Independent Living Assessment

Housing Access Centre (HAC) for the City of London & County of Middlesex
Citi Plaza | 355 Wellington Street, Suite 248, 2nd Floor | London ON N6A 3N7
Tel: 519 661-0861 | E-mail: hac@london.ca

For office use only

Client number

Applicant information

Last name	First name and middle initial	Cellular telephone number

Home telephone number	Can we call you at home?	Work telephone number, including extension	Can we call you at work?
	◯ Yes ◯ No		◯ Yes ◯ No

Apartment number	Current address

City	Province	Postal code	E-mail address

Is there a substitute decision-maker in place for your financial affairs?

◯ No ◯ Yes - *provide their name and telephone number:* _____

The above named applicant has applied for rent-geared-to-income assistance. In order to be eligible, the applicant must be able to live independently in a housing unit with or without support services. If support services are required they must be arranged for by the applicant prior to housing.

The information provided is collected by the City of London Housing Access Centre on behalf of Housing Providers in the City of London and the County of Middlesex, pursuant to the *Housing Services Act (2011) Sections 169-176*.

An applicant who can cope in an independent living situation must be able to meet the following requirements:

1. Able to manage the activities of daily living such as:
   - Mobility
   - Budgeting
   - Housekeeping
   - Cooking
   - Personal hygiene

2. Able to assume the responsibility of a tenant/member under the *Residential Tenancies Act* (2006) and/or *The Co-operative Corporations Act*, which includes paying rent/member charge and maintaining the unit in a good state of repair.

3. Be in receipt of any needed support services, such as:
   - Case management
   - Life skills training
   - Social or vocational/rehabilitation services
   - Treatment program, such as assessment and counseling

Applicant's Declaration and Consent to Disclosure

I hereby authorize the release of any required information to the Housing Access Centre. I fully understand the information being provided will be used in the evaluation of my application for rent-geared-to-income housing. I hereby authorize the Housing Access Centre to retain the information provided on file and provide a copy to the Housing Provider if requested.

_____ _____

Date Signature of applicant

Name of witness: _____ Signature of witness: _____

Personal information contained on this form or in attachments is collected, pursuant to the *Housing Services Act (2011) Sections 169-176* or the *Municipal Freedom of Information and Protection of Privacy Act, (R.S.O. 1990, c M.56)*. This information will be used to determine suitability and eligibility for housing applied to, continuation of housing and the appropriate rent scale and rent geared-to-income charge. Personal information may be disclosed to housing providers, other municipal or provincial departments and agencies that assist in the provision of social housing and social agencies providing social assistance to the applicant. All applicants must consent to the verification, disclosure and the transfer of information given on this form and attachments by or to any of the above entities and you are required to provide supporting material for the purpose of processing the application.

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Request for medical information *(to be completed by physician)*

Your patient has applied for rent-geared-to-income housing. Under the *Housing Services Act (2011)*, an individual must be able to live independently in a housing unit, with or without the aid of support services. Independent living requirements have been listed on previous side. Please be as specific as possible in your evaluation so that we may make a decision as to whether the accommodation the applicant has chosen meets their needs. The information will remain confidential.

Name of physician	Organization name *(if applicable)*	
Address		Phone number / extension
City	Province	Postal code

What are the medical diagnosis, duration and level of disability?

How are the medical problems aggravated by the present accommodation? Please explain.

Is the applicant in a hospital or other medical facility and able to return to their place of residence?

○ Yes Please explain:

○ No

Will the applicant require any special features such as: wheelchair access, grab bars, other? Please explain

What other kinds of service are in place or being recommended for this applicant in order to live independently? Please explain.

Physician's Verification and Declaration (*to be completed by the physician)*

Place office stamp here. (if applicable)

I certify that this information represents my professional opinion and to the best of my knowledge and belief, is true and correct.

Date _____ Signature _____

Physician may give this form directly to the patient or mail to the address at the top of this form. ***Do not fax, original form is required.***

Confirmation of services for independent living *(to be completed by support service agency)*

The applicant has indicated that (a) he/she is currently receiving services from your agency and/or; (b) he/she has arranged for services to be put in place with your agency and that these services will coincide with the date he/she will be housed.

Please indicate on a separate agency letterhead what services and frequency your agency is presently or will be providing to assist the applicant with independent living.

Name of contact	Agency name	
Address	Phone number / extension	Fax number