

Disability Tax Credit Patient Screening Form

Having a diagnosis of a disability does not automatically qualify you for a Disability Tax Credit. The requirements of this program are much more stringent, and whether or not you qualify is decided by government adjudicators based on the information submitted. Qualifying for a Disability Tax Credit requires there to be a very significant impact on your day to day activities, rather than just a diagnosis.

In order to complete your Disability Tax Credit Form accurately and completely, we require certain information from you. As such, please complete the following questionnaire. Please circle the correct answer for each question, and complete the bottom section of this form.

1. Are you legally blind in both eyes (vision worse than 20/200)? **Yes** **No**
2. Are you unable to speak, or do you take you three times as long to speak as the average individual of your age? **Yes** **No**
3. Are you unable to hear in a quiet environment, even when wearing hearing aids?
 Yes **No**
4. Does it take you three times as long as the average individual your age to walk, even when using your assistive devices (eg: wheelchair, walker, cane)? **Yes** **No**
5. Are you unable to personally manage your bowel and bladder functions (excluding urinary incontinence), or does it take you three times longer than the average individual your age to do so? **Yes** **No**
6. Are you unable to feed yourself? **Yes** **No**
7. Are you unable to dress yourself or does it take you three times as long as the average individual your age to get dressed? **Yes** **No**
8. Are you severely restricted in every day mental functions such as memory, judgement, goal setting, problem solving, simple interactions with others or basic self-care, even with the use of medications or assistive devices? **Yes** **No**
9. Do you require life sustaining therapy at least three times per week, for an average of at least 14 hours per week (eg: dialysis)? **Yes** **No**

What was the year of the diagnosis? _____

What was the year that your diagnosis began to impact you in the significant ways listed above?

Please provide a detailed explanation for any yes answers above. Please include information about how your disability affects your day to day function. Please feel free to attach additional information if there is insufficient space below.