NOVA SCOTIA

Department of Growth & Development
Housing Services

Accessible Housing Program

Confirmation of Medical Condition or Disability & Recommended Home Adaptations/Modifications

TO THE CLIENT AND THE HEALTH CARE PROFESSIONAL:

The personal information collected on this form will be used to help evaluate what financial assistance the Accessible Housing Program may be able to provide for recommended adaptations / modifications to the residence. The information is collected in accordance with the Freedom of Information and Protection of Privacy Act. The information will only be used for the purpose identified or another purpose if we are authorized by law or if we obtain your consent.

SECTION A: CLIENT TO READ & COMPLETE

I authorize the release of information provided on this form by my Health Care Professional, to / by the Department of Growth and Development for use by the Accessible Housing Program.

Name of Client (Please Print) _____

Signature of Client_____ **Date** _____

SECTION B: TO BE COMPLETED BY LICENSED HEALTH CARE PROFESSIONAL

Is the patient's disability mobility related?	**YES** ☐ **NO** ☐
Is the condition permanent?	**YES** ☐ **NO** ☐
Does the patient use a mobility aid? (check all that apply) **None** ☐ **Cane** ☐ **Walker** ☐ **Motorized Wheelchair** ☐ **Manual Wheelchair** ☐	
Are the adaptations required for discharge from the hospital?	**YES** ☐ **NO** ☐
Adaptations/modifications recommended for the home:	
Name of Health Care Professional:	**Title or Professional Designation:**
Telephone Number:	**Address:**

Signature of Health Care Professional: _____

Date: _____

NOTE: CONFIDENTIAL ONCE COMPLETED