Clear Data Help

DISABILITY TAX CREDIT CERTIFICATE

6729

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Part A – To be completed by the person with the disability (or a legal representative)

Step 1: Complete Part A (**please print**). Remember to sign, where applicable, at the bottom of this page.

Step 2: Take this form to a qualified practitioner (use the table on the next page to find out who can certify the sections that apply). The qualified practitioner completes Part B.

Step 3: Complete and send the **original** certified form (Part A and Part B) to your tax centre (see the chart on the previous page). **This form must be submitted in its entirety** (pages 1 to 9).

When reviewing your application, if we need more information, we may contact you or a qualified practitioner (named on this certificate or any attached document) who knows about your impairment.

Information about the person with the disability

First name and initial	Last name	☐ Female ☐ Male
Mailing address (Apt No – Street No Street name, PO Box, RR)		Social insurance number
City	Province or territory / Postal code	Date of birth Year Month Day

Information about the person claiming the disability amount (if different from above)

First name and initial	Last name	Social insurance number

The person with the disability is: ☐ my spouse or common-law partner ☐ other (specify) _____

Answer the following questions for **all** of the years that you are claiming the disability amount for the person with the disability.

1. Does the person with the disability live with you? ☐ Yes ☐ No

   If **yes**, for which year(s)? _____

2. If you answered **no** to Question 1, does the person with the disability depend on you for regular and consistent support for one or more of the basic necessities of life such as food, shelter, or clothing? ☐ Yes ☐ No

   If **yes**, for which year(s)? _____

Give details about the regular and consistent support you provide for food, shelter or clothing to the person with the disability (if you need more space, attach a separate sheet of paper). We may ask you to provide receipts or other documents to support your request for the transfer of the disability amount.

As the person claiming the disability amount, I certify that the information given on this form is, to the best of my knowledge, correct and complete.

Signature	Telephone number	Date Year Month Day
It is a serious offence to make a false statement.		

Authorization

As the person with the disability or their legal representative, I authorize the qualified practitioner(s) having relevant clinical records to provide or discuss the information contained in those records on or with this certificate to the Canada Revenue Agency for the purpose of determining eligibility for the disability tax credit or other related programs.

Signature	Telephone number	Date Year Month Day

Privacy Act, Personal Information Bank number CRA PPU 218

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Part B – Must be completed by the qualified practitioner

Before completing this form, read the instructions below.
For more information, go to **www.cra.gc.ca/qualifiedpractitioners**.

Your patient must have an impairment in physical or mental functions which is both severe and prolonged. You must assess the following two criteria of your patient's impairment **separately**:

- **Duration** of the impairment – The impairment must be prolonged (it must have lasted, or be expected to last, for a continuous period of at least 12 months).
- **Effects** of the impairment – The effects of your patient's impairment must be such that, even with therapy and the use of appropriate devices and medication, your patient is restricted all or substantially all of the time (at least 90% of the time).

  The effects of your patient's impairment must fall into one of the following categories:
  - Vision
  - Markedly restricted in a basic activity of daily living
  - Life-sustaining therapy
  - The cumulative effect of **significant restrictions** (for patients who are significantly restricted in two or more of the basic activities of daily living, including vision, but do not quite meet the criteria for **markedly restricted**)

Step 1: Complete **only** the section(s) on pages 3 to 8 that apply to your patient. See the table below to find out which page(s) to complete and to determine which sections you can certify.

Note
Whether completing this form for a child or an adult, assess your patient relative to someone of a similar chronological age who does not have the marked or significant restriction.

	Section:	Go to:	To certify the applicable section, you have to be a:
	Vision	Page 3	Medical doctor or optometrist
Markedly restricted in a basic activity of daily living	• Speaking	Page 3	Medical doctor or speech-language pathologist
	• Hearing	Page 3	Medical doctor or audiologist
	• Walking	Page 4	Medical doctor, occupational therapist, or physiotherapist (physiotherapist can certify only for 2005 and later years)
	• Elimination (bowel or bladder functions)	Page 4	Medical doctor
	• Feeding	Page 5	Medical doctor or occupational therapist
	• Dressing	Page 5	Medical doctor or occupational therapist
	• Performing the mental functions necessary for everyday life	Page 6	Medical doctor or psychologist
	Life-sustaining therapy	Page 7	Medical doctor
	Cumulative effects of significant restrictions in two or more basic activities of daily living, including vision (applies to 2005 and later years)	Page 8	Medical doctor or occupational therapist (occupational therapist can only certify for walking, feeding and dressing)

Step 2: Complete the "**Effects of impairment**," "**Duration**," and "**Certification**" sections on page 9.

