City of Kawartha Lakes
Human Services
Box 2600, 68 Lindsay Street North
Lindsay, ON K9V 4S7
705-324-9870
cklhumanservices@kawarthalakes.ca

Medical Request for Additional Bedroom

Community Housing

The City of Kawartha Lakes has established local eligibility rules for determining the size and type of unit permissible for a household receiving financially assisted housing. HP009 Occupancy Standards. In some circumstances, the household may require a unit size or type that is outside the principals within that standard operating procedure. These individual special requests will be considered only at the request of the household, based on the following circumstances:

1. A spouse who would normally share a bedroom requires a separate bedroom because of a disability or medical condition. Spouses will not normally qualify for an additional bedroom unless a second bed cannot be accommodated within a shared bedroom. A household will not qualify for an additional bedroom based on a snoring condition alone.
2. A room is required to store equipment that a member of the household needs because of a permanent disability or medical condition, and the equipment is too large to be reasonably accommodated in a unit size for which the household would normally qualify.
   The following equipment will not normally qualify a household for an additional bedroom:
   continuous positive airway pressure (CPAP) machines
   ii. air-filtration systems
   iii. vapourizers or humidifiers
   iv. walkers, wheelchairs or scooters
   v. massage tables or
   vi. exercise equipment
3. A room is required for an individual who provides full-time overnight support services to a member of the household. When a household requests an extra bedroom for medical reason, the Housing Provider and Service Manager must determine if the household qualifies under HP009 Occupancy Standards. From time to time, the Housing Provider may ask for new information to verify that the household still qualifies for the extra bedroom.

Applicant Last Name * **Applicant First Name** * **Birth Date (MM/DD/YY)** *

Mailing Address (Street, PO Box, City, Province, Postal Code):

Home phone: **Cell/Text:** **Email:**

The personal health information disclosed on this form will only be used for the purposes of evaluating the household's eligibility for an additional bedroom. The use and disclosure of the personal health information in this report will be subject the Housing Services Act, 2011, the Health Information Protection Act as applicable, and in the case of the City of Kawartha Lakes, the Municipal Freedom of Information and Protection of Privacy Act.

This section is to be completed and signed by the patient or, if the patient is less than 16 years of age, this section should be completed by a parent or guardian.

I consent to my doctor disclosing the personal health information requested on this form to the City of Kawartha Lakes for the purposes identified on this form.

Date (MM/DD/YY) *

The section below is to be completed and signed by the patient's doctor.

Doctor's name:

Doctor's phone number:

Doctor's mailing address (street, city, province, postal code):

Applicants are eligible for an extra bedroom based on a medical condition or disability. Does this patient have a medical conditon or disability?

- ☐ Yes
- ☐ No

If yes, please complete the balance of the form identifying the impairments of the medical condition or the disability, which would require the patient to have an extra bedroom.

How long has this patient been under your care?

Please describe your patient's impairments

Are these impairments permanent? If not, what is the expected duration of the impairments?

Does your patient's impairment require them to have a separate bedroom. If yes, why?

If a room is being requested to store medical equipment, what is the medical equipment?

If a room is being requested for a caregiver, is your patient able to manage the activities of daily living without assistance?

- ☐ Yes
- ☐ No

If NO, what services do they require?

Does your patient require overnight care?

- ☐ Yes
- ☐ No

If YES, what services do they require?

Doctor's signature: I certify that this information represents my best professional judgment and is true and correct to the best of my knowledge.

Date (MM/DD/YY) *