## Instructions

This form is required for rent-geared-to-income (RGI) households who wish to have withdrawals, payments or gifts excluded from their income for the purposes of their RGI rent calculations, specifically expenses falling under *O. Reg. 298/01 S. 50 (3) subsection 57*:

*"57. Payments from a trust or life insurance policy or gifts or other voluntary payments that are applied to,*

*i. expenses for items or services that are needed for a member of a household because of that member’s disability and that are not and will not be otherwise reimbursed"*

For the purposes of this form, a person with a disability is as defined in the *Ontario Disability Support Program Act, 1997*, as follows:

***"4*** *(1) A person is a person with a disability for the purposes of this Part if,*

1. *the person has a substantial physical or mental impairment that is continuous or recurrent and expected to last one year or more;*
2. *the direct and cumulative effect of the impairment on the person’s ability to attend to his or her personal care, function in the community and function in a workplace, results in a substantial restriction in one or more of these activities of daily living; and*
3. *the impairment and its likely duration and the restriction in the person’s activities of daily living have been verified by a person with the prescribed qualifications.  1997, c. 25, Sched. B, s. 4 (1)."*

This form must be completed by a qualified Health Care Professional who knows the applicant well enough to comment on their disability or impairment.

The following qualified Health Care Professionals may complete this form:

* Family doctor or other physician, including psychiatrist
* Physiotherapist
* Optometrist
* Audiologist
* Psychologist or Psychological Associate
* Chiropractor
* Occupational Therapist
* Speech Language Pathologist
* Registered Nurse

**Please return this completed form by Mail or Drop off in person to:**

**<Insert name and address of housing provider>**

## Purpose of Collection

The personal information disclosed on this form will be used only for the purpose of evaluating the exclusion of certain income when calculating the household's RGI rent under the *Housing Services Act, 2011,* specifically *O. Reg. 298/01 S. 50(3) subsection 57*. This personal information may also be disclosed to the City of Toronto, solely for the purpose of evaluating compliance with *O. Reg. 298/01 S. 50(3) subsection 57*. Additionally, the information may be shared as necessary for the purpose of making decisions or verifying eligibility for assistance under the Act, the *Ontario Disability Support Program Act, 1997*, the *Ontario Works Act, 1997* or the *Child Care and Early Years Act, 2014.* The use and disclosure of the personal information in this report will be subject to:

* the *Housing Services Act, 2011*, and
* in the case of the City of Toronto, the *Municipal Freedom of Information and Protection of Privacy Act*.

Questions about the collection, use and disclosure of this information can be directed to <insert housing provider contact information (name or job title, address, phone and email) – this should be the Privacy Officer>.

## Section 1: Primary Contact for Household

|  |  |
| --- | --- |
| First Name | Last Name |
| Address | Telephone Number |

## Section 2: Patient Consent:

*If the patient is less than 16 years of age or unable to provide consent in writing by reason of physical or mental disability, the consent must be signed by the patient’s parent, legal guardian, trustee, or power of attorney for personal care and property ("Patient Representative").*

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| --- |
| I consent to the Health Care Professional disclosing the personal health information requested on this form to <insert name of housing provider> for the purposes identified on this form. I also consent to <insert name of housing provider> disclosing this personal health information to the City of Toronto for the limited purposes stated above.  |
| Patient First Name | Patient Last Name |
| Signature of Patient or Patient Representative | Date (yyyy-mm-dd) |
| Health Care Professional Name (First, Last) | Health Care Professional Telephone Number |
| Health Care Professional Address (Street Number, Street Name, Suite/Unit Number, City/Town, Province, Postal Code) |

## Section 3: Insurance

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| --- |
| Does the household have any other insurance coverage (other than OHIP) that may pay, in part or in full, for these items or services? * Yes
* No
 |
| **If yes, please provide further details** (for example, the type of coverage, amount of coverage anticipated, etc.). |

## Section 4: Description of Services or Items Required (to be completed by Health Care Professional)

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| --- |
| What are the items or services required?  |
| Are the items or services needed for this household member's disability? * Yes
* No
 |
| What are the anticipated costs of this item or service? |

**Note:** The household may be required to submit evidence of the final expenses resulting from these items or services.

## Health Care Professional Verification

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