Complete and return this form by mail or email to:
Halton Access to Community Housing (HATCH)
Housing Services Division
Social & Community Services Department
1151 Bronte Rd. Oakville, ON L6M 3L1
Email: accesshalton@halton.ca

MEDICAL FORM

Request for Terminal Illness Priority, Wheelchair Accessible Unit and/or an Additional Bedroom

TO BE COMPLETED BY PATIENT (Section A)

Section A - Patient Information:

Name: Date of Birth:

Address:

Release by Patient: I hereby authorize my physician to release the following medical information to the Region of Halton – Halton Access to Community Housing (HATCH) and I understand that the information will be confidentially retained in my file.	
Patient's Signature:	Date:

TO BE COMPLETED BY PHYSICIAN (Sections B, C or D)

Important Note: Your patient has applied for housing or a transfer on medical grounds for a terminal illness priority, wheelchair accessible unit and/or an additional bedroom. The information provided by you will assist us in determining the eligibility of your patient. Please complete section B for terminal illness priority, section C for wheelchair accessible requests and/or section D for requests for additional bedroom(s).

Section B - Request for Medical Priority due to Terminal Illness

Please answer the following questions:
Life expectancy is ☐ Less than two years ☐ More than two years
Diagnosis of illness:
Please provide any additional information that may be helpful:

Note: For Sections C or D - A medical diagnosis does not have to be disclosed, only a description of the nature of the disability/medical condition that confirms there is a medical need for a wheelchair accessible unit and/or an additional bedroom.

Section C - Request for a Wheelchair Accessible Unit

Please answer the following questions:
Is the patient in a wheelchair? ☐Full-time ☐Part-time ☐Does not use one
Is the patient's condition ☐Permanent ☐ Temporary
If the patient's condition is temporary, what is the expected duration?
Please provide any additional information that may be helpful:

Section D - Request for an Additional Bedroom

Please check off the applicable reason(s) your patient is requesting an additional bedroom and provide the required information.

☐ **Medical Condition/Disability**

Is the Medical Condition/Disability permanent or expected to continue for an indefinite period of time?

Yes ☐ No ☐ If No, what is the expected duration? _____

Please describe the nature of the disability/medical condition and why an extra bedroom is required:

Note: Under Halton's approved Policy the following conditions would not typically warrant approval of a second bedroom:

- snoring/sleep apnea
- frequent night time waking or insomnia
- temporary medical conditions

☐ **Pregnancy**

Please state the expected due date: _____
Y/M/D

☐ **Storage of Medical Equipment** (e.g. dialysis equipment)

Please specify the medical equipment required to manage the patient's medical condition and the reason why an extra bedroom is required:

☐ **Caregiver – Overnight accommodation of an individual to provide support services that are required due to a medical condition/disability.**

An additional bedroom may be granted if an overnight caregiver is required to assist with the patient's medical condition/disability and does not maintain a residence elsewhere.
Specify Details:

Halton REGION

Please provide any additional information that may 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.

PLEASE PROVIDE DOCTORS STAMP

_____
Physician's Name (Printed)

_____
Physician's Signature

_____
Phone Number