Ministry of Community and Social Services
Ontario

Office Use Only

Application for
Assistance under the *General Welfare Assistance Act*
Benefits under the *Family Benefits Act*

☐Application ☐Update Report

Form 1

Trans Type	Today's date D M Y	Office I.D.	Caseload	Case Identification Name	Date D M Y	Seq.	Reference Number
1	Pgm.	Pgm. Stat	CC/RA	Eff. Date of Grant D M Y	STEP Period	Expiry Date/Ineligibility D M Year	Reason Exp./Inel. 1 2
2	Eff. date change M Y	Reason for Hold 1 2	100% M	I.W.S.	Date entered prov. D M Y	Pending Stat. M F	Non-Resid. Auth. Date D M Y
3	Inc. St. NR date M Y	No Drug Card					
5	Effective Date - Transfer D M Y	Program	Change to Office	Chge. to Cld.	FBA Date to Refer. D M Y	Alter. Ref. Off.	GWA Ref. Office
	No Letter: Y	No Profile: Y					

Has the applicant previously applied for assistance under the *General Welfare Assistance Act* or for benefits under the *Family Benefits Act*?
☐no ☐yes ☐GWA ☐FBA — Location — Date of Last Assistance — Amount $

1. Qualifying Categories Indicate categories under which application is being made.

Family Benefits Act
- ☐age 65 or more
- ☐60 - 64 year old
- ☒disabled, blind, permanently unemployable
- ☐sole support parent
- ☐Vocational Rehabilitation Services
- ☐other, provide details

General Welfare Assistance Act
- ☐inability to obtain employment
- ☐head of family whose spouse is absent
- ☐disability
- ☐old age
- ☐student
- ☐other, provide details

2. Applicant

Surname [redacted] Given name [redacted] Init. [redacted]

☒Mr. ☐Mrs. ☐Ms. ☐Miss

Birth date D M Y: [redacted] 16 1

☒single ☐spousal ☐deserted ☐divorced ☐married ☐widowed ☐separated

Other/previous name

Address: HURONIA REGIONAL CENTRE

Telephone no. Area: 705 326 7361

Apt. no.

Postal code: L3V 6L2

BOX 1000 ORILLIA, ONT.

Social Insurance no. [redacted] Health no. [redacted] Ver. Highest level education

Next of Kin: Mr. [redacted] Relationship: Father Address: [redacted]

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Municipal code

Hlth	Empl	Ed	GAINS Type	NL

3. Spouse

Surname of Spouse — Given name — Other name (maiden)

Social Insurance no. — Health no. — Ver. — Birthdate D M Y

Education - highest level

Hlth	Empl	Ed	GAINS Type

Action Code

4. Dependant(s) living with you - Name(s) on birth certificate(s)

Given name — Surname — Birthdate D M Y — St. — Ed.

School name — Grade — Health no. — Ver. — AC

Given name — Surname — Birthdate D M Y — St. — Ed.

School name — Grade — Health no. — Ver. — AC

Given name — Surname — Birthdate D M Y — St. — Ed.

School name — Grade — Health no. — Ver.

Do you have any dependants not living with you? ☐no ☐yes, provide details in Section 16

Is any other person using this address for any other reason? ☐no ☐yes, provide the following:

Name — Reason — Relationship

5. Present Employment/Training A - Applicant S - Spouse D - Dependant

	Date Started D M Y	No. of Hours Monthly	Type of Work (GWA Only)	Employer name and address	Job Type	Own Trans	Length of Empl.	Propd. Act.
A								
S								
D (GWA only)								

6. Past Experience (within the past year)

	Job Type	Type of Work (GWA Only)	Date Last Employed D M Y	Reason for Leaving	UI Eligibility Date D M Y	UI Status	Own Trans	Reason Unempl.	Length of Empl.	Propd. Act.
A										
S										
D (GWA only)										

Turn to PAW to begin on Page 1

7. Living Conditions

Type

Boarding (Room & meals provided) | Monthly Amount | Verified Y N | With whom: FULL CARE - HURONIA REGIONAL CENTRE | M F | Relationship | Effective Date D M Y: 01 3 | 12 | 94 23

If you are a sole support parent under 18, do you live with your parents? ☐ no ☐ yes
If yes, is/are your parent(s) ☐ beneficiary of Family Benefits ☐ in receipt of General Welfare Assistance

If you are a sponsored immigrant, do you live with your sponsor? ☐ no ☐ yes
If yes, is your sponsor ☐ beneficiary of Family Benefits ☐ in receipt of General Welfare Assistance

Renting ☐ subsidized ☐ unsubsidized | Monthly Amount | Verif. Y N | Mortgage balance | Verif. Y N | Condo. fees | Verif. Y N

Own home/ condominium | Landlord/Mortgage Holder | Address | Telephone no.

