## Instructions

The City of Toronto has established Local Occupancy Standards for Rent-Geared-to-Income (RGI) housing. This form is required for RGI households who wish to request an additional bedroom, beyond what is permitted by the City's Local Occupancy Standards, for medical reasons.

The City's Local Occupancy Standards permit a household to qualify for an extra bedroom if:

1. A spouse who would normally share a bedroom requires a separate bedroom because of a disability or medical condition. Spouses will not normally qualify for an additional bedroom unless a second bed cannot be accommodated within a shared bedroom. A household will not qualify for an additional bedroom based on a snoring condition alone.
2. A room is required to store equipment that a member of the household needs because of a permanent disability or medical condition, and the equipment is too large to be reasonably accommodated in a unit size for which the household would normally qualify.

The following equipment will **not** normally qualify a household for an additional bedroom:

* continuous positive airway pressure (CPAP) machines
* air-filtration systems
* vaporizers or humidifiers
* walkers, wheelchairs, or scooters
* massage tables, or
* exercise equipment

1. A room is required for an individual who provides full-time overnight support services to a member of the household. When a household requests an extra bedroom for a medical reason, the housing provider must determine if the household qualifies under the Local Occupancy Standards. From time to time, the housing provider may ask for new information to verify that the household still qualifies for the extra bedroom.

This form must be completed by a qualified Health Care Professional who knows the applicant well enough to comment on their medical condition or disability that may require an additional bedroom.

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 on this form is collected under the legal authority of the *Housing Services Act, 2011, S.O. 2011, c. 6, Schedule 1, sections 42-67*.

The personal information disclosed on this form will be used only for the purpose of evaluating the household's eligibility for an additional bedroom due to a medical reason under the City of Toronto's Local Occupancy Standards under the *Housing Services Act, 2011* (HSA). This personal information may also be disclosed to the City of Toronto, solely for the purpose of evaluating compliance with the Local Occupancy Standards. Additionally, the information may be shared as necessary for the purpose of making decisions or verifying eligibility under the HSA, 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 form 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 <name of privacy officer for housing provider including name, address and phone number>.

## Section 1: Main Applicant Information

|  |  |
| --- | --- |
| First Name | Last Name |
| Applicant's 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").*

|  |  |
| --- | --- |
| 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 Professionals Telephone Number |
| Health Care Professionals Address (Street Number, Street Name, Suite/Unit Number, City/Town, Province, Postal Code) | |

## Section 3: Description of need for additional bedroom (to be completed by Health Care Professional)

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| --- |
| How long has this patient been under your care? |
| Does your patient have a medical condition or disability which makes it necessary for them to have a separate bedroom? (see the instructions on the first page of this form)   * Yes * No |
| Why does a person with this medical condition or disability need an additional bedroom? |
| What is the expected duration of this condition? |
| Is the room requested to store medical equipment?   * Yes * No |
| What is the medical equipment to be stored? |
| What are the dimensions of the medical equipment? |
| Could this equipment reasonably be accommodated in the current unit or unit size for which the household would normally qualify?   * Yes * No |
| If no, please explain why? |

## Section 4: Additional bedroom for a full-time overnight caregiver

Note: Caregiver Verification will also be required.

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| Does your patient require a full-time overnight caregiver?   * Yes * No |
| Is the need for overnight care long-term?   * Yes * No |
| What services does your patient require? |

## Health Care Professional Verification

|  |  |  |
| --- | --- | --- |
| 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) |