Niagara Regional Housing

APPENDIX B **ACCESSIBLE UNIT REQUEST**
ANNUAL REVIEW

Return this form to: *HOUSING PROVIDER NAME*
Fax 905-
In Person *insert office hours*

Tenant/Member Name:_____ Phone # _____

Address:_____

IMPORTANT NOTE TO PHYSICIANS

Your patient is requesting an accessible unit in rent-geared-to-income housing.

There are a number of units that have been modified with accessibility features to accommodate people with physical disabilities. Accessible units have varying degrees of modifications and vary by housing provider. Some may have roll-in showers, lowered counters, roll-under sinks, lowered light switches, front stove controls, lowered cabinets, barrier free bathroom, etc.

The use of a scooter or walker does not necessarily qualify a person for an accessible unit.

Please complete the following:

Does the patient require any of the following modifications to their accommodation to manage regular activities of daily living (bathing, eating, dressing, toileting, etc)? Please check all that apply:

EXTERIOR

- ☐ automatic door opener
- ☐ barrier free access to the building/unit/front entrance

KITCHEN

- ☐ lowered counters/accessible cupboards/shelves
- ☐ knee space under sinks

GENERAL UNIT

- ☐ barrier free access into the unit and throughout the unit
- ☐ lowered light switches/raised outlets

BATHROOM

- ☐ barrier free roll in shower
- ☐ lowered sink/counter
- ☐ knee space under sink

Are there any other modifications the patient would require to manage their activities of daily living? Please explain below:

_____

_____

PHYSICIAN'S RELEASE

I hereby certify that this information represents my best professional judgment and is true and correct to the best of my knowledge.

_____ _____
Physician's Name (printed) Phone

_____ _____
Physician's Signature Date

Space for physician's stamp

CONSENT & RELEASE FROM TENANT/MEMBER

I understand that *PROVIDER NAME* requires the requested personal health information to determine my continued eligibility for an accessible unit.

I authorize my physician to release the information requested on this form to *PROVIDER NAME*, and I consent to *PROVIDER NAME* using, verifying and retaining this information in my housing file.

_____ _____

Tenant/Member Name (printed) Tenant/Member Signature

_____

Date

Office Use Only

□ Remains eligible for accessible unit

□ No longer eligible Reason: _____

Date: _____

Staff Signature: _____

*Personal information contained on this form is collected under the authority of the Housing Services Act, 2011 and subject to the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA), 1991 and the Personal Health Information Protection Act (PHIPA), 2004. The information will be used only for the purposes of determining continued eligibility for an additional bedroom. In requesting an additional bedroom, the tenant/member consents to the collection, use and disclosure, including verification, of the information provided to *HOUSING PROVIDER* in their request or supporting documents.*