Taxes (annual) | Verif. Y N | Fire Ins. (annual) | Verif. Y N | Utilities (monthly) | Verif. Y N | Heating costs (Mthly) | Verif. Y N | Equal Billing ☐ yes ☐ no

Do you pay the total accommodation costs? ☐ yes ☐ no; if no | Amt. paid by you | Amt. paid by cores. | No. of sharers M F | Effective Date of Cores. D M Y

Are you, your spouse or dependant in a hospital, nursing home or other institution? ☐ no ☐ yes, provide the following:
A / S / D | Name and address of institution | Date of admission | Expected date of discharge

8. Income

	Received Y N	A S D	Description	Monthly Amount	Verif. Y N
OAS/GIS/SA/WSA					
GAINS A					
Annuities, Superan, Insur. Ben.					
Earned Interest					
Canada Pension Plan, QPP					
Pension Act (Canada)					
War Veterans' Allowance					
Unemployment Insurance					
Foreign Pensions/U.S. Soc. Sec.					
Workers' Compensation					
Comp. for Victims of Crime					
Official Guard./Public Trustee					
Privately Administered Trust					
Mortgage Rec./Loan Agreement					
Farm or Business					
Rental ☐housing ☐land ☐garage ☐other					
Support Payments					
Other			PNA	202.39	

9. Earnings/Training

	Gross	Monthly Amounts Code	Net	Verif. Y N	Child. Care Exp.	Type	Verif. Y N	Work related exp. (disabled)	Verif. Y N
Applicant									
Spouse									
Dependant (GWA only)									

10. Roomers/Boarders

A/S | Amount | No. M | No. F

R/B	Effective Date D M Y	M F	Name	Relationship	Amount

Is any Roomer or Boarder your child, grandchild, foster child of you or your spouse? ☐no ☐yes, are they ☐a beneficiary of Family Benefits, ☐in receipt of General Welfare Assistance, ☐attending an educational institution, ☐without financial assistance? ☐no, ☐yes provide details:

Is any other person living in the home? (eg. landlord) ☐ no ☐ yes, provide the following:
Name | Relationship - provide details in Section 16

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Direct Bank Deposit
Branch | Institution | Account Number

Client Information Update Report Details
CIUR Comp Code | Mail Out | Last CIUR/Visit D M Y | Next CIUR/Visit D M Y | Grant Duty O'ride | Invst. Comp. O'ride

No.	Reason	Bring Forward	Date M Y

No.	Description	Worker's Comment

11. Assets

Personal Property	Y	N	Details	Value $	Verified Y	Verified N
Cash on hand						
Chequing/Savings Accounts (Banks, Trust Companies, Credit Unions)						
Investments (Bonds, Shares, RRSP, Term Deposits)						
Life Insurance (Cash Surrender Value)						
Receivables (Mortgages, Loans, Accounts Receivable)						
Vehicles						
Safety Deposit Box						
Valuables (coins, stamps, jewellery)						
Prepaid Funeral (Amount in excess of allowable exemption)						
Beneficial interest in Assets held in trust (Official Guardian, Public Trustee)						
Privately Administered Trust			Acquired by inheritance? ☐ Yes ☐ No			
Financial Interest in Business						
Other						

Real Property - other than Principal Residence ☐ no ☐ yes, provide the following:

Lot and Plan/Concession	Address	A	S	D	Owned or Life Tenancy	Rented	Vacant	Occupied	Year Purchased	Current Market Value $	Equity $	Verified Y	Verified N

Have you, your spouse or any dependant disposed of any assets (personal or real property) within the last three years or since the last report?
☐ no ☐ yes, provide details:

Are any assets expected in the future by you, your spouse, or any dependants? ☐ no ☐ yes, provide details:

12. Other Financial Resources

Are there any other financial resources to which the applicant/spouse or dependent child(ren) may be entitled? ☐ no ☐ yes, provide the following:

