**Complete and return this form by mail or in person**:
Halton Access to Community Housing (HATCH)
Housing Services Division
Social & Community Services Department
690 Dorval Drive, 7th Floor
Oakville, ON L6K 3X9

# MEDICAL FORM

**Request form for:**

- **Medical Priority (Terminal Illness) - Section B**
- **Wheelchair Accessible Unit – Section C**
- **Additional Bedroom – Section D**

## TO BE COMPLETED BY PATIENT (Section A)

## Section A - Patient Information:

Name: Date of Birth:

Address:

| **Release by Patient**: I hereby authorize my physician to release the following medical information to the Region of Halton – Halton Access to Community Housing (HATCH) and I understand that the information will be confidentially retained in my file. | |
|---|---|
| Patient's Signature: | Date: |

The personal health information disclosed on this form will be used only for purposes of determining an applicant's eligibility for an additional bedroom and is collected under the authority of the *Housing Services Act, 2011*. In applying for rent-geared-to-income housing and/or the applicant's request for an additional bedroom, medical priority or a wheelchair accessible unit, the applicant consents to the collection, use and disclosure, including verification, of the information provided to Halton Region in their application and supporting documents.

## TO BE COMPLETED BY PHYSICIAN (Sections B, C or D)

**Please print clearly**

**Important Note:** Your patient has applied for community housing or a transfer on medical grounds for a terminally ill priority, wheelchair accessible unit and/or an additional bedroom. The information provided by you will assist us in assessing their application to determine if our accommodation will meet the needs of your patient. Please complete section B for terminal illness priority, section C wheelchair accessible requests and/or section D for requests for additional bedroom(s).

Please note that we will only assign an additional bedroom under the following circumstances:

- A member of the household is pregnant.
- One of the spouses/partners requires a separate bedroom due to a significant disability or diagnosed chronic (long-term) and serious medical condition with permanent symptoms.
- An extra bedroom is required to store life sustaining assistive devices or medical equipment that is required due to a significant disability or diagnosed chronic (long-term and serious medical condition and the equipment cannot be accommodated elsewhere in the unit (e.g. dialysis machine).
- To accommodate a caregiver, who will reside with the household full time for the purpose of providing required daily and/or overnight support services to a member of the household with a significant disability or a diagnosed chronic (long-term) and serious medical condition. (Note: The caregiver cannot be a relative and cannot maintain accommodation elsewhere).

If you believe that any of the above criteria apply to your patient, please complete the appropriate section of this form.

## Section B - Request for Medical Priority due to Terminal Illness

| **Please answer the following questions:** |
|---|
| Life expectancy is ☐ Less than two years ☐ More than two years |
| Diagnosis of illness: |
| Please provide any additional information that may be helpful: |

***Note:*** For Sections C or D - A medical diagnosis does not have to be disclosed, only a description of the nature of the disability/medical condition that confirms there is a medical need for a wheelchair accessible unit and/or an additional bedroom.

Housing Services Division
The Regional Municipality of Halton
690 Dorval Drive, 7th Floor, Oakville, ON L6K 3X9
Tel (905) 825-6000 1-866-442-5866 Toll Free Fax (905) 825-8274

## Section C - Request for a Wheelchair Accessible Unit

| **Please answer the following questions:** |
|---|
| Is the patient in a wheelchair? ☐ Full-time ☐ Part-time ☐ Does not use one |
| Is the patient's condition ☐ Permanent ☐ Temporary |
| If the patient's condition is temporary, what is the expected duration? |
| Please provide any additional information that may be helpful: |

## Section D - Request for an Additional Bedroom

**Please check of the applicable reason(s) your patient is requesting an additional bedroom and provide the required information.**

☐ **Medical Condition/Disability**

**Note**: Under Halton Region's approved Policy, an additional bedroom will not be granted for the following:

- snoring/sleep Apnea
- frequent night time waking or insomnia
- temporary medical conditions
- exercise equipment

- Is the diagnosed medical condition/disability significant and permanent or expected to continue for an indefinite period?

  Yes ☐ No ☐ If No, what is the expected duration? _____

- Can the patient safely navigate stairs? Yes ☐ No ☐

Housing Services Division
The Regional Municipality of Halton
690 Dorval Drive, 7th Floor, Oakville, ON L6K 3X9
Tel (905) 825-6000 1-866-442-5866 Toll Free Fax (905) 825-8274

- Please describe the nature of the disability/medical condition and why having an extra bedroom will contribute to your patient's overall well being and management of this serious medical condition or disability.

_____

_____

_____

_____

_____

_____

☐ **Pregnancy**

- Please state the expected due date: _____
  Y/M/D

☐ **Storage of Medical Equipment** (e.g. dialysis equipment)

- What medical equipment or life sustaining assistive devised require additional storage space as they cannot be accommodated elsewhere in the unit due to the size of the unit or storage space within the unit?

_____

_____

_____

_____

Housing Services Division
The Regional Municipality of Halton
690 Dorval Drive, 7th Floor, Oakville, ON L6K 3X9
Tel (905) 825-6000 1-866-442-5866 Toll Free Fax (905) 825-8274

☐ **Caregiver – Overnight accommodation of an individual to provide support services that are required due to a medical condition/disability.**

An additional bedroom may be granted if an overnight caregiver is required to assist with the patient's medical condition/disability and does not maintain a residence elsewhere.

- Is your patient able to manage the activities of daily living without assistance?

  Yes ☐ No ☐ If No, what services are required?

  _____
  _____
  _____

- Does your patient require over night care?

  Yes ☐ No ☐ If Yes, how many nights per week? _____

Please provide any additional information that may be helpful:

## Physician's Release

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

PLEASE PROVIDE DOCTORS STAMP

_____
Physician's Name (Printed)

_____
Physician's Signature

_____
Phone Number

Housing Services Division
The Regional Municipality of Halton
690 Dorval Drive, 7th Floor, Oakville, ON L6K 3X9
Tel (905) 825-6000 1-866-442-5866 Toll Free Fax (905) 825-8274