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: 20 Weber St E, Kitchener, N2H 1C3

Medical Form

This form is used to determine special accommodations an applicant may require in their building or unit. If you are unsure if this form is required, please speak to community housing before having your physician fill it in.

Patients Name: Date of Birth:

Release by Patient: I hereby authorize my physician to release and clarify the following medical information to the Region of Waterloo's Community Housing Access Centre (CHAC) and I understand that such information is **confidentially** retained in my file.

Patient's Signature: Date:

Important Notice to the Physician

Your patient has applied for housing and this form requires completion for one of the following reasons**: to verify your patient's ability to live independently; to identify what supports are required to enable your patient to live independently; or to verify their need for a modified/wheelchair accessible unit**. The information that you provide will allow CHAC to determine whether our housing program can accommodate your patient's needs.

Please type and/or print your report

1. Type of Disability/Medical problems (indicate all that apply):
   Psychiatric: ☐ Developmental: ☐ Physical: ☐

2. Specific health Problem(s) (**If patient is terminally ill, specify both the diagnosis and life expectancy**):

3. Are your patient's health problem(s) aggravated by their current housing accommodations?
   Yes ☐ No ☐
   What specific elements of the patient's current housing are exacerbating their health:

4. As a result of the above health problem(s), is your patient totally and permanently disabled, and of such a nature that functional ability can be improved by more suitable housing conditions?

   Yes☐ No☐

   If yes, explanation must be provided stating what conditions would be required:

5. How do you think your patient's medical status will be affected by being housed in a subsidized unit?

   Improve☐ Deteriorate☐ No Change☐ Not Predictable☐

6. Treatment and medication required:

7. Does your patient use a wheelchair? Yes☐ No☐

   If yes, please specify frequency: Always

8. Does your patient have any special housing requirements (i.e. barrier free building, grab bars, unable to do stairs, needs elevator, etc.)? Yes☐ No☐

   If yes, please explain:

9. Keeping in mind that your patient is applying for independent living with no support staff to monitor your patient's health/physical/emotional requirements **or** provide assistance with basic daily functions such as cooking, cleaning, bathing, shopping, etc. in your medical opinion is your patient able to live independently? Yes☐ Yes, with assistance☐ No☐

   If yes, with assistance, please identify what assistance is required and who will provide same:

10. Please provide any additional information that might be helpful:

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: