MAIN-GERRARD**CO-OP**

Medical Need for an Above-Ground Unit

Name of applicant:	
Applicant's address:	

Important note to doctors and their patients:

MAIN-GERRARD COMMUNITY DEVELOPMENT Co-operative Inc. provides rent-geared-to-income assistance to members who qualify under a subsidy program funded by the Federal government. The program has rules that limit members eligibility for internal transfers, including removal from the internal priority list after a transfer, but may permit a household to maintain priority for an additional transfer if it is medically necessary. When a household requests an internal transfer for a medical reason, the Co-op must determine if the household qualifies under the subsidy program rules.

The personal health information disclosed on this form will be used only for the purpose of evaluating the household's eligibility and need for an above-ground unit. This personal health information may also be disclosed to the Agency for Co-operative Housing and/or Canada Mortgage and Housing Corporation •solely for the purpose of evaluating compliance with the subsidy program rules. .

The patient must complete and sign this section. If the patient is less than 16 years of age, a parent or guardian must complete and sign this section.

I consent to my doctor disclosing the personal health information requested on this form

to: Main Gerrard Community Development Co-operative, Inc.

for the purposes identified on this form. I also consent to the housing provider disclosing this personal health information to the Agency for Co-operative Housing and/or Canada Mortgage and Housing Corporation for the limited purposes stated above.

Signature of patient or parent /guardian:	
Date:	

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The patient's doctor must complete and sign this section.	
Doctor's Name (PLEASE PRINT):	
Speciality (If applicable)	
Address:	
Phone:	
How many years has this patient been under your care?	
What is the medical condition or disability that makes it necessary for your patient to reside in an above-ground unit?	
Are there any further restrictions on the type of unit based on medical need?	
Why does a person with this medical condition or disability need to reside in an above ground unit?	
What is the expected duration of the medical condition or disability?	

Doctor's signature

I have read both pages of this form. I certify that this information represents my best professional judgment and is true and correct to the best of my knowledge.

Signature	***Date***