Name	Address	For (name)	Amount $
☐ sponsorship			
☐ support			
☐ other - specify			

Has an application been made for any types of income for which the applicant/spouse or dependent child(ren) may be eligible?
☐ no ☐ yes, provide details:

Previous Spousal Relationships **Applicant** ☐ yes, provide details in Section 16 ☐ no **Spouse** ☐ yes, provide details in Section 16 ☐ no

13. Special Items

Are any of the following items required by you, your spouse or any other beneficiary? ☐ no ☒ yes

☐ special diet ☐ pregnancy item ☐ travel/transportation ☒ community start up ☐ guide dog allowance

14. Residence

If born outside Canada, provide the following:		Arrival date	Verified yes	Verified no	Current status	Landing date	Verified yes	Verified no
Applicant								
Spouse								
Dependant(s)								

List all places of applicant's residence within the last 12 months (GWA only)

From (month/year)	To (month/year)	Address	Municipality	Province

15. Update Report Only

Have you or your spouse or any dependant been absent from Ontario since the last report? ☐no ☐yes; provide details:

Did you receive Social Assistance from any other province/state/country while absent from Ontario? ☐no ☐yes; provide details:

Have you or your spouse or your dependant been in hospital, nursing home, detention centre or other institution for more than 1 month since the last report?

	Name and address of institution	Date entered	Date released
☐no ☐yes, Name			

16. Additional Information from Section 1 to 15 (e.g. Health numbers for dependent children)

Forms, documents, certificates to follow (specify):

Note: The Criminal Code of Canada s.s. 380 (1) states that everyone who by deceit, falsehood or other fraudulent means defrauds the public of any property, money or valuable security, is guilty of an offence.

The *Family Benefits Act*, Sec. 19/*General Welfare Assistance Act*, Sec. 16 states that a person who knowingly obtains or receives a benefit/assistance that he/she is not entitled to obtain or receive under the Act and the regulations is guilty of an offence.

17. Statutory Declaration (complete spousal information if applicable)

1. I, _____ (full name) do solemnly declare that I am the Applicant/Recipient (or the person applying on behalf of the Applicant/Recipient) named in this application.
2. I, _____ (full name) do solemnly declare that I am the spouse of the above mentioned Applicant/Recipient named in this application.
3. I/We have been interviewed by the Welfare Administrator or his/her representative or by the Director of the Income Maintenance Branch of the Ministry of Community and Social Services or his/her representative. I/We understand the eligibility criteria. I/We have supplied the information in this application to the best of my/our knowledge and belief. All statements are true and no information required to be given has been withheld or omitted.
4. Should an allowance be granted or continued on the basis of the information in this application, I/we will notify the Welfare Administrator, the Director or his/her representative as the case may be, of any change of relevant circumstances of any beneficiary of the allowance/assistance to be provided, including any change in circumstances pertaining to assets, income or living arrangements.
5. I/We acknowledge that the information contained in this application may be used for the purpose of applying for and verifying eligibility for assistance under *General Welfare Assistance Act* and benefits under *Family Benefits Act* and I/we undertake to provide any additional information that may be required at that time.
6. I/We make this solemn Declaration conscientiously believing it to be true [redacted] effect as if made under oath by virtue of the *Canada Evidence Act*.

Declared before me at the _____

of _____

in the _____ of _____

X this 1st day of May, 19 97.

X _____
Signature/mark of applicant/recipient or person applying on behalf of applicant/recipient

_____
Signature/mark of spouse where applicable

_____
A Commissioner etc.

Notice with Respect to the Collection of Personal Information
(Freedom of Information and Protection of Privacy Act)
(Municipal Freedom of Information and Protection of Privacy Act)

This information is collected under the legal authority of the *Family Benefits Act*, R.S.O. 1990, c.F.2, or the *General Welfare Assistance Act*, R.S.O. 1990, c.G.6, the *Ministry of Health Act*, Section 6(2) and the *Ontario Drug Benefit Act*, 1986. The information will be used for the purpose of:

- Administering the Ontario Government Income Maintenance Program. For more information contact your nearest Municipal or Community and Social Services office.
- Administering payment of prescription drug claims and conducting drug use review for the Ontario Drug Benefit Program. For more information contact: the Director, Drug Programs Branch, 6th Floor, 7 Overlea Blvd., Toronto, Ontario. M4H 1A8. Telephone: (416) 327-8109.

