Niagara Region

Additional Bedroom Request

Mailing Address:

Niagara Region
Housing Services
1815 Sir Isaac Brock Way P.O. Box 344
Thorold, ON L2V 4T7
niagararegion.ca

905-980-6000 Toll free: 1-877-263-7215
Fax: 905-935-0476
Email: housing@niagararegion.ca

Please complete and return this form.

Applicant Contact Information

First name: Last name:

Address: City/Town: Postal/Zip Code:

Email address: Telephone number:

Medical Information

Your patient has applied for housing and is requesting an extra bedroom based on medical grounds. To assess the request, we need more information.

An extra bedroom may be requested under one of these circumstances. Review each one and provide an explanation, where applicable.

☐ A household member needs a separate bedroom because a medical condition or disability affects the sleep patterns of their spouse/same-sex partner. List the medical condition or disability and describe how it interferes with the sleep patterns of the partner.

☐ A household member needs a separate bedroom because the use of required medical equipment affects the sleep patterns of their spouse/same-sex partner. List the specific medical equipment and describe how it interferes with the sleep patterns of the partner.

☐ A separate bedroom is needed to store medical equipment. A household member has a significant mobility issue and needs **more than one** piece of large equipment to move around. List the medical equipment that needs an extra bedroom for storage.

Physician's Release

Physician's name: _____

Telephone Number: _____

Date (mm/dd/yyyy): _____

Physician's signature: _____

Physician's Stamp

Applicant Consent and Release

I: _____ understand that Niagara Region Housing Services requires the requested personal health information to determine my eligibility for an additional bedroom.

I authorize my physician to release the information requested on this form to Niagara Region Housing Services, and I consent to Niagara Region Housing Services using, verifying and retaining this information in my housing file.

Applicant signature: _____ Date (mm/dd/yyyy): _____

Office Use Only

☐ Approved ☐ Denied Date (mm/dd/yyyy): _____ Staff initials: _____

Any personal information or personal health information submitted will be collected, used and disclosed, where applicable, by members of Regional staff in accordance with the Municipal Freedom of Information and Protection of Privacy Act or the Personal Health Information Protection Act. Any information you share will be used only for the intended purpose for which it was provided.