Clear Form

Ontario

Ministry of Community and Social Services

Ontario Disability Support Program
Employment Supports

Verification of Disability / Impairment

INSTRUCTIONS

Applicants are required to complete the attached "Consent To Release Medical Information" before taking this form to a Health Care Professional.

The “Verification of Disability/Impairment Form” must be completed by a qualified Health Care Professional who knows the applicant well enough to comment on his/her disability or impairment and the difficulties that he/she may have in finding or keeping a job.

The following qualified Health Care Professionals may complete this form:

- Family doctor or other physician, including psychiatrist
- Physiotherapist
- Optometrist
- Audiologist
- Psychologist or Psychological Associate
- Chiropractor
- Occupational Therapist
- Speech Language Pathologist
- Registered Nurse

The following applicants ***are not*** required to complete this form:

- Applicants in receipt of ODSP Income Support as a person with a disability;
- Applicants registered as legally blind with the Canadian National Institute for the Blind (CNIB);

The following applicants ***may not*** be required to complete this form. Please contact your ODSP office to inquire:

- Applicants who are former/current students of a school/program for students with disabilities;
- Applicants who have a report completed by a qualified Health Care Professional that verifies their disability and meets the requirements of ODSP Employment Supports.

The applicant must return both the “Verification of Disability/Impairment” form and the “Consent to Release Medical Information” form together with the “Application for Employment Supports” form to the contact listed below.

For more information, please contact:
http://www.mcss.gov.on.ca/en/mcss/programs/social/odsp/employment_support/index.aspx

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Ontario Disability Support Program
Employment Supports

Consent to Release Medical Information

I, _____ * am applying to
Name of Applicant *(please print)*

receive Employment Supports under the *Ontario Disability Support Program Act, 1997,* from the Ministry of Community and Social Services of the Province of Ontario.

I hereby authorize _____ to disclose to
Name of Health Care Professional *(please print)*

representatives of the Ministry of Community and Social Services the medical and related information requested in the attached *Verification of Disability/Impairment Form* for the purpose of verifying my initial and on-going eligibility for ODSP Employment Supports.

In the event that I request a review of any decisions made by the Ministry regarding my initial or on-going eligibility for Employment Supports under the *Ontario Disability Supports Program Act, 1997,* I acknowledge that any or all of the information provided pursuant to this consent may be released to the Dispute Resolution Committee.

I fully understand the nature and purpose of this consent and give my consent and authorization voluntarily.

_____ *	_____
Signature of Applicant	Date *(yyyy/mm/dd)*
_____	_____ **
Name of Witness (*please print)*	Signature of Witness

* In situations where the applicant is unable to provide consent in writing, by reason of physical or mental disability, the consent of the trustee, legal guardian or, if there is no legal guardian, the next of kin (with the applicant's verbal consent), will suffice.

** Please have your signature witnessed by anyone over the age of 18 years.

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Ministry of Community and Social Services

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To be Completed by the Applicant

Please ***print*** the following personal information:

☐ Mr. ☐ Ms. ☐ Mrs.

Last Name	First Name

Date of Birth	Day	Month	Year

Address

City	Postal Code

Home Telephone / TTY	Work Telephone	
( )	( )	Ext.

To be Completed by the Health Care Professional

Applicants may be eligible to receive Employment Supports if they meet certain conditions including having a physical or mental impairment that is continuous or recurrent and expected to last one year or more, and that presents a substantial barrier to competitive employment.

Please complete and sign this report and return it to your patient/client.

The information will be used in connection with your patient's/client's application for ***ODSP Employment Supports***. The purpose of ODSP Employment Supports is to help people with disabilities prepare for, obtain, and maintain competitive employment.

The Ministry of Community and Social Services is not responsible for any payment related to the completion of this form.

1. Please describe the nature of the applicant's disability(ies) or impairments(s):

   Primary disability: _____

   Secondary disabilities (if any): _____

2. Is/are the disability(ies) or impairment(s) continuous or recurrent/sporadic:

   ☐ Continuous ☐ Recurrent/sporadic

   If recurrent/sporadic, please describe: _____

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3. Is/are the disability(ies) or impairments(s) likely to continue for:

☐ Less than 1 year
☐ 1 year or more

4. Please describe how the disability(ies) or impairment(s) present(s) a substantial barrier, if any, to employment (e.g. preparing for, obtaining or maintaining employment):

5. Are there any medical or other conditions/requirements that would prevent participation in part-time or full-time training or employment?

☐ Yes ☐ No

If yes, please explain

6. Additional Comments:

Name of Health Care Professional *(please print)*

Address	Telephone Number ( )
City/Town Postal Code	Fax Number ( )
Signature of Health Care Professional	Date *(yyyy/mm/dd)*

Notice with Respect to the Collection of Personal Information
(Freedom of Information and Protection of Privacy Act)

The information is collected under the legal authority of the *Ontario Disability Support Program Act*, S. O. 1997, c.25, Schedule B, sections 32 and 33 for the purpose of providing employment supports to enable persons with disabilities to obtain and maintain employment. For more information contact

_____ at ( ) _____ ,

in your local ODSP office.

Print Form