The Residences of St. Joseph's

# Form 5 – Disability Verification Form

## Applicant Information

| Last name | First name and middle initial | Cellular telephone number | |
|---|---|---|---|
| Home telephone number | Can we call you at home? ☐ Yes ☐ No | Work telephone number, including extension | Can we call you at work? ☐ Yes ☐ No |
| Apartment number | Current address | | |
| City | Province | Postal code | E-mail address |

Is there a substitute decision-maker in place for your financial affairs?

☐ No ☐ Yes - provide their name and telephone number: _____

The above named applicant has applied for a fully modified/accessible unit at The Residences of St. Joseph's in Guelph. In order to be eligible for such accommodation under the Canada-Ontario Affordable Housing Program, the applicant must substantiate that they be able to live independently in a housing unit with or without support services. If support services are required they must be arranged for by the applicant prior to housing.

An applicant who can cope in an independent living situation must be able to meet the following requirements:

1. Able to manage the activities of daily living such as:
   - Mobility
   - Budgeting
   - Housekeeping
   - Cooking
   - Personal hygiene
2. Able to assume the responsibility of a tenant under the Tenant Protection Act, which includes paying rent and other accommodation charges and maintaining the unit in a good state of repair.
3. Be in receipt of any needed support services, such as:
   - Case management
   - Social or vocational/rehabilitation services
   - Life skills training
   - Treatment program (assessment and counseling)

## Applicant's Declaration and Consent to Disclosure

I hereby authorize the release of any required information to St. Joseph's Housing Corporation Inc. Guelph. I fully understand the information being provided will be used in the evaluation of my application for housing. I hereby authorize St. Joseph's Housing Corporation Inc. Guelph to retain the information provided on file.

_____ _____

*Date* *Signature of applicant*

_____ _____

*Name of witness:* *Signature of witness*

Your completed Disability Verification Form and any attached documents can be mailed or delivered to:

**St. Joseph's Housing Corporation Inc. Guelph**
**401 Edinburgh Road**
**Guelph ON Canada N1H 0A5**
**Attention: Building Manager**

**COMPLETED FORM WILL NOT BE ACCEPTED BY FAX, ORIGINAL FORM REQUIRED**

# Form 5 - Disability Verification Form

## Request for Medical Information *(to be completed by health care professional)*

Your patient/client has applied for affordable housing at The Residence of St. Joseph's which is funded under the Canada-Ontario Affordable Housing Program. Under this Program, an individual must be able to live independently within a housing unit, either with or without the aid of support services. Independent living requirements have been listed on previous side. Please be as specific as possible in your evaluation so that we may make a decision as to whether the accommodation the applicant has chosen meets their needs. **You may use this form, or your own reporting format, to provide the required information. All information will remain confidential.**

| Name of Physician or Health Care Worker | | Organization name (if applicable) |
|---|---|---|
| Address | | Phone number / extension |
| City | Province | Postal code |

What are the medical diagnosis, duration and level of disability?

How are the medical problems aggravated by the present accommodation? Please explain

Is the applicant in a hospital or other medical facility and able to return to their place of residence?

☐ Yes Please explain:
☐ No

Will the applicant require any special features such as: wheelchair access, grab bars, other? Please explain

What other kinds of service are in place or being recommended for this applicant in order to live independently? Please explain.

## Verification and Declaration *(to be completed by health care professional)*

Place office stamp here. (if applicable)

I certify that this information represents my professional opinion and to the best of my knowledge and belief, is true and correct.

_____ _____

*Date* *Signature*

Physician or health care professional may provide form directly to the patient or mail to the address above. Do not fax, original form is required.

## Confirmation of Services (*to be completed by support service agency*)

The applicant has indicated that (a) he/she is currently receiving services from your agency and/or; (b) he/she has arranged for services to be put in place with your agency and that these services will coincide with the date he/she will be housed. Please indicate, on a separate agency letterhead, what services and frequency your agency is presently or will be providing to assist the applicant with independent living.

| Name of contact | Agency name | |
|---|---|---|
| Address | Phone number / extension | Fax number |