For Office Use Only

[redacted]

Ministry of Community and Social Services
Ontario

Consent to Disclose and Verify Information
Family Benefits Act
General Welfare Assistance Act
Form 3

1. I, THOMAS SLARK (full name), consent to the release of information to an authorized representative of:

☐ _____ (Municipality)

☐ _____ (Indian Band)

☒ Ministry of Community and Social Services

for the purpose of determining or verifying my initial or ongoing eligibility for social assistance, administering my social assistance, or collecting information about me, my spouse (where my spouse has joined in this consent), my dependants or my foster children for these purposes.

2. Without restricting the generality of the consent in section 1, I specifically consent to the release of information relating to any bank account, safety deposit box, assets of any nature or kind whatsoever held by me or on my behalf or by or on behalf of my spouse, any of my dependants or foster children, alone or jointly with any other person, in any financial institution.

I further consent to an authorized representative of the municipality or Indian Band, or Ministry of Community and Social Services, disclosing to any party personal information about me, my spouse (where my spouse has joined in this consent), or any of my dependants or my foster children for the purpose of determining or verifying my initial or ongoing eligibility for social assistance or administering my social assistance.

4. I further consent to the exchange of information between the municipality or Indian Band, the Ministry of Community and Social Services, or the Government of Canada, the government of any other province or territory, the Government of Ontario, or any agency, Ministry or department of any of the foregoing, in order to verify information for the purposes of determining or verifying my initial or ongoing eligibility for social assistance or administering my social assistance.

5. I understand that this consent will apply to inquiries made regarding a period of time during which I am or have been in receipt of social assistance. I further understand that the inquiries may take the form of electronic data exchanges.

Dated at Huronia Regional Centre - Orillia, X [redacted] (Signature/mark of applicant/recipient)

X this 15th day of May 19 97. _____ (Witness)

I, _____ (full name of spouse, if applicable), am the spouse of the above named

_____ (name of applicant/recipient), I have read the consent set out above and I join in this consent.

Dated at _____, _____ (Signature/mark of spouse of applicant/recipient)

this _____ day of _____ 19 ____. _____ (Witness)

0985 (06/94)

Français au verso

[redacted]

Ministry of Community and Social Services
Ontario

Medical Report 4

General Welfare Assistance Act . Family Benefits Act . Vocational Rehabilitation Services Act

Name [redacted]

Social Insurance number [redacted]

Huronia Regional Centre

Box 1000

Orillia, Ontario

Sex ☒ male ☐ female

Date of birth [redacted] 19 61

O.H.I.P. number [redacted]

Postal code [redacted]

Caseload number [redacted]

1. Is this person a regular patient of yours? ☒ yes ☐ no
   If yes, how frequently have you seen this patient in the past 2 years?
   as needed

2. When did you last see this patient? give date:
   April 23/97 — med. review
   for what reasons?
   med. Review

3. List other significant/relevant conditions and diagnoses for which this patient has been treated.
   Epilepsy

4. Briefly describe nature of treatment rendered or proposed (include place and date of relevant hospitalization).
   Dilantin
   Pin and plate D'nip - 1978

5. What is your prognosis for your patient's condition?
   Developmentally Handicapped — cause unknown

6. Does your patient require the use of any medical prosthetic device (i.e.; wheelchair, artificial limb, etc.) ☐ yes ☒ no
   If yes, please describe:

7. In your opinion do any of these conditions limit this patient's activities pertaining to normal living, such as: self care, communication or motor activities? ☒ yes ☐ no
   if yes, please describe:
   Unable to live alone

8. Do you expect sufficient improvement to tak[redacted]n of this patient to allow him/her to:

a) return to his/her previous work or occupation ☐ yes ☐ no

if yes, when? N/A

full or part-time (hours/day) _____

b) return to any other type of work or occupation ☐ yes ☐ no

if yes, when? N/A

full or part-time (hours/day) _____

Nature of work training program only

9. In your opinion, what specific factors or conditions might adversely affect training, employment or academic progress? (Please specify any activities or working conditions that are to be avoided.)

