



Verification of Disability or Medical Condition

Applicant/Tenant Name: _____

Date of Birth: _____
(mm/dd/yyyy)

CONSENT TO RELEASE MEDICAL INFORMATION

I hereby authorize my physician _____ to release and clarify the following medical and related information requested in this Verification of Disability or Medical Condition, 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 specific 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*.

Applicant/Tenant Signature

Date (mm/dd/yyyy)

IMPORTANT NOTICE TO THE PHYSICIAN

The person named herein as applicant/tenant has applied for a modified/partially modified unit, an additional bedroom for medical reasons, or an accommodation. The information you provide will assist us in assessing the application and the applicant/tenant's ability to live independently. This information is to be used in connection with the applicant/tenant's request for:

- a transfer to a ground floor unit;
- a transfer to another building/unit;
- a modified unit;
- an additional bedroom for medical reasons;
- absence from the unit for more than 90 days due to medical reasons;
- an accommodation due to a disability.

Please be specific in your evaluation, as the information you provide will assist us in determining eligibility and suitability of accommodations to meet the applicant/tenant's needs. Please complete and sign this report and return it to the applicant/tenant for submission to his/ her Housing Case Manager.

MEDICAL INFORMATION

1. Specify the disability/health issue(s) that requires accommodation(s):

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	Yes	No
2. Is the specific health issue(s) identified above permanent?	<input type="checkbox"/>	<input type="checkbox"/>
<p>a) If yes, explain how these specific health issue(s) can be improved by more suitable housing and what is required to make the housing suitable?</p> <div style="border: 1px solid black; height: 150px; margin-top: 5px;"></div>		
<p>b) If no, how long would you anticipate the health issue(s) to impact on the ability of the applicant/tenant to live independently in their current accommodations?</p> <div style="border: 1px solid black; height: 150px; margin-top: 5px;"></div>		

3. Does the applicant/tenant have any specific housing requirements? Please identify below:					
	Yes	No		Yes	No
Wheelchair accessible?	<input type="checkbox"/>	<input type="checkbox"/>	Lowered cabinets?	<input type="checkbox"/>	<input type="checkbox"/>
Lowered counters?	<input type="checkbox"/>	<input type="checkbox"/>	Front stove controls?	<input type="checkbox"/>	<input type="checkbox"/>
Roll-in shower?	<input type="checkbox"/>	<input type="checkbox"/>	Strobe lights?	<input type="checkbox"/>	<input type="checkbox"/>
Roll-under sinks?	<input type="checkbox"/>	<input type="checkbox"/>	Unable to do stairs?	<input type="checkbox"/>	<input type="checkbox"/>
Lowered light switches?	<input type="checkbox"/>	<input type="checkbox"/>	Other (Specify):	<input type="checkbox"/>	<input type="checkbox"/>

Other:

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	Yes	Yes, with assistance*	No
4. (a) In your medical opinion is the applicant/tenant able to live independently? <i>*If with assistance, please identify the assistance required and who will provide same.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
4. (b) Is a caregiver required between the hours of 11 p.m. and 7 a.m. on an ongoing basis?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
5. Is an additional bedroom required for the storage of equipment/medical supplies? <i>If yes, please explain: Note: Medical equipment does not include a scooter, a sleep apnea machine or exercise equipment.</i>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
6. Does applicant/tenant require a separate bedroom from spouse/partner due to a diagnosed medical condition? <i>If yes, please explain:</i>	<input type="checkbox"/>	<input type="checkbox"/>

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

PLEASE INCLUDE THE DOCTOR'S STAMP

Physician's Signature: _____ Date: _____
(mm/dd/yyyy)

Name: _____

Address: _____

Postal Code: _____ Phone Number: _____

FOR OFFICE USE ONLY

Approved By: _____ **Date:** _____
Case Manager's Name (mm/dd/yyyy)