Definition

Markedly restricted – means that **all or substantially all of the time** (at least 90% of the time), and even with therapy (other than therapy to support a vital function) and the use of appropriate devices and medication, either:

- your patient is unable to perform one or more of the basic activities of daily living (see above); or
- it takes your patient an **inordinate amount of time** (defined in the introduction of this form) to perform one or more of the basic activities of daily living.

Vision (Complete this section if applicable, and **all sections on page 9**.) Not applicable ☐

Your patient is considered **blind** if, even with the use of corrective lenses or medication:

- visual acuity in **both** eyes is 20/200 (6/60) or less with the Snellen Chart (or an equivalent); or
- the greatest diameter of the field of vision in **both** eyes is 20 degrees or less.

Is your patient **blind**, as described above? Yes ☐ No ☐

If **yes**, in what year did your patient's blindness begin (this is not necessarily the same as the year in which the diagnosis was made, as with progressive diseases)? Year ____

What is your patient's visual acuity **after correction**? Right eye _____ Left eye _____

What is your patient's visual field **after correction** (in degrees if possible)? Right eye _____ Left eye _____

Speaking (Complete this section if applicable, and **all sections on page 9**.) Not applicable ☐

Your patient is considered **markedly restricted** in speaking if, all or substantially all of the time (at least 90% of the time), he or she is **unable** or takes an **inordinate amount of time** to speak so as to be understood by another person familiar with the patient, in a quiet setting, even with appropriate therapy, medication, and devices.

Notes
Devices for speaking include tracheoesophageal prostheses, vocal amplification devices, and other such devices.
An **inordinate amount of time** means that speaking so as to be understood takes **three times** the normal time required by an average person who does not have the impairment.

Examples of markedly restricted in speaking:

- Your patient must rely on other means of communication, such as sign language or a symbol board, all or substantially all of the time (at least 90% of the time).
- In your office, you must ask your patient to repeat words and sentences several times, and it takes an inordinate amount of time for your patient to make himself or herself understood.

Is your patient **markedly restricted** in speaking, as described above? Yes ☐ No ☐

Is the marked restriction in speaking present **all or substantially all of the time** (at least 90% of the time)? Yes ☐ No ☐

If **yes**, when did your patient's marked restriction in speaking begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)? Year ____

Hearing (Complete this section if applicable, and **all sections on page 9**.) Not applicable ☐

Your patient is considered **markedly restricted** in hearing if, all or substantially all of the time (at least 90% of the time), he or she is **unable** or takes an **inordinate amount of time** to hear so as to understand another person familiar with the patient, in a quiet setting, even with the use of appropriate devices.

Notes
Devices for hearing include hearing aids, cochlear implants, and other such devices.
An inordinate amount of time means that hearing so as to understand takes **three times** the normal time required by an average person who does not have the impairment.

Examples of markedly restricted in hearing:

- Your patient must rely completely on lip reading or sign language, despite using a hearing aid, to understand a spoken conversation, all or substantially all of the time (at least 90% of the time).
- In your office, you must raise your voice and repeat words and sentences several times, and it takes an inordinate amount of time for your patient to understand you, despite the use of a hearing aid.

Is your patient **markedly restricted** in hearing, as described above? Yes ☐ No ☐

Is the marked restriction in hearing present **all or substantially all of the time** (at least 90% of the time)? Yes ☐ No ☐

If **yes**, when did your patient's marked restriction in hearing begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)? Year ____

Walking (Complete this section if applicable, and **all sections on page 9**.)

Not applicable ☐

Your patient is considered **markedly restricted** in walking if, all or substantially all of the time (at least 90% of the time), he or she is **unable** or requires an **inordinate amount of time** to walk even with appropriate therapy, medication, and devices.

Notes

Devices for walking include canes, walkers, and other such devices.

An **inordinate amount of time** means that walking takes **three times** the normal time required by an average person who does not have the impairment.

Examples of markedly restricted in walking:

- Your patient must always rely on a wheelchair outside of the home, even for short distances.
- Your patient can walk 100 metres (or approximately one city block), but only by taking an inordinate amount of time, stopping because of shortness of breath or because of pain, all or substantially all of the time (at least 90% of the time).
- Your patient experiences severe episodes of fatigue, ataxia, lack of coordination, and problems with balance. These episodes cause your patient to be incapacitated for several days at a time, in that he or she becomes unable to walk more than a few steps. Between episodes, your patient continues to experience the above symptoms, but to a lesser degree. However, these symptoms cause him or her to require an inordinate amount of time to walk, all or substantially all of the time (at least 90% of the time).

