# Request for Additional Bedroom

Community Services and Housing Department
Housing Services Branch

*For office use only*
HAU Client # ________________

Applicant/Patient Name:

______________________________________________________

Address: ______________________________________________

Phone: ____________________

## Consent and Release from Applicant/Patient

I understand that The Regional Municipality of York requires the requested personal health information to determine my eligibility for an additional bedroom in a rent-geared-to-income (RGI) unit.

By this consent, I am hereby authorizing ________________________________ (physician's name) to disclose the information requested on this form to the Community Services and Housing Department, The Regional Municipality of York.

I hereby consent to The Regional Municipality of York collecting this information for the purpose stated above.

______________________________________ ____________________
Patient's Signature Date

## Important Note to Physicians

Your patient is requesting an additional bedroom in rent-geared-to-income (subsidized) housing. Your patient may qualify if:

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

Please complete the following sections.

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 ☐

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

   ______________________________________________________

   ______________________________________________________

   ______________________________________________________

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3. As a result of the medical condition, does the patient require space to store medical supplies or equipment?

   Yes ☐ No ☐

   If yes, please check the boxes that apply:

| | |
|---|---|
| ☐ Commode chair | ☐ Scooter |
| ☐ Oxygen tanks | ☐ Walker |
| ☐ Hoyer lift | ☐ Wheelchair |
| ☐ Nebulizer/compressor | ☐ Other (please explain) ______________________________ |

## Physician's Declaration

| | |
|---|---|
| I hereby certify that this information represents my best professional judgment and is true and correct to the best of my knowledge.<br><br>_______________________________________________<br>_______________________________________________<br>Physician's Name (printed) and Address<br><br>____________________<br>Telephone Number<br><br>______________________________ ____________________<br>Physician's Signature Date | PHYSICIAN'S STAMP |

**NOTICE**: In accordance with s.29(2) of the *Municipal Freedom of Information and Protection of Privacy Act* and s.18(1) of the *Personal Health Information Protection Act, 2004*, personal information on this form is being collected under the legal authority of the *Social Housing Reform Act, 2000* for the principal purpose of determining the applicant's eligibility for housing units. If you have questions about this collection, please contact the Manager, Housing Programs, Community Services and Housing Department, The Regional Municipality of York, at 17250 Yonge Street, Newmarket, Ontario, L3Y 6Z1 or phone 905-830-4444 ext. 2071.