Algoma District Services Administration Board
Conseil d'administration des services du district d'Algoma

REQUEST FOR MEDICAL PRIORITY STATUS FORM

PATIENT / PARENT / GUARDIAN RELEASE:
I _____ (tenant name), authorize _____ (physician / medical professional) to complete the form below. I understand that this information will be kept on my file with the Algoma District Services Administration Board (ADSAB).

This information is confidential.

Signature:	Date:

TO BE COMPLETED BY THE TENANT / PATIENT:

Applicant Name: (Please print)	Phone:	Cell:

Current Address:

I require special consideration for the following type of housing, due to an existing medical condition, circumstance or mobility limitations:

- ☐ A ground /single level unit or access to an elevator
- ☐ A wheelchair accessible unit **(Wheelchair requirements must be verified by a medical practitioner)**
- ☐ An additional bedroom required for storage of medical equipment
- ☐ An additional bedroom due to pregnancy**. (Medical Practitioner must verify pregnancy and due date)**
- ☐ A unit located closer to a facility providing medical treatment for an existing condition
- ☐ Other unit modifications required _____

TO BE COMPLETED BY THE MEDICAL PRACTITIONER AT THE REQUEST OF PATIENT

Your patient is applying for a 100% barrier free, wheelchair accessible social housing unit **or** is requesting priority status for a specific social housing unit, such as a lower floor or an additional bedroom.

Due to the limited availability of ADSAB housing, priority must be assigned to tenants that require special considerations to the housing they qualify for. Priority is determined in part by a medical issue or special circumstance made worse by a current housing situation. The information you provide will help us to determine if a higher priority should be assigned to your patient, over other households.

Many factors can intensify pressures and problems in a patient's current housing/accommodation. With this in mind, please describe below how your patient's current accommodation is adversely affecting their health and how a specific unit would improve their medical condition or prevent deterioration. Please also give some indication of the urgency and/or seriousness of the situation.

Based on your observations/treatment of this patient, special consideration should be given for the type of housing requested above by your patient ☐ I agree ☐ I disagree

Medical Practitioner Signature & Stamp	Date:
	Telephone Number:

Return this completed form and supporting documentation to the:
Attention of Housing Services - Waitlist
MAIL: Algoma District Services Administration Board (ADSAB)
2 Elizabeth Walk, Elliot Lake, ON, P5A 1Z3
IN PERSON: Any ADSAB Office
FAX: 705-842-3747