



119 Van Order Drive, Kingston, ON K7M 1B9 🏠 Fax (613) 546-9375 🏠 Phone (613) 546-5591 www.kfhc.ca

**Request for a Modified Unit or Additional Bedroom
With
Verification of Disability or Medical Condition**

NOTE: If applicants requesting a modified unit also require a rent subsidy, an Application for RGI Assistance Form Part “A” must be completed at the Social Housing Registry located at 362 Montreal Street, Kingston, Social Housing Registry Program, Community and Family Services Department, City of Kingston, 362 Montreal Street, Kingston, ON Canada K7K 3H5, Phone: 613-546-2695, extension 4769 E-mail: theregistry@cityofkingston.ca

A) Applicant Information

| | | |
|--------------------|------------|---------------|
| Applicant: Surname | Given Name | Date of Birth |
|--------------------|------------|---------------|

| | | |
|-----------------------|------------|---------------|
| Co-Applicant: Surname | Given Name | Date of Birth |
|-----------------------|------------|---------------|

Address (number, street, apartment number)

| | |
|-----------|-------------|
| City/Town | Postal Code |
|-----------|-------------|

| | | |
|----------------|----------------|----------------|
| Home Telephone | Work Telephone | E-mail address |
|----------------|----------------|----------------|

| | | |
|-----|-----|------|
| () | () | Ext. |
|-----|-----|------|

INSTRUCTIONS

Please complete and sign this form. The information is to be used in connection with your request for a modified unit due to a disability or medical condition, as identified in the Kingston & Frontenac Housing Corporation Special Needs Access to Modified Unit Policy.

The following qualified Health Care Professionals may complete the attached Verification form:

- Family doctor or other physician
- Physiotherapist
- Chiropractor
- Occupational Therapist

Note: Please complete the “Consent to Release Medical Information” (on the reverse) before taking this form to your Health Care Professional. Consent to Release Medical Information must be signed by the member of the household who wishes to apply for a Modified Unit or a person authorized on their behalf, or as required by the Health Care Professional.

IMPORTANT: The qualified person completing this form may charge you an administration fee for verification of disabilities or medical condition, which charge is your sole responsibility.

B) Consent to Release Medical Information

I/am, we/are requesting a modified unit due to disability and/or medical condition.

I/We understand that this information will be used for the purpose of verifying my eligibility for a modified unit under the Housing Services Act, 2011. I/We fully understand the nature and purpose of this consent and give my/our consent and authorization voluntarily.

I/We hereby authorize _____ to disclose to Kingston & Frontenac Housing Corporation the medical and related information requested in the attached Verification of Disability or Medical Condition form.

Dated the _____ day of _____ 20_____

Signature _____
(Member of household)

Signature _____
(Member of household)

For further information - Please contact:

Kingston & Frontenac Housing Corporation
119 Van Order Drive
Kingston, ON K7M 1B9
Tel: (613) 546-5591
Fax: (613) 546-9375

**C) VERIFICATION OF DISABILITY or Medical Condition
(to be completed by Health Care Professional)**

Important message to Health Care Professional:

Please complete and sign this form and return it to your patient/client, or mail or fax it to the Kingston & Frontenac Housing Corporation at the address listed above.

The Applicant listed below is requesting a modified housing unit to assist them due to a disability or medical condition. The information you provide is to be used to determine eligibility for a modified unit to assist your patient/client. Applicants must be able to live independently. Details on types of unit modifications and locations of housing units are attached.

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

Applicant's Surname (please print) Given Name Date of Birth (mm/dd/yr)

Applicant's Current Address

1. Please describe the nature of this patient/client's disability or medical condition(s) as it relates to the request for a modified housing unit.

2. Does your patient/client use/require a wheelchair? YES NO

3. What other devices does your patient/client use? i.e. Scooter, Walker

4. Is the disability or medical condition continuous? YES NO

5. Does your patient/client require an additional bedroom to accommodate their physical/medical needs – Please explain:

6. Additional Comments: Please describe if or how a modified unit, if allocated, will assist or relieve the medical condition of your patient/client or their family.

7. What unit modifications do you think would assist this patient/client (i.e. roll-in shower, lowered countertops, widened doorways, grab bars, strobe lights).
