



Community and Health Services Department

Capital Plan Update

Date:	
Corporation Name:	
Project Name:	
Mailing Address	
Contact Person:	
Phone:	
Fax:	
Email:	

Do you have sufficient funds to complete this work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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This form should be completed by any housing provider who has an approved capital plan and:

- needs additional funds for work already approved or
- has emergency expenditures or
- needs to have additional work done that was not listed in the approved plan

This work should not be done without Regional approval.

If you need help completing this form, please contact your Program Coordinator.

Print Name: _____

Board Chair or Other Authorized Board Member

Signature: _____

Date: _____

Change to Approved Annual Capital Plan

Description of Work:	
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No.	What building element are you replacing?	Why is the work needed?	Where is the work being performed? (e.g. in unit, in corridor, etc.)	What are you replacing with?	Last time replaced?	Estimated Budget (Including any Consulting Fees and Applicable Taxes) Give a Range - minimum to maximum
Total:						

Emergency Work

Description of Work:	
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No.	What building element are you replacing?	Why is the work needed?	Where is the work being performed? (e.g. in unit, in corridor, etc.)	What are you replacing with?	Last time replaced?	Estimated Budget (Including any Consulting Fees and Applicable Taxes) Give a Range - minimum to maximum
Total:						