MEDICAL VERIFICATION FORM

For office use only:

Tenant #: ____________________

Patient Name:_______________________________________

Address: ____

____ Telephone: ________________

Consent and Release from Patient

I hereby authorize my physician to release any medical information to the Regional Municipality of York, Community and Health Services Department and Housing York Inc.

I hereby give permission for this information to be retained on file by the Regional Municipality of York, Community and Health Services Department and Housing York Inc.

___________________________ ___________________

Patient's signature Date

Important Note to Physicians:

Your patient is requesting a transfer from one rental unit to another. A transfer request for medical reasons falls into one of the following categories. Please check the appropriate box and complete the corresponding section:

☐ Part A : Additional Bedroom Request

☐ Part B: Modified Unit

☐ Part C: General Health & Well Being Request

PART A: ADDITIONAL BEDROOM REQUEST

Your patient is requesting an additional bedroom, they may qualify if:

a) Spouses cannot share a bedroom due to a disability or medical concern
b) Additional space is required to store medical equipment needed because a member of the household has a disability or significant medical condition.

1) Does your patient have a medical condition that will adversely affect the health of one or both spouses by sharing a bedroom?

Yes ❒ No ❒

1a) If yes, please explain how separate bedrooms would improve the patient's prognosis.

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2) As a result of the medical condition does the patient require space to store medical supplies or medical equipment? Yes ❒ No ❒

If yes, please check the boxes that apply:

- ❒ Commode chair
- ❒ Oxygen tanks
- ❒ Hover lift
- ❒ Nebulizer/compressor
- ❒ Scooter
- ❒ Walker
- ❒ Wheelchair
- ❒ Other (please explain):__________________

PART B: MODIFED UNIT REQUEST

Your patient is requesting an accessible unit which will have varying degrees of modifications (i.e. widened doorways, hallways, roll-in shower, etc…)

1) Does your patient require a mobility aid (e.g. wheelchair, scooter, walker)?

Yes ❒ No ❒

2) In what situations does your patient use the mobility aid? Please explain.
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3) Does your patient have a deteriorating medical condition that will increase the need for unit modifications? If yes, please explain.
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PART C: GENERAL HEALTH & WELL BEING REQUEST

Your patient is requesting a transfer to a different unit due to medical reasons.

1) How is the patient's existing unit having an adverse affect on the patient's health?
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2) Please explain how a transfer to a different unit would improve the patient's prognosis?
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Physician's Release: I hereby certify that this information represents my best professional judgment and is true and correct to the best of my knowledge. ____________________________ Contact Tel # Physician's Name (printed) ________________ _____________________________ Physician's signature	SPACE FOR PHYSICIAN'S STAMP

The personal health information disclosed on this form will be used only for the purpose of determining a tenant's eligibility for an internal transfer and is collected under the authority of the Social Housing Reform Act, 2000. In applying for a transfer to another rent-geared-to-income unit,, the applicant consents to the collection, use and disclosure, including verification, of the information provided to the Regional Municipality of York in their application or supporting documents.