THE DISTRICT OF THUNDER BAY
SOCIAL SERVICES ADMINISTRATION BOARD

# MEDICAL REPORT

**OFFICE USE ONLY:**

| **Applicant Name:** | **Confirmation #:** |
|---|---|
| | |

**Applicant complete:**

| | | | |
|---|---|---|---|
| **Name of Member of Household completed for:** | | | |
| **Please indicate member by checking box:** | **Applicant** ☐ | **Co-Applicant** ☐ | **Dependant** ☐ |
| **Date of Birth:** | | | |
| **Applicant's Address:** | | | |

**IMPORTANT NOTE TO PHYSICIAN / NURSE PRACTITIONER:**

☐ **Physician** ☐ **Nurse Practitioner**

Your patient may be applying for Exceptional status for Rent-Geared-To-Income assistance. Exceptional status is only assigned for medical reasons if an applicant has a terminal illness that can pose a personal risk to the applicant / co-applicant or dependent should they be required to wait a prolonged period of time for housing. **Please specify the patient's medical condition and how their current accommodation poses such a risk!** General statements indicating that the client will simply benefit from a certain type or location of unit are insufficient. **This report must include the office stamp and signature of the Physician/Nurse Practitioner.**
***Your report will remain confidential.***

**Physician/Nurse Practitioner complete:**

**Primary Diagnosis:**

_____

_____

**Prognosis:**

_____

_____

**Secondary Diagnosis:**

_____

_____

**Prognosis:**

Would you categorize the patient's current medical status as: Terminal ☐ Yes ☐ No

**Please indicate how their current accommodation poses a risk to the patient**

Do you feel that your patient is capable of living independently in a self-contained unit?
☐ Yes ☐ No ☐ With Support

Explain the services that are or will be in place to ensure independent living.

If your diagnosis indicates behavioral/psychological problems that may be considered anti-social, violent, destructive, or self-destructive, please explain below.

**ADDITIONAL BEDROOM REQUEST**: **If the applicant requires an additional bedroom for medical reasons (i.e. storage of medical equipment, oxygen tank, wheelchair, walker, etc).**

**Please explain below AND list all medical equipment required.**

***…Continued on next page***

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| **Physician/Nurse Practitioner's Certification:**<br>I certify that this information represents my best professional judgment and is true and correct to the best of my knowledge and belief. | |
|---|---|
| **Office Stamp:** | |
| **Physician/Nurse Practitioner Name (please print):** | |
| **Physician/Nurse Practitioner Signature:** | |

**Physician/Nurse Practitioner may give this form directly to the patient or mail to 231 May St S, Thunder Bay ON P7E 1B5.**

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## Authorization/Release by Patient:

I, _____(print name), hereby authorize The District of Thunder Bay Social Services Administration Board (TBDSSAB), to collect personal information concerning myself including all medical information necessary to complete this form from my physician/nurse practitioner. I further authorize my physician/nurse practitioner to release any required medical information to TBDSSAB.

Personal information contained on this form or in attachments is collected by TBDSSAB pursuant to the *Freedom of Information and Protection of Privacy Act*, (R.S.O. 1990, c.F.31) of the *Municipal Freedom of Information and Protection of Privacy Act*. (R.S.O. 1990,c.M.56). This information will be used to determine eligibility for rent-geared-to-income assistance, the size and type of unit eligible for, the placement of the household on the waiting lists, and the amount of geared-to-income rent. Personal information may be disclosed to Non Profit Housing Corporations, the Ministry of Municipal Affairs and Housing, and other municipal/provincial and federal departments and agencies that assist in the provision of affordable housing and to social agencies providing financial assistance to the applicant. Information provided by the household may be shared for the purposes of making decisions or verifying eligibility for assistance under the *Housing Services Act Act*, (2011), the *Ontario Disability Support Program Act*, (1997), the *Ontario Works Act*, (1997), or the *Day Nurseries Act.* The applicant consents to the verification, disclosure, and transfer of information given on this form and attachments by or to any of the above entities and will provide any required supporting material.

Questions about this collection should be directed to The Chief Privacy Officer, 231 May Street South, Thunder Bay ON P7E 1B5, (807) 766-4209 or 1-866-363-0929.

| **Applicant's Signature:** | **Date:** |
|---|---|
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