Social Housing Registry Program
362 Montreal Street
Kingston, ON K7K 3H5

Telephone: 613-546-2695
Fax: 613-546-2623
Email: theregistry@cityofkingston.ca

Housing and Social Services Department
City of Kingston

Verification of Disability or Medical Condition for A Modified or Additional Bedroom

This form must be completed by:

- **A physician or nurse practitioner licensed to practice in Ontario; or**
- **An Occupational Therapist or Physiotherapist regulated under the Regulated Health Professionals Act (1991) who is in good standing with their regulatory body and hold a current registration number.**

_____	_____	_____
Applicant: Last Name	First Name	Date of Birth

Consent to Release Medical Information

I hereby authorize _____ to release and disclose the
(Print Name of Health Care Professional)

information requested in this Verification of Disability or Medical Condition form to the Social Housing Registry with the City of Kingston. I understand that this information will be used to verify my request for specific housing accommodations to address my medical condition.

Name of applicant: _____
(Print Name)

Signature: _____

Date: _____

Notice with Respect to the Collection of Personal Information

Personal information contained as defined by the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA), including (but not limited to): names, addresses, and phone numbers, in this form or in attachments, is collected by the Social Housing Registry Program pursuant to the *Housing Services Act 2011*, Personal Health Information Protection Act 2004 (as applicable), and will be used only for the purpose of evaluating the household's eligibility for a modified unit due to disability or medical condition under local occupancy standards. Freedom of Information and Protection of Privacy Act (R.S.O. 1990 c. F31) or the Municipal Freedom of Information and Protection of Privacy Act (R.S.O. 1990 C.m.56). Pursuant to the Provincial/Municipal Freedom of Information and Protection of Privacy Act, I give my consent to: disclose the information given on this form to non-profit housing corporations, co-operatives, municipal department, and agencies that assist in the provision of affordable housing and social agencies providing social assistance to me and persons listed in this application.

Questions about this collection should be directed to the Manager of Social Housing Registry Program: 362 Montreal Street, Kingston, ON K7K 3H5

This form can be returned to any one of the following locations:

Social Housing Registry Program	**Rural Access Point at Loughborough Housing Corporation**	**Rural Access Point at North Frontenac Non-Profit Housing Corporation** ****please call ahead to ensure the office is open****
362 Montreal Street Kingston, ON K7K 3H5 Tel: 613-546-2695	4377 William Street, Box 400 Sydenham, ON K0H 2T0 Tel: 613-376-3686	1020 Elizabeth Street Sharbot Lake, ON K0H 2P0 Tel: 613-279-3366

Important message to Health Care Professional:

Please complete and sign this form and return it to your patient/client, or mail or fax it to the Social Housing Registry Program at the address/number provided.

The Applicant listed on this form is requesting a modified housing unit to assist them due to a disability or medical condition. The information you provide will assist us in assessing the application and the applicant's ability to live independently.

Medical Information

1. Please specify the of this patient/client's disability or medical condition(s) that requires accommodation(s).

_____

_____

_____

2. Is the disability or medical condition identified above permanent? YES ◯ NO ◯

3. Is the disability or medical condition likely to continue? Less than a year ◯ More than a year ◯

4. How can these specific health condition(s) be improved by more suitable housing and what is required to make the housing suitable?

_____

_____

_____

5. Does your patient/client use/require a wheelchair? YES ◯ NO ◯

If not, can your patient/client climb stairs? YES ◯ NO ◯

If yes, explain how many flights of stairs: _____

6. What other devices does your patient/client use? i.e., Scooter, Walker

_____

_____

_____

7. What unit modifications do you feel would assist or are required for this patient/client?

	Will assist	Required	Not needed
Wheelchair adjusted heights	◯	◯	◯
Lowered switches and outlets	◯	◯	◯
Lowered cabinets/counters	◯	◯	◯
Front stove controls	◯	◯	◯
Roll in shower	◯	◯	◯
Other (specify):	◯	◯	◯

Request for Additional Bedroom – Spouse or Equipment Storage

Occupancy standards are used to determine the size of unit (number of bedrooms) a household qualifies for when applying for and residing in subsidized units.
Households may qualify for an additional bedroom if a spouse who would normally share a bedroom requires a separate bedroom because of a disability or medical condition(s).
An additional bedroom may also be provided to store equipment that a household member may need based on physical disability. For example, a hospital bed, an electric wheelchair, or a scooter.

8. Does your patient/client require a separate bedroom for a spouse due to a diagnosed medical condition? YES ◯ NO ◯
If yes, please explain: _____

_____

_____

9. Is an additional bedroom required for the storage of equipment/medical supplies? YES ◯ NO ◯
If yes, please explain what type of equipment is required:

_____

_____

_____

10. Does the patient currently own the equipment listed above? YES ◯ NO ◯

11. In your medical opinion, is the applicant able to live independently?
YES ◯ NO ◯ With Supports ◯
If with supports, identify what supports are required and who will provide the supports?

_____

_____

_____

12. Is a caregiver required between the hours of 11 pm and 7 am on an ongoing basis?
YES ◯ NO ◯

_____

_____

_____

13. Please provide any additional information that might be helpful.

_____

_____

_____

Name (please print)	Profession	Agency/ Organization
Address		Telephone Number
City/Town	Postal Code	Fax Number
Signature of Health Care Professional		Date