Region of Waterloo
PLANNING, HOUSING AND COMMUNITY SERVICES
Housing

COMMUNITY HOUSING ACCESS CENTRE
235 King Street East, 6th Floor, Kitchener, ON N2G 4N5
Phone: (519) 575-4833 Fax: (519) 893-8648
Email: chac@region.waterloo.on.ca

REQUEST FOR TERMINALLY ILL PRIORITY

ALL PAGES/SECTIONS OF THE REQUEST FORM MUST BE COMPLETED

Who may request Terminally Ill Priority Status: Any member of a household applying for rent-geared-to-income (RGI) assistance, that is 16 years of age or older, may request the household be given Terminally Ill Priority where at least one member of the household meets the following criteria:

- A member of the applicant household has been medically diagnosed as having a terminal illness with a life expectancy of **two years or less**.
- The household must qualify for rent-geared-to-income assistance, as households with a market rent level income will not be considered for this priority.

Requesting Terminally Ill Priority Status

In order to request Terminally Ill Priority Status, please complete all sections of this form and attach a completed ***Medical Form –*** *ROWCAS FORM F014*.

Name of Applicant: _____**Birth date**:_____

Consent to the Sharing of Information and/or Documentation

I, _____, consent to the sharing of all information and/or documentation relating to my request for Terminally Ill Priority Status with housing providers, the Region of Waterloo's housing staff and Access site staff that are part of the Region of Waterloo Co-ordinated Access System, for the purpose of verifying the information and/or documentation provided to determine my eligibility for Terminally Ill Priority Status.

Signature of Applicant _____ Date _____

Witness _____ Date _____

File # _____

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MEDICAL FORM

Patient's Name:	**Date of Birth:**

Release by Patient: I hereby authorize my physician to release and clarify the following medical information to the Region of Waterloo's Community Housing Access Centre and I understand that such information is ***confidentially*** retained in my file.

Patient's Signature	Date

IMPORTANT NOTE TO THE PHYSICIAN

Your patient has applied for housing/transfer on medical grounds, for a wheelchair modified unit or an extra bedroom for medical reasons. The information that you provide will assist us in assessing that application and determining their ability to live independently. It is essential that you are as specific as possible in your evaluation so that we may make a correct decision as to whether our accommodation meets your patient's needs.

Please type and/or print your report

1. Type of Disability/Medical Problems: (please circle correct one).	**Psychiatric**		**Developmental**		**Physical**	
	Yes	*No*	*Yes*	*No*	*Yes*	*No*

2. Specific Health Problem(s): **Please note, if patient is terminally ill, specify both the diagnosis and life expectancy**

3. Are your patient's health problem(s) aggravated by their current accommodations? **What specific elements of the patient's current housing are exacerbating their health**:	*Yes*	*No*

4. As a result of the above health problem(s), is your patient totally and permanently disabled, and of such a nature that functional ability can be improved by more suitable housing conditions?	*Yes*	*No*
If yes, **explanation must be provided stating what conditions would be required**:		

5. How do you think your patient's medical status will be affected by being housed in a subsidized unit:			
Improve	*Deteriorate*	*No Change*	*Not Predictable*

6. Treatment and medication required:

7. Does your patient have any special housing requirements, IE: wheelchair modified unit, barrier free access, grab bars, unable to do stairs, needs elevator, etc?: *If yes, explanation required*:	*Yes*	*No*

8. Keeping in mind that your patient is applying for independent living with no support staff to monitor your patient's health/physical/emotional requirements OR provide assistance with basic daily functions such as cooking, cleaning, bathing, shopping, etc. - in your medical opinion is your patient able to live independently?		
Yes	*Yes, with assistance**	*No*
**If with assistance, please identify what assistance is required and who will provide same*:		

9. Please provide any additional information that might be helpful:

10. Is an extra bedroom required for the storage of equipment/medical supplies? *If yes, explanation required*:	*Yes*	*No*

11. Does patient require own/separate bedroom from spouse/partner due to a diagnosed medical condition? *If yes, explanation required*:	*Yes*	*No*

PLEASE PROVIDE DOCTORS STAMP

Physician's Signature:	
Date:	
Name:	
Address:	
Postal Code:	Phone Number: