



Saskatchewan Disability Rental Housing Supplement Application

To complete an application over the telephone please call:
 Toll Free 1-888-488-6385 or in Regina 787-4723
 or complete and return the paper application.

Applicant:

Saskatchewan Health Services Number:			
First Name and Initial:	Last Name:	Gender	Birthdate (year/month/day)

Spouse (if applicable):

Full Name	Gender	Birthdate (year/month/day)	Health Services Number
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Children (if applicable):

Full Name	Gender	Birthdate (year/month/day)	Health Services Number
Full Name	Gender	Birthdate (year/month/day)	Health Services Number
Full Name	Gender	Birthdate (year/month/day)	Health Services Number
Full Name	Gender	Birthdate (year/month/day)	Health Services Number
Full Name	Gender	Birthdate (year/month/day)	Health Services Number

Social Insurance Numbers

Applicant: _____ Spouse (if applicable) _____

Does your income fluctuate or change from month to month? Yes No

Password:

A password is required to confirm your identity any time you speak to a Client Service Specialist. You should not share your password with anyone. It is used to change information on which your supplement is calculated.

Please provide a password _____

Home Phone Number: (306) _____ No Phone

Home Address

Apt. Number and Street	
City/Town	Postal Code

Mailing Address (if different than home address):

Apt. Number and Street	
City/Town	Postal Code

Optional

Would you like someone (for example, a family member, community advocate, or support person) to receive notification when letters are sent to you regarding the Disability Rental Housing Supplement? Yes No

If yes, please provide the person's name and address:

Name (and agency if applicable):

Apt. Number and Street:

City/Town:

Postal Code:

Disability Self Assessment

1. Because of a physical disability, a mental/cognitive disability or health problem, do you or your spouse/son/daughter need an assistive device or aid, changes to your environment or support from others in order to carry out activities or tasks in the home? Yes No

Activities can include: getting in and out of the home, getting around inside the home, climbing stairs, using the toilet, preparing food, housekeeping and cleaning, bathing and taking care of personal hygiene, communicating with others, avoiding health and safety hazards, accessing emergency services, maintaining emotional well-being, managing a daily routine.

2. Is this disability or health problem expected to last a year or more? The disability or health problem does not have to be continuous. It could also be recurrent or cyclical.
 Yes No

To be eligible for the Disability Rental Housing Supplement you must have answered YES to both questions #1 and #2.

3. Please provide the name(s) of each person having a disability:

Full Name	Birthdate (year/month/day)
Full Name	Birthdate (year/month/day)
Full Name	Birthdate (year/month/day)
Full Name	Birthdate (year/month/day)
Full Name	Birthdate (year/month/day)

Housing Supports in Your Current Housing Environment

The following is designed to help you identify features in your home that assist you or a family member with your/their disability.

Accessibility Supports

1. Does your home have any special features to help you or a family member enter or leave? Yes No

If yes, please check the features that apply.

- Ramp
- Street Level Entrance
- Automatic Door
- Elevator or Lift Device
- Widened Doorways or Hallways
- Adequate Floor Space For Turning a Wheelchair
- Other (please identify): _____

Built-in or Fixed Disability-related Modifications or Physical Features

2. Does your home have any built-in or fixed disability-related modifications or physical features that address your or a family member's disability? Yes No

If yes, please check the location and identify the disability-related modifications or physical features:

- Safety and security features: _____
- Doors and thresholds: _____
- Kitchen: _____
- Bathroom: _____
- Hallways and Stairs: _____
- Home Environment/Other (please identify) _____

Modifications can include: visual alarms, lever handles on doors or faucets, visual and tactile marking of changes in floor level/stair edges, or having a service animal.

Physical features can include: reduced noise/soundproof residence, enhanced ventilation, air conditioning, enhanced lighting/sunlight/window size, more space/privacy, additional cupboard space to minimize visual clutter, and enhanced safety and security features (access to onsite emergency response, outside entrance with an intercom system, security doors, deadbolts, call buttons, electronic monitoring system, phone extensions rounded edge fixtures, bolted down furniture, locking bedroom doors and cabinets).

Location Related Supports:

- 3. Is your home located close to services and supports that you use on a regular basis because of your or a family member's disability? Services or supports can include: grocery store, drug store, medical treatment or facilities, bus routes, family, friends or neighbours that provide support to you. Yes No

- 4. Is your home located in a neighbourhood away from certain factors that may affect your or a family member's disability? This can include a home located in a quiet neighbourhood away from busy areas or a neighbourhood with reduced distractions or a neighbourhood in which you feel safe. Yes No

If you answered yes to question 3 and/or question 4 you will need to have a reference person or agency who may be contacted to confirm you have a disability-related limitation that require these supports. A reference person must be someone who has known you for at least six months and is reasonably familiar with your need for location related supports.

Reference Person

I understand that I may be contacted to confirm the individual's need for location related supports.

