Residential Charges
TAX INFORMATION RELEASE FORM

Manitoba Health

Why We Require Your Information

The information requested on this form is necessary for the Residential Charges office to determine and verify your, your spouse's, or your common-law partner's annual entitlement to a reduced residential/authorized charge as provided for under *The Health Services Insurance Act, The Mental Health Act* and regulations made thereunder. Any information you provide will be protected in accordance with *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act*. For additional information, please contact the Residential Charges office, Manitoba Health, at 300 Carlton Street, Winnipeg MB, R3B 3M9 or phone (204) 786-7150.

Please Print

Section A Facility Information

_____ _____
Facility Name Facility Number

Section B Client Information

_____ _____
Surname Given Name

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __
Social Insurance Number Personal Health Identification Number (from Health Registration Certificate)

Marital Status: Single/Widowed/Divorced ☐ Married/Common-law Relationship ☐ Separated ☐

I hereby authorize the Canada Revenue Agency to release information from my income tax returns and other required tax information to the Manitoba Department of Health. I understand that the information is necessary for and will be used solely for the purposes outlined above and will not be disclosed to any person without my approval. I understand that, if I wish to withdraw this consent, I may do so at any time by writing to the Residential Charge Coordinator. This authorization is valid for the two taxation years prior to the year of signature of this consent, as well as for the current taxation year and each subsequent consecutive taxation year for which a reduced residential/authorized charge is requested by me or on my behalf.

_____ _____
Signature of Client or his/her Legal Representative Date

SECTION C Spouse/Common-law Partner Information (if applicable)

_____ _____
Surname Given Name

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __
Social Insurance Number Personal Health Identification Number (from Health Registration Certificate)

Do you reside in a facility? No ☐ Yes ☐ If yes, please name the facility: _____

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_____ _____
Signature of Spouse/Common-law Partner or his/her Legal Representative Date

SECTION D Legal Representative Information (if applicable)

If you have signed this form as a legal representative**,** please print your name and address below and attach a copy of the Power of Attorney or Order of Committeeship.

_____ _____
Surname Given Name

_____ _____
Address Postal Code

When complete, this form (and if applicable a copy of Power of Attorney or Order of Committeeship), is to be returned to the facility.