tenant/member consents to the collection, use and disclosure, including verification, of the information provided to *HOUSING PROVIDER* in their request or supporting documents.*