Community and Social Services Division
Housing Department

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 provide the United Counties of Leeds and Grenville (UCLG), Community and Social Services Division, with medical information limited to the verification of my disability or medical condition and the functional limitations or restrictions related to my request for accommodation.

I understand that this information will be used to assess my request for housing accommodation. UCLG will use this information to determine reasonable accommodation(s) that may be required to address disability-related barriers.

The collection, use and disclosure of the personal health information by UCLG will be completed in accordance with applicable legislation, including 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 above has requested a housing accommodation due to a disability or medical condition.

The role of the physician is to provide information regarding:

- The diagnosed medical condition(s), disability or health-related limitations;
- The functional limitations or restrictions due to the condition;
- The impact of these limitations on the individual's ability to safely and independently access or use their current housing;
- The expected duration of the limitations or restrictions.

The physician is not required to recommend a specific housing unit, building, or accommodation. The Housing Provider will review the medical information provided and determine reasonable and appropriate options.

Please provide only information relevant to the accommodation request.

MEDICAL INFORMATION

1. Does the applicant/tenant have a medical condition or disability that results in functional limitations requiring consideration for a housing accommodation?

   ☐ **Yes**

   ☐ **No**

   a) If yes, please describe the relevant functional limitations or restrictions (do not provide unnecessary medical details):

2. Is the limitation or restriction:

   ☐ **Permanent**

   ☐ **Temporary**

   a) If temporary, please indicate the expected duration:

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3. How do the identified limitations or restrictions impact the applicant/tenant's ability to use or access their current housing?

4. Are there specific functional housing related barriers that should be considered?

   ☐ **Yes**
   ☐ **No**

   Please identify the barrier(s):

   ☐ **Stairs**
   ☐ **Mobility limitations** _____
   ☐ **Accessibility barriers** _____
   ☐ **Other:** _____
   _____
   _____
   _____
   _____

5. In your medical opinion, is the applicant/tenant able to live independently?

   ☐ **Yes**
   ☐ **Yes, with support**
   ☐ **No**

   If supports are required, identify the type of support required (do not identify service providers unless relevant):

   _____
   _____
   _____
   _____

6. Is overnight caregiver support medically required on an ongoing basis?

   ☐ **Yes**
   ☐ **No**

   If yes, please explain the functional reasons:

   _____
   _____
   _____
   _____

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7. Is additional space required due to medically necessary equipment or supplies?

   ☐ **Yes**
   ☐ **No**

   If yes, please describe the equipment/supplies and the functional need:

   _____
   _____
   _____
   _____

   Note: This does not include personal preference items, recreational equipment or standard household items, or the storage of motorized mobility devices.

8. Is a separate bedroom medically required due to a disability or medical condition?

   ☐ **Yes**
   ☐ **No**

   If yes, please explain the functional reason:

   _____
   _____
   _____
   _____

PLEASE INCLUDE THE DOCTOR'S STAMP

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

Name: _____

Address: _____

Postal Code: _____ Phone Number: _____

FOR OFFICE USE ONLY

The Housing Provider will review the medical information provided and determine reasonable accommodation options based on:

O Verified disability-related limitations/restrictions
O Housing availability
O Applicable Policies and legislation
O available reasonable accommodation options

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