Region of Waterloo
COMMUNITY SERVICES

COMMUNITY HOUSING ACCESS CENTRE
Phone: 519-575-4400 TTY: 519-575-4608
Email: housingapplication@regionofwaterloo.ca
Website: https://www.regionofwaterloo.ca/chac
Address: 20 Weber St E, Kitchener, ON N2H 1C3

Medical Form

This medical form is used to determine the special accommodations an applicant may require in their future community housing building or unit.

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 community housing and this form requires completion for one of the following reasons**: 1. to verify your patient is terminally ill and/or; 2. to verify their ability to live independently and/or; 3. to identify what supports are required to enable your patient to live independently and/or; 4. 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. Specific health Problem(s) (**If patient is terminally ill, specify both the diagnosis and life expectancy**):

2. Does your patient use a wheelchair regularly within their home that would require a wheelchair modified unit? ☐ Yes ☐ No

3. Does your patient safely navigate stairs? ☐ Yes ☐ No

If no, please explain:

4. Does your patient require a barrier-free building? (i.e. barrier-free entrance, elevator, etc) ☐ Yes ☐ No

If yes, please explain:

5. 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:

6. 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: