RIVERDALE CO-OPERATIVE HOUSES
1363 Queen Street East, Toronto, Ontario M4L 1C7 Phone: (416) 461-7044 ▲ Fax: 461-7047

685 Queen Street East
Medical Verification Form

Completion of this Medical Verification Form is required if you are applying for an accessible or barrier-free unit at Riverdale Co-operative House's new affordable housing project at 685 Queen Street East. ***Sections 4 and 5 must be completed by your physician***. Please complete a separate form for each household member with accessibility needs.

Riverdale Co-operative Houses will not reimburse applicants for any costs related to the completion of this form.

Section 1: Applicant Information

First Name: _____ Last Name: _____

Address (including postal code): _____

_____

Phone Number: _____ Email Address: _____

Section 2: Consent and Release from Applicant

I understand that Riverdale Co-operative Houses requires the requested health information to determine my eligibility for an accessible or barrier-free unit at 685 Queen Street East.

By this consent, I am hereby authorizing _____ (physician's name) to disclose the information requested on this form to Riverdale Co-operative Houses.

I hereby consent to Riverdale Co-operative Houses collecting this information for the purpose stated above.

Applicant Signature: _____ Date: _____

Section 3: Important Information about Accessible and Barrier-Free Units

There are units at 685 Queen Street East which have been modified to be accessible for people living with physical disabilities who use a mobility device such as a wheelchair. Availability of units is limited. Units may include modifications such as:

- Lowered countertop
- Roll under cooktop
- Handrails or grab bars
- Roll-in shower

- Accessible toilet seat height
- Roll under sinks
- Widened doorways
- Slanted wall mirror

Modifications may vary between units. Barrier-free units may not include all modifications listed above.

To be eligible for an accessible or barrier-free unit:

- An applicant must complete the 685 Queen Street East Application Form for Membership and Accommodation
- One or more household members requires accessibility modifications as a result of a condition that requires the permanent or regular use of a mobility device. The use of a scooter or walker does not necessarily qualify an applicant for a universal barrier-free unit.
- The household member requiring the accessible or barrier-free unit must be able to live independently or has the necessary supports in place to be able to live independently.

Applicants must notify Riverdale Co-operative Houses if their needs change after submission of this medical verification form.

Section 4: Barrier-Free Unit Assessment (TO BE COMPLETED BY PHYSICIAN)

Your patient is requesting an accessible or barrier-free unit at 685 Queen Street East.

1. Does your patient require a mobility device? ☐ Yes ☐ No

   If yes, please indicate which:

   ☐ Wheelchair ☐ Scooter ☐ Walker ☐ Other: _____

2. Does your patient require the use of a mobility device on a permanent or temporary basis?

   ☐ Permanent ☐ Temporary.

   If temporary, what is the expected duration? _____

3. Does your patient have a deteriorating medical condition that will increase the need for unit modifications over time?

   ☐ Yes ☐ No

   If yes, please indicate the modifications that are expected and indicate the time frame:

   _____

   _____

   _____

4. Can your patient use a bathtub? ☐ Yes ☐ No

5. Does your patient require a walk-in or roll-in shower? ☐ Yes ☐ No

6. Please use this space to add any additional comments that you think are relevant to your patient's request for an accessible or barrier-free unit.

   _____

   _____

   _____

Section 5: Physician's Declaration (TO BE COMPLETED BY PHYSICIAN)

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): _____

Address (including postal code): _____

_____

Phone Number: _____

How many years has this patient been under your care? _____

Physician Signature: _____ Date: _____

Physician's Stamp:

If you have any questions or concerns about the **collecting and sharing of this information**, please contact Riverdale Co-operative Houses at manager@riverdalecoop.ca.