

**ACCOMMODATION / ACCESSIBILITY REQUEST**

If you are a current Toronto Community Housing tenant who requires an accessible unit, unit modifications, or other accommodation based on a *Human Rights Code* identified need, please have a qualified medical practitioner who is licensed to practice in Canada complete this form.

While some requests may result in a transfer to another Toronto Community Housing unit, Toronto Community Housing will always try to reasonably accommodate the need in the current unit before considering a transfer.

If you need this information in an alternative format or another language, please contact the Client Care Centre at 416-981-5500.

**Important note to licensed healthcare professionals and their patients:**

- The use of a **scooter** or **walker** does not necessarily qualify a patient for a modified unit or a transfer to another unit.
- **Modified units** provide varying degrees of modifications and accessibility depending on individual need.

**PATIENT INFORMATION**

To be completed by a qualified medical practitioner who is licensed to practice in Canada:

|    |   |
|----|---|
| 1. | <p><b>Patient details:</b></p> <p>First name: _____</p> <p>Last name: _____</p> <p>Address: _____ Unit #: _____</p> <p>Date of birth (mm/dd/yy): _____</p> <p>Parent/Guardian’s name (if patient under 18): _____</p> |
| 2. | <p>How many years has this patient been under your care? _____</p>  |

|    |  |   |  |
|----|--|---|--|
| 3. | <p>You understand and agree that you are providing your own qualified medical opinion with respect to the facts stated in this form and you understand and agree that when this form refers to a “medical reaction”, the reaction referred to is one that is outside the range of how an average person would react.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |   |  |
| 4. | <p>Please provide your medical opinion with respect to the patient’s functional abilities that are relevant and apply. Include additional details in section 6.</p> <p>If the ability is not relevant to the request, place a diagonal line through the text box.</p>  |   |  |
| a. | <p><b>Walking</b></p> <p><input type="checkbox"/> Full abilities</p> <p><input type="checkbox"/> Up to 100 metres</p> <p><input type="checkbox"/> 100-200 metres</p> <p><input type="checkbox"/> Other (specify)</p> <p>_____</p>  | <p><b>Standing</b></p> <p><input type="checkbox"/> Full abilities</p> <p><input type="checkbox"/> Up to 15 minutes</p> <p><input type="checkbox"/> 15-30 minutes</p> <p><input type="checkbox"/> Other (specify)</p> <p>_____</p>   | <p><b>Stair Climbing</b></p> <p><input type="checkbox"/> Full abilities</p> <p><input type="checkbox"/> Up to 5 steps</p> <p><input type="checkbox"/> 5-10 steps</p> <p><input type="checkbox"/> Other (specify)</p> <p>_____</p>      |
| b. | <p><b>Sitting</b></p> <p><input type="checkbox"/> Full abilities</p> <p><input type="checkbox"/> Up to 30 min</p> <p><input type="checkbox"/> 30 min-1 hour</p> <p><input type="checkbox"/> Other (specify)</p> <p>_____</p>   | <p><b>Lifting Floor to Waist</b></p> <p><input type="checkbox"/> Full abilities</p> <p><input type="checkbox"/> Up to 5 kg</p> <p><input type="checkbox"/> 5-10 kg</p> <p><input type="checkbox"/> Other (specify)</p> <p>_____</p> | <p><b>Lifting Waist to Shoulder</b></p> <p><input type="checkbox"/> Full abilities</p> <p><input type="checkbox"/> Up to 5 kg</p> <p><input type="checkbox"/> 5-10 kg</p> <p><input type="checkbox"/> Other (specify)</p> <p>_____</p> |
| c. | <p><b>Hearing:</b> able to hear in-suite and building smoke and CO alarms</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |   | <p><b>Hearing:</b> Other relevant restrictions (specify)</p> <p>_____</p>  |

|           |  |   |  |
|-----------|--|---|--|
| <p>d.</p> | <p><b>Chemicals or Scents</b></p> <p><input type="checkbox"/> No restrictions/full abilities</p> <p><input type="checkbox"/> Medical reaction triggered by scent</p> <p><input type="checkbox"/> Medical reaction triggered by touch</p> <p><input type="checkbox"/> Other (specify)<br/>_____</p>   | <p><b>Chemicals or Scents: How long after exposure does reaction subside?</b></p> <p><input type="checkbox"/> Within 5 minutes (e.g. of mopping floor)</p> <p><input type="checkbox"/> 5-15 minutes</p> <p><input type="checkbox"/> 15-30 minutes</p> <p><input type="checkbox"/> Other (specify)<br/>_____</p> | <p><b>Chemicals or Scents: Distance from patient</b></p> <p><input type="checkbox"/> Within 5 feet from areas patient occupies</p> <p><input type="checkbox"/> 5-20 feet from areas patient occupies</p> <p><input type="checkbox"/> Other (specify)<br/>_____</p> |
| <p>e.</p> | <p><b>Chemicals/Scents:</b> The following chemicals or scents cause a medical reaction (list names of chemicals and severity of reaction):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>  |   |  |
| <p>f.</p> | <p><b>Environmental exposure</b></p> <p><input type="checkbox"/> No restrictions/full abilities</p> <p><input type="checkbox"/> Medical reaction triggered by heat (specify temperature, duration and reaction)</p> <p><input type="checkbox"/> Medical reaction triggered cold (specify temperature, duration and reaction)</p> <p><input type="checkbox"/> Other (Specify)<br/>_____</p> | <p><b>Noise</b></p> <p><input type="checkbox"/> Within 5 feet from areas patient occupies</p> <p><input type="checkbox"/> 5-20 feet from areas patient occupies</p> <p><input type="checkbox"/> Other (specify)<br/>_____</p>   |  |

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|--|--|--|--|--|---|--|--|--|--|-------------------------------------|--------------------------|--|--|---|--|--|--------------------------|--|--|--------------------------|
| 5.   | Please provide your medical opinion with respect to the patient’s <b>functional restrictions</b> that are relevant and apply. Include additional details in section 6.<br><br>If the ability is not relevant to the request, place a diagonal line through the text box.   |  |  |  |   |  |  |  |  |                                     |                          |  |  |   |  |  |                          |  |  |                          |
| a.   | <b>Bending/twisting or repetitive movement</b><br>(specify) <input type="checkbox"/><br><br>_____<br><br>_____<br><br>_____<br><br>_____<br><br>_____  | <b>Limited use of hands:</b><br><table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: left;">Left</td> <td style="width: 5%;"></td> <td style="width: 45%; text-align: right;">Right</td> </tr> <tr> <td><input type="checkbox"/> gripping</td> <td></td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> pushing/pulling</td> <td></td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> twisting</td> <td></td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> hand strength</td> <td></td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> other (specify)</td> <td></td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> </table> <hr/> | Left                                       |  | Right                                   | <input type="checkbox"/> gripping            |  | <input type="checkbox"/>                     | <input type="checkbox"/> pushing/pulling |                                     | <input type="checkbox"/> | <input type="checkbox"/> twisting              |  | <input type="checkbox"/>                                    | <input type="checkbox"/> hand strength |  | <input type="checkbox"/> | <input type="checkbox"/> other (specify) |  | <input type="checkbox"/> |
| Left   |  | Right  |  |  |   |  |  |  |  |                                     |                          |  |  |   |  |  |                          |  |  |                          |
| <input type="checkbox"/> gripping              |  | <input type="checkbox"/>   |  |  |   |  |  |  |  |                                     |                          |  |  |   |  |  |                          |  |  |                          |
| <input type="checkbox"/> pushing/pulling       |  | <input type="checkbox"/>   |  |  |   |  |  |  |  |                                     |                          |  |  |   |  |  |                          |  |  |                          |
| <input type="checkbox"/> twisting              |  | <input type="checkbox"/>   |  |  |   |  |  |  |  |                                     |                          |  |  |   |  |  |                          |  |  |                          |
| <input type="checkbox"/> hand strength         |  | <input type="checkbox"/>   |  |  |   |  |  |  |  |                                     |                          |  |  |   |  |  |                          |  |  |                          |
| <input type="checkbox"/> other (specify)       |  | <input type="checkbox"/>   |  |  |   |  |  |  |  |                                     |                          |  |  |   |  |  |                          |  |  |                          |
| 6.   | Additional comments on <b>abilities</b> and/or <b>restrictions</b><br><br>_____<br><br>_____<br><br>_____<br><br>_____<br><br>_____  |  |  |  |   |  |  |  |  |                                     |                          |  |  |   |  |  |                          |  |  |                          |
| 7.   | Does the patient use a mobility device that is medically required?<br><br>If yes, what mobility device(s) is required (check all that apply):<br><table style="width: 100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Cane</td> <td><input type="checkbox"/> Stationary walker</td> </tr> <tr> <td><input type="checkbox"/> Gurney wheelchair</td> <td><input type="checkbox"/> Rolling walker</td> </tr> <tr> <td><input type="checkbox"/> Wheelchair stroller</td> <td><input type="checkbox"/> Manual wheelchair</td> </tr> <tr> <td><input type="checkbox"/> Electric wheelchair</td> <td><input type="checkbox"/> Scooter</td> </tr> <tr> <td><input type="checkbox"/> Hoyer lift</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other (specify) _____</td> <td></td> </tr> </table> | <input type="checkbox"/> Cane  | <input type="checkbox"/> Stationary walker | <input type="checkbox"/> Gurney wheelchair | <input type="checkbox"/> Rolling walker | <input type="checkbox"/> Wheelchair stroller | <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Electric wheelchair | <input type="checkbox"/> Scooter         | <input type="checkbox"/> Hoyer lift |                          | <input type="checkbox"/> Other (specify) _____ |  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |  |  |                          |  |  |                          |
| <input type="checkbox"/> Cane                  | <input type="checkbox"/> Stationary walker   |  |  |  |   |  |  |  |  |                                     |                          |  |  |   |  |  |                          |  |  |                          |
| <input type="checkbox"/> Gurney wheelchair     | <input type="checkbox"/> Rolling walker  |  |  |  |   |  |  |  |  |                                     |                          |  |  |   |  |  |                          |  |  |                          |
| <input type="checkbox"/> Wheelchair stroller   | <input type="checkbox"/> Manual wheelchair   |  |  |  |   |  |  |  |  |                                     |                          |  |  |   |  |  |                          |  |  |                          |
| <input type="checkbox"/> Electric wheelchair   | <input type="checkbox"/> Scooter   |  |  |  |   |  |  |  |  |                                     |                          |  |  |   |  |  |                          |  |  |                          |
| <input type="checkbox"/> Hoyer lift            |  |  |  |  |   |  |  |  |  |                                     |                          |  |  |   |  |  |                          |  |  |                          |
| <input type="checkbox"/> Other (specify) _____ |  |  |  |  |   |  |  |  |  |                                     |                          |  |  |   |  |  |                          |  |  |                          |
| 8.   | Is the patient currently hospitalized? If yes, is expected discharge imminent?   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No  |  |  |   |  |  |  |  |                                     |                          |  |  |   |  |  |                          |  |  |                          |

|     |   |   |
|-----|---|---|
| 9.  | Are the functional restrictions temporary and expected to be resolved or substantially resolved within the year (e.g. broken ankle)?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| 10. | Can the patient access and use the bathroom (including bathing or showering facilities) in their current unit?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| a.  | Can the patient use a bathtub?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| b.  | Does the patient require a walk-in/roll-in shower?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| c.  | Does the patient require additional knee clearance under the sink?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| d.  | For any other requirements the patient has in their bathroom, please explain further in section 6.  |   |
| 11. | Can the patient access and use the kitchen facilities in their current unit?<br><br>If no, explain further in section 6.  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| a.  | Can the patient access their oven and fridge?   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| b.  | Does the patient require additional knee clearance under the sink or kitchen counter?   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| c.  | What is the patient's reach capacity (i.e. ability to access items from kitchen cupboards)?<br><br>_____<br>_____<br>_____  |   |
| d.  | For any other requirements the patient has in their kitchen, please explain further in section 6.   |   |
| 12. | Do the functional restrictions prevent the patient from being able to perform activities of daily living in their unit (i.e. self-care, personal hygiene, eating, making decisions, completing tasks, etc.)?<br><br>If yes, specify:<br>_____ | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |

|     |   |   |
|-----|---|---|
|     | <hr/> <hr/> <hr/> <hr/>   |   |
| 13. | <p>What measures might (by the household <i>and</i> by Toronto Community Housing) enable the household member to perform activities of daily living in their existing unit?</p> <hr/> <hr/> <hr/> <hr/>                                     |   |
| 14. | <p>If the patient is seeking a transfer to another residential unit, what are you expecting the other unit to have (that the patient's current unit does not have) that would address the needs of the patient?</p> <hr/> <hr/> <hr/> <hr/> |   |
| 15. | <p>Is the unit causing or contributing to the impairment?<br/>If yes, how is it doing so?</p> <hr/> <hr/>   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| 16. | <p>In your professional opinion, do you believe that nothing short of a move will result in the household member being able to perform activities of daily living in their unit?</p>  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |



## Specific Information related to Request for Additional Bedroom

### Important Note to Doctors and their Patients

The City of Toronto has established Local Occupancy Standards for rent-geared-to income housing. These Standards permit a household to qualify for an extra bedroom if:

- A. A spouse who would normally share a bedroom requires a separate bedroom because of a disability. 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.

- B. A room is required to store equipment that a member of the household needs because of a permanent disability, 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:

- i. continuous positive airway pressure (CPAP) machines;
- ii. air-filtration systems;
- iii. vaporizers or humidifiers;
- iv. walkers, wheelchairs, or scooters;
- v. massage tables; or
- vi. exercise equipment.

