Print Form

# Request for Modified Accessible Unit

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 a modified accessible unit in rent-geared-to-income (RGI) housing.

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 a modified accessible unit in rent-geared-to-income (subsidized) housing.

There are a number of social housing units in the Region that have been modified to accommodate people with physical disabilities. The units have varying degrees of modifications. Modifications may include widened doorways, roll-in showers, grab bars and door knobs. A detailed inventory of modified units is available on York Region's website at www.york.ca.

Please complete the following sections.

1. Does your patient require a mobility aid?

   Yes ☐ No ☐

   If yes, check all that apply:
   - Wheelchair ☐
   - Walker ☐
   - Scooter ☐
   - Other ☐

2. In what situations does your patient require the mobility aid? Please explain.

_____

_____

_____

3. Does your patient have a deteriorating medical condition that will increase the need for unit modifications over time?

Yes ☐ No ☐

If yes, please indicate the modifications that are expected to be required and indicate time frame:

_____

_____

_____

## 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.

_____

_____
Physician's Name (printed) and Address

_____
Telephone Number

_____ _____
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.