Is your patient **markedly restricted** in walking, as described above? Yes ☐ No ☐

Is the marked restriction in walking present **all or substantially all of the time** (at least 90% of the time)? Yes ☐ No ☐

If **yes**, when did your patient's marked restriction in walking begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)? Year ____

Elimination – bowel or bladder functions (Complete this section if applicable, and **all sections on page 9**.)

Not applicable ☐

Your patient is considered **markedly restricted** in elimination if, all or substantially all of the time (at least 90% of the time), he or she is **unable** or requires an **inordinate amount of time** to personally manage bowel or bladder functions, even with appropriate therapy, medication, and devices.

Notes

Devices for elimination include catheters, ostomy appliances, and other such devices.

An **inordinate amount of time** means that personally managing elimination takes **three times** the normal time required by an average person who does not have the impairment.

Examples of markedly restricted in elimination:

- Your patient needs the assistance of another person to empty and tend to his or her ostomy appliance on a daily basis.
- Your patient is incontinent of bladder functions, all or substantially all of the time (at least 90% of the time), and requires an inordinate amount of time to manage and tend to his or her incontinence pads on a daily basis.

Is your patient **markedly restricted** in elimination, as described above? Yes ☐ No ☐

Is the marked restriction in elimination present **all or substantially all of the time** (at least 90% of the time)? Yes ☐ No ☐

If **yes**, when did your patient's marked restriction in elimination begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)? Year ____

Feeding (Complete this section if applicable, and **all sections on page 9**.) Not applicable ☐

Your patient is considered **markedly restricted** in feeding if, all or substantially all of the time (at least 90% of the time), he or she is **unable** or requires an **inordinate amount of time** to feed himself or herself, even with appropriate therapy, medication, and devices.

Notes

Feeding oneself **does not** include identifying, finding, shopping for or otherwise procuring food.

Feeding oneself **does** include preparing food, **except** when the time associated is related to a dietary restriction or regime, even when the restriction or regime is required due to an illness or health condition.

Devices for feeding include modified utensils, and other such devices.

An **inordinate amount of time** means that feeding takes **three times** the normal time required by an average person who does not have the impairment.

Examples of markedly restricted in feeding:

- Your patient requires tube feedings, all or substantially all of the time (at least 90% of the time), for nutritional sustenance.
- Your patient requires an inordinate amount of time to prepare meals or to feed himself or herself, on a daily basis, due to significant pain and decreased strength and dexterity in the upper limbs.

Is your patient **markedly restricted** in feeding, as described above?	Yes ☐ No ☐
Is the marked restriction in feeding present **all or substantially all of the time** (at least 90% of the time)?	Yes ☐ No ☐
If **yes**, when did your patient's marked restriction in feeding begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)?	Year

Dressing (Complete this section if applicable, and **all sections on page 9**.) Not applicable ☐

Your patient is considered **markedly restricted** in dressing if, all or substantially all of the time (at least 90% of the time), he or she is **unable** or requires an **inordinate amount of time** to dress himself or herself, even with appropriate therapy, medication, and devices.

Notes

Dressing oneself **does not** include identifying, finding, shopping for or otherwise procuring clothing.

Devices for dressing include specialized buttonhooks, long-handled shoehorns, grab rails, safety pulls, and other such devices.

An **inordinate amount of time** means that dressing takes **three times** the normal time required by an average person who does not have the impairment.

Examples of markedly restricted in dressing:

- Your patient cannot dress without daily assistance from another person.
- Due to pain, stiffness, and decreased dexterity, your patient requires an inordinate amount of time to dress on a daily basis.

Is your patient **markedly restricted** in dressing, as described above?	Yes ☐ No ☐
Is the marked restriction in dressing present **all or substantially all of the time** (at least 90% of the time)?	Yes ☐ No ☐
If **yes**, when did your patient's marked restriction in dressing begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)?	Year

Mental functions necessary for everyday life

Not applicable ☐

(Complete this section if applicable, and **all sections on page 9**.)

Your patient is considered **markedly restricted** in performing the mental functions necessary for everyday life (described below) if, all or substantially all of the time (at least 90% of the time), he or she is **unable** or requires an **inordinate amount of time** to perform them by himself or herself, even with appropriate therapy, medication, and devices (for example, memory aids and adaptive aids).

Note
An **inordinate amount of time** means that your patient takes **three times** the normal time required by an average person who does not have the impairment.

