



United Counties of Leeds and Grenville

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Powered Mobility Device Registration Form

The United Counties of Leeds and Grenville Housing Department supports tenants' right to full integration in and participation in their housing community without discrimination. It is the policy of the Housing Department to allow tenants the use of powered mobility devices within public housing to meet their mobility needs. As such, only tenants with a medical mobility need will be permitted to store a powered mobility device indoors due to the fire-risk.

A "powered mobility device" is defined as either a battery powered personal mobility device with three or more wheels that is steered manually, or a powered wheelchair-type device controlled by a joystick, and is intended for indoor and outdoor use.

Instructions:

- 1. Please complete the below registration and responsibilities form to request approval to have a mobility device stored in your unit.
2. The enclosed Powered Mobility Device Medical Verification Form must be completed and attached to verify that the device is medically required.
3. Make or request a copy of the form for your records and reference.

Electric Vehicle Information
Tenant Name: _____
Address: _____ Phone Number: _____
Make and model of the mobility device: _____
Weight: _____ Width: _____ Depth: _____ Height: _____
Battery Type: wet cell [] dry cell []
Turning Radius: _____
Does the chair adjust to fit in smaller spaces? [] Yes [] No

Powered Mobility Device Tenant Responsibilities

If my powered mobility device is approved to be stored within my public housing unit, I understand and agree to the following terms and conditions:

- 1. It is strongly recommended that the tenant purchase and maintain insurance that will include liability insurance in case of either damage to the building or injury involving other people who may be living in or visiting the building. Contact your Case Manager for information about the Housing Services Corporation low-cost tenant insurance.

Note: If you are in receipt of Ontario Works or Ontario Disability Support benefits you may be able to have the cost of tenant insurance included in your shelter costs. Contact your Case Manager for further information.

- 2. I am expected to have care and control of my powered mobility device at all times. Anyone using these devices on Counties property will give right of way to any pedestrian and those with disabilities, and will travel at a reasonable, safe, and prudent speed.

Operators of such devices assume all liability associated with such devices, such as damages to properties or persons.

Powered Mobility Device Medical Verification Form

Tenant Name: _____ Date of Birth: _____

Consent to Release Information

I hereby authorize my physician _____ to release and clarify the following medical and related information requested in this Powered Mobility Device Medical Verification Form, to the United Counties of Leeds and Grenville (Leeds Grenville), Community and Social Services Division. I understand that such information will be used to verify my request for housing accommodation to address my disability or medical condition. The use and disclosure of the personal health information by Leeds Grenville is subject to the *Housing Services Act, 2011*, the *Health Information Protection Act* as applicable, and the *Municipal Freedom of Information and Protection of Privacy Act*.

Tenant Signature

Date (mm/dd/yy)

Important Notice to the Physician

The person herein as tenant has requested an accommodation to use and store a powered mobility device (e.g. scooter or wheelchair) in their unit. Due to the associated fire risk, only tenants with a verified medical need will be permitted to store a powered mobility device indoors. The information you provide will be used to determine:

- if the powered mobility device may be stored in the tenant's unit;
- if the tenant will transfer to a ground floor unit;
- if the tenant will transfer to another building/unit; or
- if the tenant is able to store the powered mobility device in a designated location outdoors.

Medical Information

	Yes	No
1. Does the tenant have a disability or health condition that requires the use of a powered mobility device (e.g. power wheelchair or mobility scooter) for activities of daily living?	<input type="checkbox"/>	<input type="checkbox"/>
2. Intended use of the mobility device: select all that apply	<input type="checkbox"/>	<input type="checkbox"/>
a) Home (indoors)	<input type="checkbox"/>	<input type="checkbox"/>
b) Home (outdoors)	<input type="checkbox"/>	<input type="checkbox"/>
c) Community – shops, appointments, work	<input type="checkbox"/>	<input type="checkbox"/>
d) Other – specify _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the specific health issue(s) that affects mobility long-term (6 months or longer) or permanent?	<input type="checkbox"/>	<input type="checkbox"/>

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	Yes	No
4. Considering the building information indicated below, is the tenant able to safely walk from their buildings parking lot to their unit without their powered mobility device?	<input type="checkbox"/>	<input type="checkbox"/>
a) Does the tenant require a first floor unit or a unit that is in a building that has a lift/elevator?	<input type="checkbox"/>	<input type="checkbox"/>
b) Could the tenant safely climb a flight of stairs?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
5. Standard sized public housing units can accommodate powered mobility devices that are 29" wide or smaller without modifications or adaptations. Will a powered mobility device of standard size met the tenant's needs?	<input type="checkbox"/>	<input type="checkbox"/>
If no, please explain size requirements for device needed in the space provided:		

4. Please provide any additional information that might be helpful:

PLEASE INCLUDE THE DOCTOR'S STAMP

Physician's Signature: _____	Date: _____ <small>(mm/dd/yyyy)</small>
Name: _____	
Address: _____	
Postal Code: _____	Phone Number: _____

For Office Use Only	
<input type="checkbox"/>	Approved with the following additional conditions listed (if applicable):
<input type="checkbox"/>	Denied due to the following reasons:
_____	_____
Program Supervisor Signature	Date