



# 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**