Request for an Additional Bedroom

Please complete and sign this request form. The information you provide will be used in connection with your request for an additional bedroom due to a disability or medical condition or conditions.

The "Verification of Disability or Medical Condition" form on page 4 and 5 of this form, must be completed and signed by:

- A physician licensed to practice in Ontario: or
- An Occupational Therapist or Physiotherapist, regulated under the *Regulated Health Professions Act, 1991* and in good standing with their regulatory body and hold a current registration number.

Before taking this form to your Health Care Professional, the "Consent to Release Medical Information" on page 3 must be signed by the household member requesting the additional bedroom and who is 16 years old or older or by a person authorized to sign on behalf of that household member.

You are responsible to pay any fee charged by the qualified person for completion of the verification form.

Notice regarding qualification for an Additional Bedroom under local Occupancy Standards:

Occupancy standards are used to determine the size of unit (number of bedrooms) a household qualifies for when applying for or residing in a subsidized unit within the Social Housing Program. Occupancy standards are generally applied based on the number of household members per bedroom.

The smallest unit a household may request is:

- 1 bedroom per 2 household members; or
- as may be permitted based on the municipal occupancy standards; and
- Spouses or partners may accept a bachelor unit.

The largest unit a household is eligible to request is:

- 1 bedroom for any 2 household members who are spouses of each other, and 1 bedroom for each additional household member.

Households may qualify for an additional bedroom if one of the spouses or partners who would normally share a bedroom requires a separate bedroom because of a disability or medical condition or conditions.

An additional bedroom may be provided to store equipment that a household member needs because of a physical disability such as a scooter, hospital bed or electric wheelchair.

An additional bedroom is not provided to accommodate a caregiver as caregivers do not live with the household on a full-time basis and continue to have another, permanent address. If the caregiver lives with the household on a permanent basis, they must be included as a member of the household for the purposes of determining eligibility.

This section is to be completed by the household member requesting the additional bedroom who is 16 years old or older or by a person authorized to sign on behalf of the household member.

Applicant/Tenant Name: Date of Birth:

Co-Applicant/Tenant Name: Date of Birth:

Current Address:

Telephone: Email:

Name of household member requesting additional bedroom:

Notice with Respect to the Collection of Personal Information:

Personal information contained in this form or in attachments is collected pursuant to the *Housing Services Act, 2011, Personal Health Information Protection Act, 2004, the Freedom of Information and Protection of Privacy Act (R.S.O. 1990 c. F31)* or *the Municipal Freedom of Information and Protection of Privacy Act (R.S.O. 1990 c. M56)*, as applicable, and will be used only to evaluate the household's eligibility for an additional bedroom due to disability or medical condition(s) under local occupancy standards.

Inquiries about this collection of information should be directed to:

The Social Housing Registry

362 Montreal Street

Kingston, ON K7K 3H5

Phone: 613-546-2695

Toll Free: 1-888-778-4531

Email: theregistry@cityofkingston.ca

Consent to Release Medical Information

I have applied for, or reside in, a subsidized unit and I am requesting a unit with an additional bedroom to accommodate my disability or medical condition. For eligibility determination, I require confirmation from my health care professional.

I understand that this information will be used for the purpose of verifying my eligibility for an additional bedroom under the *Housing Services Act, 2011,* and local occupancy standards.

I fully understand the nature and purpose of this consent and give my consent and authorization voluntarily. Please print in the following areas.

I or we, _____ hereby authorize, the health care professional

_____ to disclose the medical and related

Information requested in the attached Verification of Disability or Medical Condition

form to the following housing provider or Social Housing Registry.

_____

Date: _____

Signature: (Member of household) _____

Signature: (Member of household) _____

The information is to be used in connection with your patient's/client's request for an additional bedroom due to a disability or medical condition.

Your patient is solely responsible for any payment related to filling out this form.

Notice regarding qualification for an Additional Bedroom under local Occupancy Standards:

Households qualify for an additional bedroom if one of the spouses or partners who would normally share a bedroom requires a separate bedroom because of a disability or medical condition or conditions.

An additional bedroom may be provided to store equipment that a household member needs because of a physical disability such as a scooter, hospital bed or electric wheelchair.

An additional bedroom is not provided to accommodate a caregiver as caregivers do not live with the applicant on a full-time basis and continue to have another, permanent address. If the caregiver lives with the household on a permanent basis, they must be included as a member of the household for the purposes of determining eligibility.

Verification of Disability or Medical Condition for Additional Bedroom by Health Care Professional

Patient Full Name (Please print):_____

Patient's address:_____

1. Please describe the nature of this patients disability or medical condition or conditions

_____

_____

2. Is the disability or medical condition continuous?

   Yes ☐ No ☐

3. Is the disability or medical condition likely to continue:

   Less than 1 year ☐ More than 1 year ☐

4. Does this patient require the use of any specific medical equipment?

   Yes ☐ No ☐

5. If yes, please indicate what specific type of equipment is required:

_____

6. Does this patient currently own the equipment listed above?

   Yes ☐ No ☐

7. Does patient's disability or medical condition or conditions require him/her to have an additional or separate bedroom?

   Yes ☐ No ☐

8. If yes, please explain why an additional bedroom is required?

_____

_____

I hereby certify that this information represents my professional judgment and is true and correct to the best of my knowledge.

Signature:_____ Date:_____

Name (please print):_____

Profession:_____ Registration No:_____

Address:_____

Telephone:_____ Email:_____

Please return this completed Verification form to your patient or send it by fax or email to:

Housing Provider/Registry:_____ Fax number: _____

Email Address: _____ Attention: _____

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