Application

Medical Request for a Wheelchair Modified Unit

Section 1: Main Applicant Information

First Name		Last Name
Telephone Number		Application Number
Street Number	Street Name	Suite/Unit Number
City/Town	Province	Postal Code

Section 2: Patient Consent

(if the Patient is less than 16 years of age, a parent or guardian must complete and sign this section)

I understand that Housing Connections requires the requested information to determine my eligibility for a modified unit. I authorize my physician to release the information requested on this form to Housing Connections, and I consent to Housing Connections using, verifying, and retaining this information on my housing file.	
Patient Name (First, Last - if different from Main Applicant)	
Patient or Parent/Guardian Signature	Date (yyyy-mm-dd)

Important note to Health Care Providers and their Patients

Modified units may have:

- Widened doorways and hall space, roll-in showers, grab bars, modified kitchen appliances, lowered counters and increased size of bathroom for turning radius to accommodate residents who are confined to a wheelchair.
- Units may have varying degrees of modifications and accessibility depending on the housing provider.
- Accessible buildings are defined by grade level access to accommodate scooters, walkers, or wheelchairs. Scooters or walkers (as defined in the Housing Services Act, 2011) do not qualify an applicant for a modified unit.

Activities of daily living are considered to be everyday functions and activities individuals normally perform. This includes bathing, eating, dressing, ambulation and toileting.

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Section 3: Description of Need for Modified Unit (To be completed by Physician/Health Care Provider)

Patient's Name (First, Last - if different from Main Applicant)
How many years has this patient been under your care?
☐ Yes ☐ No Is the patient in a wheelchair?
If yes, the patient is in a wheelchair ☐ Full Time ☐ Part Time
How long is the patient expected to be in a wheelchair on a full time basis?
What modification to their accommodation does the patient require to manage daily activities?
☐ Yes ☐ No Is your patient able to manage daily activities without assistance?
If no, what supports/services does your patient need?
☐ Yes ☐ No Are these supports/services currently in place?

Section 4: Physician/Health Care Provider Verification

I certify that this information represents my best professional judgement and is true and correct to the best of my knowledge.	
First Name	Last Name
Telephone Number	Signature
Date (yyyy-mm-dd)	

Please return this completed form by Mail or Drop off in person to:
Access to Housing
Housing Connections
176 Elm Street
Toronto, ON
M5T 3M4

Shelter, Support & Housing Administration collects the personal information on this form under the legal authority of the City of Toronto Act, S.O. 2006, Chapter 11, Schedule A, s.136(c) and the Housing Services Act, 2011, S.O. 2011, c. 6, Schedule 1, ss 13, 44 and 60. The information is used to determine the eligibility for a modified unit due to a medical reason. Questions about this collection can be directed to Project Manager, Access to Housing (Housing Connections) 176 Elm Street, Toronto Ontario M5T 3M4 or by telephone at 416-397-7400.