Region of Waterloo
COMMUNITY SERVICES

COMMUNITY HOUSING ACCESS CENTRE
235 King Street East, 6th Floor, Kitchener, ON N2G 4N5
Phone: (519) 575-4400 Fax: (519) 893-8648
E-Mail: chac@region.waterloo.on.ca
Website: www.regionofwaterloo.ca/chac

REQUEST FOR TERMINALLY ILL PRIORITY

ALL PAGES/SECTIONS OF THE REQUEST FORM MUST BE COMPLETED

Who may request Terminally Ill Priority Status: Any member of a household applying for rent-geared-to-income (RGI) assistance, that is 16 years of age or older, may request the household be given Terminally Ill Priority where at least one member of the household meets the following criteria:

- A member of the applicant household has been medically diagnosed as having a terminal illness with a life expectancy of two years or less.
- The household must qualify for rent-geared-to-income assistance, as households with a market rent level income will not be considered for this priority.

Requesting Terminally Ill Priority Status

In order to request Terminally Ill Priority Status, please complete all sections of this form and attach a completed Medical Form – ROWCAS FORM F014.

Name of Applicant: _____

Birthdate: _____

Consent to the Sharing of Information and/or Documentation

I, _____, consent to the sharing of all information and/or documentation relating to my request for Terminally Ill Priority Status with housing providers, the Region of Waterloo's housing staff and Access site staff that are part of the Region of Waterloo Co- ordinated Access System, for the purpose of verifying the information and/or documentation provided to determine my eligibility for Terminally Ill Priority Status.

Signature of Applicant _____ Date _____

Witness _____ Date _____

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MEDICAL FORM

Patient's 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 NOTE 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: (please circle correct one)

   ☐. Psychiatric ☐Developmental ☐Physical

2. Specific Health Problem(s): Please note, if patient is terminally ill, specify both the diagnosis and life expectancy

_____

_____

_____

_____

3. Are your patient's health problem(s) aggravated by their current accommodations?

What specific elements of the patient's current housing are exacerbating their health:

Yes ☐No ☐

_____

_____

_____

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: ☐ full time ☐ occasionally

_____

_____

8. Does your patient have any special housing requirements? i.e. barrier free building, grab bars, unable to do stairs, needs elevator, etc.? 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 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 Name (printed)_____
Telephone_____

Physician's Signature_____
Date_____
Physician's Stamp Here