- C. An additional bedroom is required for an individual who is not a member of the household but who occupies the unit to provide full-time overnight support services to a member of the household. The household must also submit the Caregiver application forms with these types of requests.

When a household requests an extra bedroom for a medical reason, Toronto Community Housing must determine if the household qualifies under the Local Occupancy Standards. From time to time, Toronto Community Housing may ask for new information to verify that the household still qualifies for the extra bedroom.

If the patient is requesting an additional bedroom, please complete the following along with the other information requested above in this form:

|   |   |
|---|---|
| 17.   | Why does a person with this medical condition or disability need an additional bedroom? _____<br>_____<br>_____   |
| 18.   | Is a room required to store medical equipment?<br><input type="checkbox"/> Yes<br><input type="checkbox"/> No   |
| a.  | If yes, what is the medical equipment?<br>_____   |
| b.  | What are the dimensions of the medical equipment?<br>_____  |
| c.  | The bedroom(s) in this unit are the following size(s) (TCHC staff to complete):<br>_____  |
| d.  | Can the medical equipment reasonably be accommodated in the current unit?<br>If no, please explain why, and explain what square footage is required: _____<br><input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| 19.   | Does your patient's disability require them to have a separate bedroom to accommodate a full-time overnight caregiver who is not part of the household?<br>If yes, what services do they require? _____<br>_____          |
| 20.   | Is the need for full-time overnight care long-term?<br>If no, how long will the patient need overnight care? _____<br>_____ <input type="checkbox"/> Yes<br><input type="checkbox"/> No                                   |
| If a full-time overnight caregiver is required, the household must also complete the Home Care Agency's Verification Form, or the Caregiver's Verification Form if the caregiver is not affiliated with a home care agency. |   |

**Licensed Healthcare Professional (LHCP)**

I am a (check box that applies):

- |   |   |
|---|---|
| <input type="checkbox"/> GP/Family Physician    | <input type="checkbox"/> Oncologist             |
| <input type="checkbox"/> Allergist/Immunologist | <input type="checkbox"/> Ophthalmologist        |
| <input type="checkbox"/> Cardiologist           | <input type="checkbox"/> Psychiatrist           |
| <input type="checkbox"/> Dermatologist          | <input type="checkbox"/> Pulmonologist          |
| <input type="checkbox"/> Neurologist            | <input type="checkbox"/> Rheumatologist         |
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Clinical Psychologist  |
|   | <input type="checkbox"/> Other (specify): _____ |

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

LHCP stamp  
or  
Provincial Registration #

|                          |                     |
|--------------------------|---------------------|
| LHCP Name (please print) | Contact Tel. Number |
| LHCP Signature           | Date (mm/dd/yy)     |

**Patient Consent**

I understand that Toronto Community Housing Corporation requires the personal information requested on this form to determine my eligibility for an accessible unit, unit modifications or other accommodation. I authorize my licensed healthcare professional to release information requested on this form to Toronto Community Housing Corporation and I consent to Toronto Community Housing Corporation using, verifying, disclosing and retaining this information, my application and any supporting documentation on my housing file to the extent it is necessary in order to respond to my request for accommodation and for related tenancy purposes. For clarity, disclosure may be to an independent medical consultant, to the tenant, to the City of Toronto for the purposes of compliance with the *Housing Services Act*, etc. I

understand that Toronto Community Housing will not directly contact my healthcare professional without my prior consent. I understand that if I am the patient and not the tenant that the information collected as a result of this form will be shared with the tenant and I consent to this disclosure.

\_\_\_\_\_  
Patient's Name (please print)\*

\_\_\_\_\_  
Patient's Signature\*

\_\_\_\_\_  
Tenant's Name (if not the patient)

\_\_\_\_\_  
Tenant's Phone Number

\_\_\_\_\_  
Tenant's Account Number

\_\_\_\_\_  
Date (mm/dd/yy)

*\*If the patient is under 18 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.*

The personal information on this form is collected under the authority of the *Human Rights Code*, RSO 1990, c H19 including sections 10, 11 and 17 of that act; the *Housing Services Act, 2011*, SO 2011, c 6 Sched 1 including section 176 of that act and O Reg 367/11 including section 47(1) 5 of that regulation; and/or the *Residential Tenancies Act, 2006*, SO 2006, c 17 including section 10 of that act, and will be used only as is necessary for the purposes of determining an applicant's eligibility for an accessible unit, modifications to their current unit, transfers to another unit, and/or other accessibility/accommodation measures related to the tenancy. If you have any questions about the collection of this information, please contact Toronto Community Housing's Information Specialist at 931 Yonge Street, Toronto, ON, M4W 2H2, or 416-981-5500.