Canadian Mental Health Association
Kelowna

UTILITY RELIEF PROGRAM

PLEASE FAX COMPLETED FORM TO 250-763-4827
OR SUBMIT TO 504 SUTHERLAND AVE
KELOWNA BC V1Y 5X1

OFFICE USE ONLY
RECEIVED:

CLIENT INFORMATION			
LAST NAME		FIRST NAME	
ADDRESS			
PHONE NUMBER			
DATE OF BIRTH (M/D/Y)		TENANCY START DATE	
SOURCE OF INCOME (CHECK ALL THAT APPLY)	❒ EMPLOYMENT ❒ INCOME ASSISTANCE (IA) ❒ OLD AGE SECURITY (OAS) ❒ EMPLOYMENT INSURANCE ASSISTANCE (EI) ❒ PERSONS WITH DISABILITIES (PWD) ❒ PERSONS WITH PERSISTENT MULTIPLE BARRIERS (PPMB) ❒ GUARANTEED INCOME SUPPLEMENT (GIS) ❒ OTHER: _____		
HOUSEHOLD COMPOSITION	❒ SINGLE ❒ COUPLE ❒ FAMILY # (_____)		
TYPE OF HOUSING	❒ HOUSE ❒ APARTMENT ❒ TRAILER ❒ SECONDARY SUITE ❒ SOCIAL HOUSING ❒ RECOVERY/SOBER LIVING ❒ OTHER:_____		
ATTACHMENTS **SCAN TO: kelowna@cmha.bc.ca**	❒ **60-DAY BANK STATEMENT** ❒ **RECENT UTILITY BILL** **BOTH ATTACHEMENTS ARE REUIRED PRIOR TO SUPPLEMENT APPROVAL**		
DETAILED REASON FOR UTILITY RELIEF REQUEST			

KELOWNA BRANCH | 504 Sutherland Ave Kelowna BC V1Y 5X1 | T: 250.861.3644 | F: 250.763.4827 | www.kelowna.cmha.bc.ca

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AUTHORIZATION FOR OBTAINING / RELEASING INFORMATION
I, *(PLEASE PRINT NAME)*_____HEREBY AUTHORIZE CANADIAN MENTAL HEALTH ASSOCIATION, AND UTILITY RELIEF PROGRAM ADMINISTRATOR, TO OBTAIN AND/OR RELEASE INFORMATION TO MY UTILITY PROVIDER AND/OR BC HOUSING REGARDING UTILITY RELIEF PAYMENTS. I HEREBY RELEASE CMHA AND ITS STAFF FROM ALL MANNER OF LIABILITY, CLAIM OR DEMAND I MAY OR WILL HAVE AS A RESULT OF THEIR OBTAINING AND/OR RELEASING INFORMATION. *THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE CONSENT DATE.* PLEASE PRINT DATE: _____

SIGNATURE OF CLIENT			
WITNESS SIGNATURE			
COPY GIVEN TO CLIENT	❒ YES ❒ NO	CLIENT'S INITIALS	
CLIENT DECLINED TO TAKE A COPY	❒ YES ❒ NO	CLIENT'S INITIALS	

MENTAL HEALTH SUPPORTS:	
ALCOHOL/SUBSTANCE USE SUPPORTS:	
FAMILY PHYSICIAN:	
OTHER SUPPORTS:	

BC Housing

FORTISBC

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