Developmentally handicapped

10. If an appropriate training program is developed for your patient, is he/she medically able to participate? ☑ yes ☐ no

if yes, when? at present

full or part-time (hours/day) _____

11. Any additional information, including hospital reports, consultant's reports, other tests and comments you could provide with respect to your patient's physical, mental or emotional impairment will be of considerable assistance in determining program eligibility:

Needs constant supervision

Certificate of Attending Physician

(Please print)

I, [redacted] am a legally qualified medical practitioner and this report contains my findings and considered opinion at this time.

Signature [redacted] date 97.04.30

Address P.O. Box 1000, Orillia, ON L3V 6L2

Note: In some instances it may be necessary to release to the applicant a summary of the contents of this form.

To be forwarded to our attention in the self-addressed envelope

Ministry of Community and Social Services
Ontario

Supplementary Medical Information

Caseload no.	Case I.D. number
[redacted]	

Surname	First name	Initial	Date of birth	Health number
[redacted]		P.	[redacted] 52	[redacted]

We Need Your Help

The information you give us on this form will help the Medical Adjudicator. The Medical Adjudicator gives advice to the Director of the Income Maintenance Branch to determine if you can receive benefits under the *Family Benefits Act*.

By you filling this form out completely, we will have the best possible information about your medical history. This helps us to make a decision on your application for benefits. If you would like help in filling this out, please call our office.

Your staff contact is ✓

Office hours are ✓ Phone number is: ✓

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(Freedom of Information and Protection of Privacy Act)
(Municipal Freedom of Information and Protection of Privacy Act)

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A. Medical Condition

If something is "disabling" you, it means that it is preventing or not letting you work the way you should be able to.

1. What is the main disabling condition which gets in the way of your being able to work or carry out daily living activities?

DEVELOPMENTAL HANDICAP - SEVERE CAUSE UNKNOWN

2(a) Do you have any other disabling condition or conditions? Please check x ☑ yes ☐ no

2(b) If you checked **yes**, please give a brief description of the condition(s).

NO SPEECH
HISTORY OF EPILEPSY

B. Other Medical Information

1. Please list the **prescription** medications you are taking. How often do you take them? How much do you take?

SEE ATTACHED MY PROFILE

2(a) Please list any medical treatments, examinations, therapies or surgeries you have had in the past year.

MEDICAL ASSESSMENT - APRIL 23 1997

(b) Has your doctor arranged for any medical treatments, examinations, therapies or surgeries in the near future?
Please check x ☐ yes ☑ no

(c) If you checked **yes**, tell us what is planned.

3. Please list any special aids or devices you use to walk (for example; braces, crutches, computerized aids, brailling devices, cane, wheelchair, hearing aid, pacemaker, prosthesis, Telephone Device for the Deaf (TDD), or Bliss board).

NONE

C. Your Ability to do Different Functions:

How would you rate your ability in doing the following tasks or functions?

Put one number in each box. The numbers mean:

1 = You are fully capable of doing this function.
2 = You have minor difficulty in doing this function.
3 = You have moderate difficulty in doing this function.
4 = You have serious difficulty in doing this function.
5 = You have severe difficulty or you cannot do this function at all.

If you have received treatment for any of these functions, please use the space to describe:

- what treatment you had;
- when you had it; and
- where (clinic, city) you had the treatment.

1	Sitting	
1	Standing	
1	Walking	
1	Bending	
1	Carrying	
1	Lifting	
1	Using Hands and Fingers	
1	Breathing	
1	Sleeping	Good APPETITE - REDUCING DIET - STAFF ASSIST
3	Eating	& FEEDING.
5	Washing or Bathing	FULL ASSISTANCE REQUIRED.
4	Dressing	STAFF ASSISTANCE "
4	Other Personal Care you do	TOILETS SELF -
5	Speaking	NO SPEECH.
1	Seeing	
1	Hearing	
5	Driving a Car	
5	Using Public Transportation	FULL ASSISTANCE REQUIRED IN THE
4	Concentrating	COMMUNITY.
4	Remembering	
3	Controlling Mood Shifts or Swings	EASILY FRUSTRATED.
1	Controlling the Abuse of Food	
1	Controlling the Abuse of Alcohol or Drugs	

D. Employment, Volunteer History:

1(a). Are you working or volunteering outside your home at the present time? Please check x ☐ yes ☑ no

If you checked no, please go to question 2.

