The Residences of St. Joseph's

Form 7 – Medical Urgency 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 Special Priority Status ranking at The Residence of St. Joseph's in Guelph. The definition of medical urgency to quality for special priority can be found below.

Definition of Medical Urgency (Condition or Diagnosis leading to need for Special Priority)

Spinal Cord Injury	Stroke	Multiple Sclerosis
Muscular Dystrophy	Amputee	Visual or Hearing Impaired
Cerebral Palsy	Head Injury	Other please specify _____

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 Medical Urgency 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 7 – Medical Urgency Verification Form

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

Your patient/client has applied for Special Priority Status ranking at The Residence of St. Joseph's which is funded under the Canada-Ontario Affordable Housing Program. Please confirm the medical urgency, being as specific as possible in your evaluation, so that we may make a decision as to whether the request for Special Priority Status will be granted. **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 conditions or Diagnosis leading to the need for Special Priority?

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

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.