



Community and Health Services Department

# Application Request for Capital Reserve Funds

Corporation Name:		Date:
Project Name:		
Mailing Address:		
Contact Person:	Phone No.:	Fax No.:
Property Address:		
Type of Unit:	No. of Units:	Project Age:      Years
Balance of Replacement Reserve: \$		As of:
Description of Item(s) to be Replaced:		
Last Time Replaced:	Date of Last Inspection:	
Description of Problem(s):		

Estimate: (Please Attach Copies of all Estimates and Specifications Listed)			
<b>1</b>	Contractor:	Bid Price: \$	GST: \$
<b>2</b>	Contractor:	Bid Price: \$	GST: \$
<b>3</b>	Contractor:	Bid Price: \$	GST: \$
Estimate Chosen by Group:			
Provide Reason(s) for Making Your Choice:			
Approved by Board or Authorized Person per Spending Policy:			
Name:		Signature:	Date:

**This section to be completed by The Regional Municipality of York, Community and Health Services Department**

Recommendation:	
Comments:	
<hr/> Reviewed by Intermediate Accounting Clerk, Housing Subsidies	<hr/> Date

Recommendation:	
Comments:	
<hr/> Recommended by Program Co-ordinator, Housing Programs	<hr/> Date

Recommendation:	
Comments:	
<hr/> Approved by Manager, Housing Programs	<hr/> Date