Region of Waterloo
COMMUNITY SERVICES

Community Housing Access Centre (CHAC)
Phone: (519) 575-4400 Fax: (519) 893-8648
CHAC Website (www.regionofwaterloo.ca/chac)
CHAC E-Mail (housingapplication@regionofwaterloo.ca)
Address: 99 Regina St S, Waterloo, N2J 4G6

Request for Additional Bedroom Form

Your patient has applied for affordable housing and is requesting an additional bedroom based on medical grounds. Please note that we will only assign an additional bedroom under the following circumstances:

- The applicant or their spouse requires a separate bedroom because of a significant disability or diagnosed chronic (long-term) and serious medical condition, with symptoms that do not go away - no periodic relapse or remission. **(This does not include conditions like sleep apnea, snoring, restless leg syndrome, insomnia or frequent urination)**
- An additional bedroom is required to store life sustaining assistive devices or medical equipment required due to a significant disability or a diagnosed chronic (long-term) and serious medical condition. **(This does not include exercise equipment)**
- To accommodate a caregiver, who will reside with the household full time for the purpose of providing required daily and/or overnight support services to a member of the household with a significant disability or a diagnosed chronic (long-term) and serious medical condition. **(Note: The caregiver cannot be a relative and will not be included on the lease/occupancy agreement.)**

If you believe that any of the above criteria apply to your patient, please complete the remainder of this form.

The personal health information disclosed on this form will be used only for purposes of determining an applicant's eligibility for an additional bedroom and is collected under the authority of the Housing Services Act, 2011. In applying for rent-geared-to-income housing and/or the applicant's request for an additional bedroom, the applicant consents to the collection, use and disclosure, including verification, of the information provided to The Region of Waterloo's Community Housing program in their application and supporting documents.

Please Print Clearly

Applicant/Patient Name: Date of Birth:

Address:

Number of Years Patient under Your Care:

Name/describe the diagnosed chronic (long-term) and serious medical condition or significant disability that makes it an absolute necessity for your patient to have a separate bedroom. (Must identify the primary condition, not related symptoms)

Can your patient safely navigate stairs? **Yes** ☐ **No** ☐

- **Request for Separate Bedroom for patient (Please complete the following additional questions)**

How will having a separate bedroom contribute to your patient's overall well being and management of this serious medical condition or disability?

Is the extra bedroom such an absolute necessity that the lack of the additional bedroom would result in extreme hardship? **Yes** ☐ **No** ☐

- **Storage of medical equipment or assistive devices(Please complete the following additional questions)**

What medical equipment or life sustaining assistive devices require additional storage space as they can not be accommodated elsewhere in the unit due to the size of the unit or storage space within the unit.

- **Accommodation of a caregiver (Please complete the following additional questions)**

Is your patient able to manage the activities of daily living without assistance?

Yes ☐ **No** ☐

If **No,** what service(s) does he/she require?

Does your patient require overnight care? **Yes** ☐ **No** ☐

If **yes**, how many nights per week: 7

Declaration and Consent - This section is to be completed and signed by the patient, or if the patient is less than 16 years of age, a parent or legal guardian.

I, (the patient) consent to my doctor disclosing the personal health information requested in this form for the purposes stated above.

Signature of patient or parent/guardian:

Date:

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 Stamp Here: Physician's Name (printed):

Physician's Signature:

Date: Phone Number:

Office Use Only

Approved ☐ Denied ☐ Date: HSAC: