MEDICAL CONFIRMATION FOR A REQUEST FOR ACCOMMODATION

RELEASE BY PATIENT / PARENT / GUARDIAN:

I authorize my doctor or other qualified medical practitioner to complete the form below. I understand that this information will be kept on my file.

This information is confidential.

Signature:	Date:	
Name: (Please print)	Telephone:	Email:
Address:		

I presently live in a ( ) bedroom apartment / townhouse. (circle one)
The type of housing accommodation (circle one) that I am requesting is:

TO BE COMPLETED BY PHYSICIAN AT REQUEST OF PATIENT:

Your patient is a tenant at a rental location managed by Satellite Community Homes and has either applied for a transfer to another housing unit or an accommodation in their present unit as described above. Due to the limited availability of housing as well as budget limitations, priority must be assigned to tenants applying for transfers and those receiving accommodations. **Priority is determined in part by urgent medical problems which are made worse by a current housing situation.** The information you provide to us will help us to determine if a higher priority should be assigned over other people with medical problems as well as over others who may be overcrowded or have other serious problems with their housing.

Many factors can intensify pressures and problems in a patient's current housing situation. With this in mind, please describe below **if your patient's current housing situation is adversely affecting his/her health due to a diagnosed medical condition** and if a transfer to another unit or an accommodation in their existing unit would **significantly improve his/her medical condition or prevent deterioration.** Please also give some indication of the **urgency** and/or **seriousness** of the situation (use reverse side of form if needed).

Signed (Physician)	Date:
Name: (Please print)	Telephone Number:

Revised April 19, 2024