Region of Peel
working with you

Housing Client Services -Medical Application Form for a Restriction due to a Medical Condition

IMPORTANT INFORMATION FOR PHYSICIANS AND THEIR PATIENTS

Your patient has applied for community housing under the *Housing Services Act* (HSA) through the Region of Peel and is requesting to add a restriction to the type of unit/building for which they may be eligible.

Unit/building restrictions may be added if the requested restriction is related to a medical condition that is validated by the applicant's health care practitioner. Examples of restrictions that will require medical verification include heights, balconies, flooring type, parking (under/above ground only), or view/proximity or specific direction or location of the unit/building.

While on the centralized wait list, the medical restriction belongs to the individual to whom it is assigned, not the household. Restrictions due to medical conditions that are temporary in nature will not be approved.

When completing the questions on this form, please use plain language, print all comments and refrain from using abbreviations or acronyms.

Housing Client Services does not provide support services. If support services are required for activities of daily living, those services must be in place to be eligible for subsidized housing. Activities of daily living are everyday functions and activities individuals normally perform. These include: bathing, eating, dressing, ambulation and toileting.

Note: Your patient is responsible for any payments related to the completion of this form.

Patient's Consent and Release of Information

I understand that Housing Client Services will be receiving my personal health information to determine my eligibility for a unit/building restriction.

☐ YES ☐ NO

I authorize my physician to release the information requested on this form and I consent to Housing Client Services using, verifying and retaining this information on my centralized wait list file.

☐ YES ☐ NO

Patient's Name (print)	Unique Key
Patient's Address	
Patient's Signature	Date (mm/dd/yyyy)

Housing Client Services
10 Peel Centre Dr. Suite B, P.O. Box
2800, Brampton, ON, L6T 0E7
Phone: 905-453-1300
https://peelregion.ca/housing/

THE FOLLOWING INFORMATION MUST BE COMPLETED BY THE PATIENT

1. What is the restriction due to a medical condition that you are requesting?

2. Is the above restriction currently in place where you live? ☐ YES ☐ NO

   If **'NO'**, provide details on how you are managing:

3. Do you currently require support services? ☐ YES ☐ NO

   If **'YES'**, provide details on how you are managing:

4. Do you currently have support services in place to help manage your activities of daily living? ☐ YES ☐ NO

   If **'YES'**, please list all supports/agencies currently in place:

Agency Name

Agency Contact Person

Telephone

NOTE: If support services for activities of daily living are required, contact your local community agency.

THE FOLLOWING INFORMATION MUST BE COMPLETED BY THE PHYSICIAN

Information of the person who is requesting the restriction due to a medical condition:

Patient's Name (print) _____

Patient's Date of Birth (mm/dd/yyyy) _____

1. Is this patient currently able to manage the activities of daily living without assistance? ☐YES ☐NO
   (see page 1 for explanation of 'activities of daily living')

   a) If **'NO'**, indicate what supports the patient requires:

_____

   b) Are the above noted supports currently in place? ☐YES ☐NO

2. Does your patient require the requested restriction because of a medical condition? ☐YES ☐NO

   If **'YES'**, indicate the medical condition and explain why the restriction is required:

_____

3. Is the requested restriction to accommodate a permanent condition? ☐YES ☐NO

4. Is an accommodation for the requested restriction currently in place for the patient? ☐YES ☐NO

If 'NO', to question #4, please provide details on how the patient is currently managing:

NOTE: If support services for activities of daily living are required, please refer your patient to their local community agency.

Physician's Release of Information

I hereby certify that this information represents my best professional judgement and is true and correct to the best of my knowledge.

Physician's Name (print) _____ Contact Number _____

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

Physician's stamp	

Statement of Disclosure

The personal health information disclosed on this form will be used only for the purposes of determining an applicant's eligibility for a medical priority and is collected under the authority of the Housing Services Act, 2011 S.O. 2011 c. 6.

In applying for a medical priority, the applicant; who is in receipt of or applying for rent-geared-to- income assistance; consents to the collection, use and disclosure of the information on this form (including verification of the information) provided to Housing Client Services in their application or supporting documents.

Questions about the collection, use or disclosure of personal information, should be directed to The Regional Municipality of Peel, Human Services Department, Supervisor, Document Services, 10 Peel Centre Drive, Suite B, P.O. Box 2800, STN B, Brampton, ON L6T 0E7, or by telephone at 905-791-7800, extension 3577.