Application Form for an Additional Bedroom

# Important Information for Physicians and their Patients

Your patient is residing in rent-geared-to-income (RGI) housing subsidized through the **Region of Peel** and is requesting an additional bedroom.

When completing the questions on this form please use plain language, print all comments and refrain from using abbreviations or acronyms.

Definitions of **activities of daily living** and **caregiver** are provided below:

* **Activities of daily living**: Everyday functions and activities individuals normally perform. These include: bathing, eating, dressing, ambulation and toileting.
* **Caregiver**: An individual qualified to provide support services to a member of the household to enable the member to live independently and has signed a contract to provide daily support care, including overnight care, for a member of the household. The qualified caregiver is not a relative, does not sign the lease or occupancy agreement and does not pay rent or occupancy charges.

The Region of Peel has set occupancy standards for rent-geared-to-income housing.

Under the occupancy standards a household may qualify for an additional bedroom if, because of a disability or medical condition, an additional bedroom is necessary:

* for members of the household who normally would share a bedroom, for example: spouses, same-sex partners or siblings
* to facilitate the use or storage of medical equipment required due to the disability/medical condition (e.g. hospital bed, Hoyer lift, home dialysis equipment), or
* for a caregiver who will provide overnight support services to enable the patient/household member to live independently (i.e. with support the household member is still able to perform activities of daily living including bathing, eating, dressing, ambulation and toileting).

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| **Important:** The patient will not qualify for an additional bedroom if the medical condition can be accommodated by other modifications, such as two single beds (i.e. frequent urination/bed wetting, sleep preferences/disorders including restlessness/insomnia, or chronic pain).  The following conditions and/or medical related equipment also do not qualify the patient for an additional bedroom: | |
| * CPAP machines * Exercise equipment * Guest bedroom * Walker/Scooter | * Short term condition/Not a permanent disability (i.e. recovery from surgery) * Snoring |

**Note:** Your patient is responsible for any payments related to completion of this form

# Consent and Release from Patient

I understand that the housing provider requires the requested personal health information to determine my eligibility for an additional bedroom.

☐ Yes ☐ No

I authorize my physician to release the information requested on this form to Insert name of housing provder., and I consent to Insert name of housing provder. using, verifying and retaining this information on my subsidized housing file.

☐ Yes ☐ No

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Patient’s Name (printed)

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Patient’s Signature Date *(mm/dd/yyyy)*

**Patient Information**

Before completing this form please ensure that you have read the front to understand under which circumstances an applicant is granted an additional bedroom.

**NOTE:** The privacy statement is at the end of the form.

Please print when providing the information requested below.­­­­­­­­­­­­­­­­­­­­­­­­­­­­

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­

Patient’s Date of Birth *(mm/dd/yyyy)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­

Patient’s Address\_­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_­­­­­­­­­\_­­­­­­­­­­­­­­­­­­­­­­­­­­

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| THE FOLOWING INFORMATION MUST BE COMPLETED BY THE PHYSICIAN |
| **Before completing this form please ensure that you have read the front to understand under which circumstances an applicant is granted an additional bedroom.**   1. Does the patient need a separate bedroom because of a disability or medical condition? ☐ Yes ☐ No   If YES, please explain why a separate bedroom is required for this disability or medical condition:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2) Is the separate bedroom needed to facilitate the use of medical equipment? ☐ Yes ☐ No    If YES, specify the type of medical equipment (e.g. hospital bed, Hoyer lift, home dialysis equipment) and why an additional bedroom is required for its use or storage:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Is the separate bedroom needed for an overnight caregiver? ☐ Yes ☐ No   (**Reminder:** The definition of a caregiver for the purpose of approving an additional bedroom for a rent-geared-to-income household is on page 1 of this application).   1. If you have answered NO to all of the above, please explain why an additional bedroom is required.   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Ability to Live Independently** |
| **Physician to complete**   1. Is this patient currently able to live and function independently including the ability to manage the activities of daily living without assistance? ☐ Yes ☐ No 2. If NO, explain? What support does the patient need?   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    **Patient to complete (Only if the question above was answered NO)**   1. Do you have the required supports noted above in place to help manage your activities of daily living?   ☐ Yes ☐ No  a) If YES, please list all supports/agencies currently in place:    Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Physician’s Release** | |
| I hereby certify that this information represents my best professional judgement and is true and correct to the best of my knowledge.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician’s Name (printed) Contact Telephone No.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician’s Signature Date (mm/dd/yyyy) | |
| **Physician’s**  **stamp** |  |

# Statement of Disclosure

*The personal health information disclosed on this form will be used only for the purposes of determining an applicant’s eligibility for a modified unit and is collected under the authority of the Housing Services Act, 2011 S.O. 2011 c. 6.*

*In applying for an additional bedroom, the applicant; who is in receipt of rent-geared-to-income assistance; consents to the collection, use and disclosure of the information on this form (including verification of the information) provided to*Insert name of housing provder. *in their application or supporting documents.*

*Questions about the collection, use or disclosure of personal information, should be directed to:*

* Insert name of housing provider and contact information for designated privacy officer