(b). If you checked **yes**, what do you do when you are working or volunteering outside of your home?

(c). How many hours do you work or volunteer every day? _____ every week? _____

2(a). If you are not working or volunteering now, have your ever worked or volunteered? Please check x ☐ yes ☑ no

If you checked no, please go to question 3.

(b). If you checked **yes**, what did you do?

(c). Did you stop working or volunteering outside the home because of medical reasons? Please describe.

(d). When did you last work? Day | Month | Year _____ When did you last volunteer? Day | Month | Year _____

3. Please list the work at home and leisure activities you do (for example: hobbies, sports, vacuuming, laundry, home repairs).

Activities You Do	How Often Do You Do This Activity?	Do you Have Any Difficulty in Doing This Activity?
ENJOYS WALKS	3-4 TIMES WEEKLY	REQUIRES ASSISTANCE
SPENDS CONSIDERABLE TIME SITTING IN CHAIR OBSERVING OTHERS.		

4(a). Are you planning to try and find work in the future? Please check x ☐ yes ☑ no

Are you planning to try and find training in the future? Please check x ☐ yes ☑ no

(b). If **yes**, has your doctor told you that you have fully recovered? Please check x ☐ yes ☐ no

Has your doctor told you that you have done as well as possible from your rehabilitation? Please check x ☐ yes ☐ no

If you checked **no**, has your doctor given you a possible date for your full recovery or when you will be rehabilitated?

Please check x ☐ yes; and tell us the date month | Year _____

or ☐ no; and tell us the reason _____

(c). Please list what you would need in the workplace so you could start or return to work or training. For example: computers, Telephone Device for the Deaf (TDD), ramps, stair glides, automatic doors, ergonomic seating, special transportation, flexible work hours.

CLIENT IS NOT EMPLOYABLE. SEVERE DEVELOPMENTAL HANDICAP. REQUIRES ASSISTANCE IN MOST AREAS OF DAILY LIVING.

E. Information about your Doctors

Please give the name, address and telephone number of your medical doctor (physican). Your doctor can provide us with important information about your disability or disabilities.

Doctor #1 must be the doctor who will be completing the Ministry of Community and Social Services Medical Report form for you.
He/She may be your family physician or a specialist you see often.

Note: After reading this form, the Medical Adjudicator may need more information from your doctor(s). Your doctor(s) may charge a fee. Please discuss this with your doctor(s).

Doctor #1

[redacted]

Doctor's last name	first name	Initial	Telephone number
C/O HURONIA	REGIONAL CENTRE		(705) 326-7361

Doctor's address	City
BOX 1600 MEMORIAL AVE	ORILLIA

Province	Country	Postal code
ONTARIO		L3V 6L2

Please tell us where you see this doctor.

a. ☑ Office (address) SEE ABOVE.

b. ☐ Out Patient Clinic (Name and address) _____

c. ☐ Hospital (Name and address) _____

Why do you see this doctor? FACILITY PHYSICIAN

Doctor #2

Doctor's last name	first name	Initial	Telephone number
			( )

Doctor's address	City

Province	Country	Postal code

Please tell us where you see this doctor.

a. ☐ Office (Address) _____

b. ☐ Out Patient Clinic (Name and address) _____

c. ☐ Hospital (Name and address) _____

Why do you see this doctor? _____

If there is not enough space to list all of your doctors, please use another sheet of paper and answer the same questions.

F. Declaration

- I agree to the Medical Adjudicators getting information about my disability or disabilities from the doctors I have listed. This information can include diagnosis, medical restrictions, impairments, treatment and rehabilitation programs.
- I understand the *Family Benefits Act* allows this information to be collected.
- I understand this information will be used to determine if I am eligible for any benefits under the *Family Benefits Act.*
- The information that I have provided in this form is complete and accurate to the best of my knowledge.
- I agree to let the Ministry of Community and Social Services know of any changes in my medical condition.

- **The information I have provided in this form is complete and accurate to the best of my knowledge.**

X _____ Signature/mark of applicant/recipient/trustee

_____ Date (day, month, year)

( ) _____ Telephone no.

X [redacted] The person helping the applicant/recipient to complete this form

22/07/97 Date (day, month, year)

(705) 326-7361 Telephone no.

H.R.C. SOCIAL WORKER.

X _____ Signature of witness

_____ Date (day, month, year)