Haldimand Norfolk Housing Corporation
25 Kent Street North
Unit #2
Simcoe, ON N3Y 3S1

Request for Accommodation

Applicant/Tenant Information

Name:_____
Date: _____
Address:_____
City: _____
Postal Code:_____
Telephone:_____
Email: _____

Accommodation Request

Please check the accommodation you are requesting for yourself or a member of your household (only one request per form):

- ☐ A ground floor unit or a unit in a building with an elevator.
- ☐ A wheelchair accessible unit.
- ☐ An additional bedroom.
- ☐ A unit modification.
- ☐ Other.

Please describe:

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If your Request for Accommodation Form does not contain enough information to allow the Haldimand Norfolk Housing Corporation (HNHC) to determine an appropriate accommodation, more information will be requested.

I understand that the accommodation requested above may not be granted but that the Haldimand Norfolk Housing Corporation will attempt to provide an appropriate accommodation that does not create an undue hardship on the organization. If applicable, I consent to my doctor disclosing the personal health information in the Medical Verification Form. I confirm that the information provided is true and correct to the best of my knowledge.

Name: (please print): _____

Signature: _____

Date: _____

In most cases, supporting documents from a licensed healthcare professional will be required to process this request. It is recommended that these documents be provided at this time. Licensed healthcare professionals include:

Physician
Psychologist
Psychiatrist
Chiropractor
Physiotherapist
Occupational Therapist
Optometrist
Registered Nurse
Audiologist
Social Worker

This document should specify:

- That you have a disability, and if appropriate, the nature of the disability (e.g. mobility disability)
- Restrictions resulting from the disability (e.g. inability to climb stairs)
- The expected duration of the restrictions (e.g. permanent)
- The basis for the medical conclusions (e.g. any tests or assessments)

The accommodation seeker only needs to provide such information that is necessary to assess their needs in relation to the requested accommodation and does not have to provide a diagnosis. The corporation understands that in certain circumstances the accommodation seeker may be uncomfortable disclosing the nature of their disability.

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Medical Verification

Patient Information

Patient Name: _____

Date: _____

Number of years in your care: _____

Accommodation Request

Please check the accommodation you are supporting for your patient (only one request per form):

☐ A ground floor unit.

☐ An internal transfer to another unit or building.

☐ Permission to smoke cannabis in the unit.

☐ An additional bedroom.

☐ A unit modification.

☐ A wheelchair accessible unit.

☐ Other:_____

Accommodation Information

Please describe your credentials and relationship with the patient, which qualify you to provide this recommendation for accommodation.

Does your patient have a disability? ☐ Yes ☐ No

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Describe the nature of your patient's medical condition and the needs and limitations associated with their condition (a diagnosis s not required).

What is your recommendation for accommodating your patient's needs? Please list all types of accommodation that would be appropriate.

If your recommendation for accommodations includes cannabis consumption, please indicate whether your patient needs to smoke cannabis as opposed to consuming it by other means. (Topicals etc.)

If your recommendation for accommodation includes consumption by smoking, please indicate if your patient needs to consume inside their unit, or whether they can consume outside (for example, on their balcony).

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What is the expected duration of your patient's medical condition?

Please add any additional comments or additional information that you believe is helpful in consideration of the accommodation request.

Healthcare Practitioner Information

Name: _____

Designation: _____

Name of Professional Organization: _____

Address: _____

Telephone: _____

Signature:_____

Practitioner's Stamp

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The information collected in this form is collected by the Haldimand Norfolk Housing Corporation under the authority of the Housing Services Act, 2011 and will be used by our staff for the purpose of reviewing the application and other administrative purposes.

If you require this document in an alternative format, please contact our office at (519) 426-7792 extension 110.