Mental functions necessary for everyday life include:

- adaptive functioning (for example, abilities related to self-care, health and safety, abilities to initiate and respond to social interaction, and common, simple transactions);
- memory (for example, the ability to remember simple instructions, basic personal information such as name and address, or material of importance and interest); and
- problem-solving, goal-setting, and judgement, taken together (for example, the ability to solve problems, set and keep goals, **and** make appropriate decisions and judgements).

Note
A restriction in problem-solving, goal-setting, or judgement that markedly restricts adaptive functioning, all or substantially all of the time (at least 90% of the time), would qualify.

Examples of markedly restricted in the mental functions necessary for everyday life:

- Your patient is unable to leave the house, all or substantially all of the time (at least 90% of the time) due to anxiety, despite medication and therapy.
- Your patient is independent in some aspects of everyday living. However, despite medication and therapy, your patient needs daily support and supervision due to an inability to accurately interpret his or her environment.
- Your patient is incapable of making a common, simple transaction, such as a purchase at the grocery store, without assistance, all or substantially all of the time (at least 90% of the time).
- Your patient experiences psychotic episodes several times a year. Given the unpredictability of the psychotic episodes and the other defining symptoms of his or her impairment (for example, lack of initiative or motivation, disorganized behaviour and speech), your patient continues to require **daily** supervision.
- Your patient is unable to express needs or anticipate consequences of behaviour when interacting with others.

Is your patient **markedly restricted** in performing the mental functions necessary for everyday life, as described above? Yes ☐ No ☐

Is the marked restriction in performing the mental functions necessary for everyday life present **all or substantially all of the time** (at least 90% of the time)? Yes ☐ No ☐

If **yes**, when did your patient's marked restriction in the mental functions necessary for everyday life begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)? Year ____

Life-sustaining therapy

Not applicable ☐

(Complete this section if applicable, and **all sections on page 9**.)

Life-sustaining therapy for your patient must meet **both** of the following conditions:

- Your patient needs this therapy to support a vital function, even if this therapy has alleviated the symptoms.
- Your patient needs this therapy at least 3 times per week, for an average of at least 14 hours per week.

Your patient must dedicate the time for the therapy—that is, the patient has to take time away from normal, everyday activities to receive it. If your patient receives therapy by a portable device, such as an insulin pump, or an implanted device, such as a pacemaker, the time the device takes to deliver the therapy **does not** count towards the 14-hour per week requirement. However, the time your patient spends setting up a portable device **does** count.

Do not include activities such as following a dietary restriction or regime, exercising, travelling to receive the therapy, attending medical appointments (other than appointments where the therapy is received), shopping for medication, or recuperating after therapy.

For 2005 and later years

- If your patient's therapy requires a regular dosage of medication that needs to be adjusted daily, the activities directly related to determining and administering the dosage **are** considered part of the therapy (for example, monitoring blood glucose levels, preparing and administering the insulin, calibrating necessary equipment, or maintaining a log book of blood glucose levels).
- Activities that are considered to be part of following a dietary regime, such as carbohydrate calculation, as well as activities related to exercise, **do not count** toward the 14-hour requirement (even when these activities or regimes are a factor in determining the daily dosage of medication).
- If a child is unable to perform the activities related to the therapy because of his or her age, the time spent by the child's primary caregivers performing and supervising these activities **can** be counted toward the 14-hour per week requirement. For example, in the case of a child with Type 1 diabetes, supervision includes having to wake the child at night to test his or her blood glucose level, checking the child to determine the need for additional blood glucose testing (during or after physical activity), or other supervisory activities that can reasonably be considered necessary to adjust the dosage of insulin (excluding carbohydrate calculation).

Examples of life-sustaining therapy:

- Chest physiotherapy to facilitate breathing
- Kidney dialysis to filter blood
- Insulin therapy to treat Type 1 diabetes in a child who cannot independently adjust the insulin dosage (for 2005 and later years)

Does your patient need this therapy **to support a vital function**?	Yes ☐ No ☐
Does your patient need this therapy at least **3 times per week**?	Yes ☐ No ☐
Does this therapy take an average of at least **14 hours per week**?	Yes ☐ No ☐
If **yes**, when did your patient's therapy begin to meet the above conditions (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)?	Year ☐☐☐☐

Provide details of the therapy (for example dialysis, or for persons with diabetes, insulin pump or multiple daily injections):

Cumulative effect of significant restrictions – applies to 2005 and later years

(Complete this section if applicable, and **all sections on page 9**.)

Not applicable ☐

Answer the following questions to determine if your patient may be eligible for the disability tax credit. Also answer the questions at the bottom of this page.

