Application

Medical Request for Modified Unit

Section 1: Applicant Information (Please Print)			
Applicant First Name		Applicant Last Name	
Telephone Number		Email Address	
Street Number	Street Name		Suite/Unit Number
City/Town	Province		Postal Code

Section 2: Consent and Release from Applicant (Please Print) (If the Patient is less than 16 years of age, a parent or guardian must complete and sign this section)	
I understand that the Region of Durham requires the requested personal health information to determine my eligibility for a modified unit. I hereby authorize my physician to disclose the information requested on this form to the Region of Durham, and I consent to the Region of Durham collecting, using, verifying, and retaining this information on my housing file for the purposes stated above.	
Applicant or Parent /Guardian Name	
Applicant or Parent/Guardian Signature	Date (mm-dd-yyyy)

Important Information

Applicants must complete and submit a Durham Access to Social Housing (DASH) Waitlist Application either prior to or together with this form in order for their request for a modified unit to be processed. This original form must be submitted a copy will not be accepted.
Please note: Submission of this form does not guarantee eligibility for a modified unit.

This form will be used to determine the accessibility modifications an applicant will require in a unit. Not all units contain all the modifications listed in this application. Modified units may have:

- Widened doorways/corridors
- Roll-in shower
- Grab bars/handrails
- Modified appliances (front stove controls, side-by-side fridge/freezer)
- Lowered counters/cabinets/switches
- Roll under sinks/counters
- Turning spaces
- Automatic doors
- Front load washer/dryer

This information is collected under the legal authority of s.29(2) of the Municipal Freedom of Information and Protection of Privacy Act and Part V of the Housing Services Act, 2011 and Sections 68 to 71 of the Ontario Regulation 367/11 for the purpose of determining the applicant's eligibility for housing units prescribed. Questions about this collection should be forwarded to the Director of Housing Services, Region of Durham at 605 Rossland Rd E, Whitby ON, L1N 6A3 or 905-668-7711 or 1-800-372-1102. (06-2025)

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Information for Health Care Providers

Your patient has applied for housing assistance and this form requires completion for one or more of the following reasons:

1. to verify their ability to live independently with or without support (Activities of daily living are everyday functions and activities individuals normally perform. This includes bathing, eating, dressing, ambulation and toileting);
2. to verify their needs and identify the requirements for a modified/wheelchair accessible unit because of a condition that requires the permanent or regular use of a wheelchair. The use of a scooter or walker does not necessarily qualify an applicant for a modified accessible unit.

The information that you provide will allow the Region of Durham to determine your patient's eligibility for the Durham Access to Social Housing Waitlist and/or their eligibility for a modified accessible unit.

Section 3: Description of Need for Modified Unit (To be completed by Physician/Health Care Provider)	
Patient's Name (First, Last):	Date of Birth:
What type of mobility device is used by the patient? ☐ Wheelchair ☐ Scooter ☐ Walker ☐ Other (Specify):	
Does the patient require the use of a mobility device on a permanent or temporary basis? ☐ Permanent ☐ Temporary ☐ Other (Specify):	
If you have selected temporary basis, what is the duration the patient expected to require the use of the mobility device?	
Is your patient able to manage daily activities independently without assistance? ☐ Yes ☐ No	If no, are there supports/services currently in place? ☐ Yes ☐ No
If yes, please describe supports/services in place:	
Does your patient have a deteriorating medical condition that will increase the need for unit modifications over time? ☐ Yes ☐ No	How many years has this patient been under your care?

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Section 4: Please indicate the types of modification your patient requires (To be completed by Physician/Health Care Provider)	
☐ Grab Bars/handrails ☐ Automatic door openers in unit ☐ Lowered shelving, rods, counters and cabinets (lowered countertops/cabinets in kitchen and bathroom, accessible closets/storage) ☐ Visual or Audible fire/smoke alarms ☐ Clear turning space in each room	☐ Wheel-in shower ☐ Widened hallways and doorways ☐ Roll under sinks and counters ☐ Modified appliances (front stove controls, side-by-side fridge/freezer) ☐ Accessible light switches and outlets ☐ Easy grasping door levers and locks
Please indicate if there are other modifications required not previously listed?	
Can your patient climb stairs? ☐ Yes ☐ No	If yes, explain how many flights of stairs:

Section 5: Physician/Health Care Provider Verification	
I certify that this information represents my best professional judgement and is true and correct to the best of my knowledge.	
First Name (Print)	Last Name (Print)
Signature	Date (dd-mm-yyyy)
Professional Designation	**Physician's Stamp**
Telephone Number	
Email	

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