Relationship to Applicant: _____ Phone Number: _____

Reference Person Name (Print): _____

Reference Person Address: _____

or

Reference Agency: _____

Agency Person Contact Name (Print)

Phone Number

Reference Agency Address: _____

Information About Your Home

Please complete the following:

How much rent do you pay each month? \$ _____

Is the cost of heating your accommodations included in your rent? Yes No

How many bedrooms are in your home? _____

How many people live in your home? _____

Health and Safety Self-Assessment

In order to receive the supplement your home must meet certain minimum health and safety requirements. Please complete the following assessment.

1. a) Do all the outside doors to your residence close properly? Yes No
b) Do all the outside doors to your residence have locks that work? Yes No
2. a) Do you have a balcony that is over 2 feet off the ground? Yes No
b) If yes, does it have a railing? Yes No
c) Are the floorboards in good shape with no rotten or missing boards? Yes No
3. Are the floor boards in the steps and staircases in your home in good shape with no rotten or missing boards? Yes No
4. Does your roof or any of your windows always leak when it rains? Yes No
5. Do you have any exposed electrical wires? Yes No
6. Do both your bathroom and kitchen have hot and cold running water? Yes No
7. Does your bathroom have:
a) a working bathtub OR shower OR sink? Yes No
b) a working toilet? (It has a seat and it flushes) Yes No
8. a) Does your home have a working source of heat? Yes No
b) Can you get the temperature inside the house to 21°C or 70°F in the winter? Yes No

9. Do you have working smoke detectors?
(Batteries are changed on a regular basis) Yes No
10. Do you have a constant problem with rodents in your home? Yes No
11. Do you have a foundation that is caving in? Yes No
12. Does every bedroom have a window that opens? Yes No

Income

Are you currently receiving benefits from the Saskatchewan Assistance Plan or the Transitional Employment Allowance? Yes No

Employment and Other Income

Applicant		Spouse (If Applicable)	
What was your gross income in the previous month? Month _____ Year _____ \$ _____ Enter Gross Income		What was your spouse's gross income in the previous month? Month _____ Year _____ \$ _____ Enter Gross Income	
Employment	\$ _____	Employment	\$ _____
Child/Spousal Support	\$ _____	Child/Spousal Support	\$ _____
Old Age Security	\$ _____	Old Age Security	\$ _____
Personal Retirement Pensions	\$ _____	Personal Retirement Pensions	\$ _____
Gov't Benefits – Other	\$ _____	Gov't Benefits – Other	\$ _____
Other (Please Specify) _____	\$ _____	Other (Please Specify) _____	\$ _____

Self – Employment Income

Applicant	Spouse (If Applicable)
Are you currently self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your spouse currently self-employed ? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please complete the following	If yes, please complete the following
Are you operating the same business(es) from the 2004 tax year? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you operating the same business(es) from the 2004 tax year? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please identify any self – employment income from your 2004 tax year return: Line 160 - Rental Income \$ _____ Line 162 - Business Income \$ _____ Line 164 - Professional Income \$ _____ Line 166 - Commission Income \$ _____ Line 170 - Fishing Income \$ _____ <p style="text-align: right;">Total \$ _____</p>	Please identify any self – employment income from your spouses 2004 tax year return: Line 160 - Rental Income \$ _____ Line 162 - Business Income \$ _____ Line 164 - Professional Income \$ _____ Line 166 - Commission Income \$ _____ Line 170 - Fishing Income \$ _____ <p style="text-align: right;">Total \$ _____</p>
Were you considered self-employed for the full year? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, in what month did you start self-employment? Month _____ Have you started a business since January 2005? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide gross amount for the previous month _____	Were you considered self-employed for the full year? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, in what month did you start self-employment? Month _____ Have you started a business since January 2005? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide gross amount for the previous month _____

Farming Income

Applicant	Spouse (If Applicable)
<p>Are you currently farming?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please complete the following</p>	<p>Are you currently farming?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please complete the following</p>
<p>Were you farming in the 2004 tax year?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What is the amount in line 169 of your 2004 tax return?</p> <p>\$ _____</p> <p>Were you a farmer for the full year?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, in what month did you start farming?</p> <p>Month _____</p> <p>Have you started farming since January 2005?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, provide gross amount for the previous month _____</p>	<p>Was your spouse farming in the 2004 tax year?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What is the amount in line 169 of your spouse's 2004 tax return?</p> <p>\$ _____</p> <p>Was your spouse a farmer for the full year?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, in what month did your spouse start farming?</p> <p>Month _____</p> <p>Has your spouse started farming since January 2005?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, provide gross amount for the previous month _____</p>

Consent/Declaration

I give consent to Community Resources to use my Saskatchewan Health Services number to obtain my address and family composition from Saskatchewan Health for the purpose of determining my eligibility for the Saskatchewan Rental Housing Supplement and the Saskatchewan Employment Supplement.

I am declaring to the best of my knowledge and belief all the information on this form is true in every respect.

Signature of Applicant

Date

Signature of Spouse (if applicable)

Date

Mail to:

Community Resources
Saskatchewan Disability Rental Housing
Supplement Program
P.O. Box 2405
REGINA SK S4P 4L7

If you have any questions please call:

Toll Free: 1-888-488-6385

In Regina: 787-4723