1. Does your patient have an impairment in physical or mental functions that has lasted, or is expected to last, for a continuous period of at least 12 months? Yes ☐ No ☐

2. Even with appropriate therapy, medication, and devices, has the impairment resulted in a **significant restriction**, that is not quite a **marked restriction** (defined below), in **two** or more basic activities of daily living or in **vision** and **one** or more of the basic activities of daily living? Yes ☐ No ☐

3. Do these significant restrictions exist together, **all or substantially all of the time** (at least 90% of the time)? Yes ☐ No ☐

4. Is the cumulative effect of these significant restrictions equivalent to being markedly restricted in a single basic activity of daily living (see examples below)? Yes ☐ No ☐

Note

You **cannot** include the time spent on life-sustaining therapy.

If you answered **yes** to all of the above questions, your patient may be eligible for the disability tax credit.

Definitions

Markedly restricted – means that **all or substantially all of the time** (at least 90% of the time), and even with therapy (other than therapy to support a vital function) and the use of appropriate devices and medication, either:

- your patient is unable to perform one or more of the basic activities of daily living; or
- it takes your patient an inordinate amount of time to perform one or more of the basic activities of daily living.

Significantly restricted – means that although your patient does not **quite** meet the criteria for markedly restricted, his or her vision or ability to perform a basic activity of daily living is still substantially restricted **all or substantially all of the time** (at least 90% of the time).

Examples

Examples of cumulative effects equivalent to being markedly restricted in a basic activity of daily living:

- Your patient can walk for 100 metres, but then must take time to recuperate. He or she can perform the mental functions necessary for everyday life, but can concentrate on any topic for only a short period of time. The cumulative effect of these two significant restrictions is equivalent to being markedly restricted, such as being unable to perform one of the basic activities of daily living.
- Your patient always takes a long time for walking, dressing and feeding. The extra time it takes to perform these activities, when added together, is equivalent to being markedly restricted, such as taking an inordinate amount of time in a single basic activity of daily living.

Answer the following question(s) to certify your patient's condition:

Does your patient meet the four conditions for the cumulative effect of significant restrictions described **above**? Yes ☐ No ☐

If yes, tick at least two of the following, as they apply to your patient.

☐ vision ☐ speaking ☐ hearing ☐ walking ☐ elimination (bowel or bladder functions)

☐ feeding ☐ dressing ☐ mental functions necessary for everyday life

If **yes**, when did the cumulative effect described above begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)? Year ____

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Part B – (continued) **Patient's name:** _____

Complete **all** of the sections on this page.

Effects of impairment

The effects of your patient's impairment must be those which, even with therapy and the use of appropriate devices and medication, cause your patient to be restricted **all or substantially all of the time** (at least 90% of the time).

Note
Basic activities of daily living are limited to walking, speaking, hearing, dressing, feeding, elimination, and mental functions necessary for everyday life. Working, housekeeping, managing a bank account, and social or recreational activities are **not** considered basic activities of daily living.

Examples of effects of impairment:

- For a patient with a walking impairment, you might state the number of hours spent in bed or in a wheelchair each day.
- For a patient with an impairment in mental functions necessary for everyday life, you might describe the degree to which your patient needs support and supervision.

Describe the effects of your patient's impairment(s) on his or her ability to perform **each** of the basic activities of daily living that you indicated are or were markedly or significantly restricted (include the diagnosis, if available). If you need more space, attach a separate sheet of paper.

Effects of impairment:

Diagnosis: _____

Duration

Has your patient's impairment lasted, or is it expected to last, for a continuous period of at least 12 months? For deceased patients, was the impairment expected to last for a continuous period of at least 12 months? Yes ☐ No ☐

If **yes**, has the impairment improved, or is it likely to improve, to such an extent that the patient would no longer be blind, markedly restricted, equivalent to markedly restricted due to the cumulative effect of significant restrictions, or in need of life-sustaining therapy? Yes ☐ No ☐ Unsure ☐

Note
Additional comments related to duration may be added to the "Effects of impairment" section.

If **yes**, enter the year that the improvement occurred or may be expected to occur. Year ☐☐☐☐

Certification

Tick the box that applies to you:

☐ Medical doctor ☐ Optometrist ☐ Occupational therapist ☐ Audiologist
☐ Physiotherapist ☐ Psychologist ☐ Speech-language pathologist

As a **qualified practitioner**, I certify that the information given in Part B of this form is, to the best of my knowledge, correct and complete and I understand that this information will be used by the Canada Revenue Agency (CRA) to determine if my patient is eligible for the disability tax credit or other related programs.

Sign here

_____
It is a serious offence to make a false statement.

Print your name

Date

Telephone

Address

Note
If more information is needed, the CRA may contact you.