REQUEST FOR ACCESSIBILITY ACCOMMODATION

FORM SH-908-2019-01

The District Municipality of Muskoka acknowledges its responsibilities under the *Ontario Human Rights Code* (the Code) and other legislation to accommodate the Code-protected needs of applicants and tenants and to actively remove barriers, physical or otherwise, that may prevent those individuals from having a successful tenancy.

This form must be completed by a licensed health care professional, such as

- Physician, Registered Nurse or Registered Practical Nurse licensed to practice in Ontario
- Occupational Therapist or Physiotherapist regulated under the Regulated Health Professional Act, 1991 and in good standing with their regulatory body and hold a current registration number.

Important note to Licensed Health Care Professional

Your patient is requesting modifications to their unit or relocation to an alternate unit or building in one of the District's housing properties due to a disability or medical condition. The information you provide is to be used to determine eligibility for modifications or relocation. **Applicants must be able to live independently (including bathing, dressing, eating, mobility, toileting, housekeeping, keeping finances, etc.) either with or without support services.**

Please note the following relative to requests for modifications or relocation:

- The use of a walker or motorized scooter does not qualify a resident for modifications
- Availability of units and flexibility of housing preferences (including requests for relocation to a ground floor unit) will determine placement and will be managed according to the District's policy related to waiting lists and the *Housing Services Act*
- Depending on the design of the resident's current unit, some modifications to the unit may not be possible. In this case, the resident would normally be placed on the waiting list for relocation to an alternate, more suitable unit or building.
- Modified Units provide varying degrees of modifications and accessibility features.

Note: Your patient is solely responsible for any payment related to the completion of this form.

Please ensure information provided on this form is legible.

COMMUNITY AND PLANNING SERVICES DEPARTMENT
70 Pine Street, Bracebridge, Ontario P1L 1N3
www.muskoka.on.ca

Planning, GIS and Environment
Phone: 705-645-2100
Fax: 705-645-2207

Children's Services, Community Engagement, Housing, Ontario Works and Seniors Programs
Phone: 705-645-2412
Fax: 705-645-4272

PATIENT INFORMATION

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

1.	**Patient details:** First Name: _____ Address: _____ Unit #: _____ Date of birth (mm/dd/yy): _____ Parent/Guardian's name (if patient under 18): _____		
2.	How many years has this patient been under your care? _____		
3.	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. ☐ Yes ☐ No		
4.	Please describe the nature of your patient's medical condition or disability:		
5.	Please provide your medical opinion with respect to the patient's functional abilities that are relevant and apply. Include additional details in section 6. If the ability is not relevant to the request, place a diagonal line through the text box.		
a.	**Walking** ☐ Full abilities ☐ Up to 100 metres ☐ 100-200 metres ☐ Other (specify) _____	**Standing** ☐ Full abilities ☐ Up to 15 minutes ☐ 15-30 minutes ☐ Other (specify) _____	**Stair Climbing** ☐ Full abilities ☐ Up to 5 steps ☐ 5-10 steps ☐ Other (specify) _____
b.	**Hearing**: able to hear in-suite and building smoke and CO alarms ☐ Yes ☐ No		**Hearing:** Other relevant restrictions (specify)

6.	Please provide your medical opinion with respect to the patient's **functional restrictions** that are relevant and apply. Include additional details in section 7 below. If the ability is not relevant to the request, place a diagonal line through the text box.	
a.	**Limited use of hands**: Left ☐ gripping ☐ pushing/pulling ☐ twisting ☐ hand strength ☐ other (specify) _____	Right ☐ gripping ☐ pushing/pulling ☐ twisting ☐ hand strength ☐ other (specify) _____
7.	Additional comments on **abilities** and/or **restrictions**	
8.	Does the patient use a mobility device that is medically required? If yes, what mobility device(s) is required (check all that apply): ☐ Cane ☐ Stationary walker ☐ Gurney wheelchair ☐ Rolling walker ☐ Wheelchair stroller ☐ Manual wheelchair ☐ Electric wheelchair ☐ Scooter ☐ Hoyer lift ☐ Other (specify) _____	☐ Yes ☐ No
9.	Is the patient currently hospitalized? If yes, is expected discharge imminent? _____	☐ Yes ☐ No
10.	Are the functional restrictions temporary and expected to be resolved or substantially resolved within the year (e.g. broken ankle)?	☐ Yes ☐ No

11.	Is the medical condition or disability permanent?	☐ Yes ☐ No
12.	Can the patient access and use the bathroom (including bathing or showering facilities) in their current unit?	☐ Yes ☐ No
13.	Can the patient use a bathtub?	☐ Yes ☐ No
14.	Does the patient require a walk-in/roll-in shower?	☐ Yes ☐ No
15.	Does the patient require additional knee clearance under the sink?	☐ Yes ☐ No
16.	For any other requirements the patient has in their bathroom, please explain further in section 7 above.	
12.	Can the patient access and use the kitchen facilities in their current unit? If no, explain further in section 7.	☐ Yes ☐ No
13.	Can the patient access their oven and fridge?	☐ Yes ☐ No
14.	Does the patient require additional knee clearance under the sink or kitchen counter?	☐ Yes ☐ No
15.	What is the patient's reach capacity (i.e. ability to access items from kitchen cupboards)?	
16.	For any other requirements the patient has in their kitchen, please explain further in section 7.	
17.	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.)? If yes, specify:	☐ Yes ☐ No

18.	Does your patient have a deteriorating medical condition that will increase the need for unit modifications over time? If yes, please indicate the modifications that are expected to be required and indicate the time frame:	☐ Yes ☐ No
19.	Please describe how these modifications will assist or relieve the medical condition of your patient:	
20.	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?	
21.	Is the unit causing or contributing to the impairment? If yes, how is it doing so?	☐ Yes ☐ No
22.	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?	☐ Yes ☐ No

LICENSED HEALTHCARE PROFESSIONAL (LHCP)

I am a (check box that applies):

- ☐ GP/Family Physician
- ☐ Nurse Practitioner
- ☐ Cardiologist
- ☐ Allergist/Immunologist
- ☐ Neurologist
- ☐ Occupational Therapist
- ☐ Oncologist
- ☐ Ophthalmologist
- ☐ Psychiatrist
- ☐ Pulmonologist
- ☐ Rheumatologist
- ☐ Clinical Psychologist
- ☐ Other (specify): _____

I hereby certify that this information represents my best professional judgment and is true and correct 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 The District of Muskoka 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 The District of Muskoka and I consent to The District of Muskoka 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 for the purposes of compliance with the *Housing Services* Act, etc. I understand that The District of Muskoka 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

**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 The District of Muskoka 705-645-2231.

Personal information contained on this form is collected under the authority of the Housing Services Act, 2011 and is subject to the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA). Information will be kept confidential and used only for the purpose of assessing eligibility for disability accommodation.

Questions about this collection should be forwarded to the info@muskoka.on.ca