FREQUENTLY ASKED QUESTIONS ABOUT THE DISABILITY TAX CREDIT

Q: Who is the Disability Tax Credit for?
A: The Disability Tax Credit is for people with severe and prolonged impairments which significantly affect their ability to perform the most basic functions of everyday life.

Q: Why do I need to fill out this questionnaire?
A: Completing this questionnaire will help give your physician the information she needs to accurately complete the Disability Tax Credit application for you.

Q: Is completing the Disability Tax Credit application covered by OHIP?
A: No. There is a charge payable when you drop off your Disability Tax Credit application along with this questionnaire (see website for current rates).

Q: Is there anything else I need to do?
A: Your physician may ask that you come in for an office visit if she feels she needs to clarify something about your medical history or your answers to the Disability Tax Credit questionnaire.

Q: Who decides if I qualify for the Disability Tax Credit?
A: The Canada Revenue Agency determines who qualifies for the Disability Tax Credit. The physician who completes the Disability Tax Credit application is not involved in the decision to approve or reject someone for the tax credit.

Q: What is my physician's role in my application for a Disability Tax Credit?
A: Your physician is responsible for providing accurate medical information to the Canada Revenue Agency so that they can decide if someone qualifies for a Disability Tax Credit. The physician does not control the decision made by the Canada Revenue Agency.

Q: Where can I get more information about the Eligibility Criteria for the Disability Tax Credit?
A: You can find more information about the Eligibility Criteria on the Canada Revenue Agency's website at

https://www.canada.ca/en/revenue-agency/services/tax/individuals/segments/tax-credits-deductions-persons-disabilities/information-medical-practitioners/eligibility-criteria-disability- tax-credit.html

DISABILITY TAX CREDIT QUESTIONNAIRE

Name:
Date of Birth: ____

Please complete only the section(s) that relates to your disability. DO NOT complete sections that are not applicable to you.

1) VISION

Are you blind by the criteria in the Disability Tax Credit application? (circle one) **Y N**

What year did your vision disorder become a SEVERE IMPAIRMENT? __________

How does your visual impairment affect your day to day life? Please provide details in your response.

____
____
____
____
____

2) SPEAKING

Are you UNABLE to speak or do you take THREE TIMES LONGER than the average person to communicate via speech? (circle one) **Y N**

Do you use any devices/medications to assist with speech? If so, are you STILL significantly impaired even WITH those devices/medications? (circle one) **Y N**

What year did your speech disorder become a SEVERE IMPAIRMENT? ___________

How does your speech impairment affect your day to day life? Please provide details in your response.

____
____
____
____
____

3) HEARING

Are you UNABLE to hear or do you take THREE TIMES LONGER than the average person to understand someone who is speaking to you? (circle one) **Y N**

Do you use any devices/medications to assist with hearing? If so, are you STILL significantly impaired even WITH those devices/medications? (circle one) **Y N**

What year did your hearing disorder become a SEVERE IMPAIRMENT? ___________

How does your hearing impairment affect your day to day life? Please provide details in your response.

4) WALKING

Are you UNABLE to walk or do you take THREE TIMES LONGER than the average person to walk a short distance (ie, a city block)? (circle one) **Y N**

Do you use any devices/medications to assist with walking? If so, are you STILL significantly impaired even WITH those devices/medications? (circle one) **Y N**

What year did your walking disorder become a SEVERE IMPAIRMENT? ___________

How does your walking impairment affect your day to day life? Please provide details in your response.

5) ELIMINATING

Are you UNABLE to personally manage your bowel or bladder functions or do you take THREE TIMES LONGER than the average person to perform those functions? (circle one) **Y N**

Do you use any devices/medications to assist with elimination? If so, are you STILL significantly impaired even WITH those devices/medications? (circle one) **Y N**

What year did your difficulty with elimination become a SEVERE IMPAIRMENT? _________

How does your elimination impairment affect your day to day life? Please provide details in your response.

____
____
____
____

6) FEEDING

Are you UNABLE to feed yourself or cook for yourself or do you take THREE TIMES LONGER than the average person to feed yourself or cook for yourself? (circle one) **Y N**

Do you use any devices/medications to assist with feeding and/or cooking? If so, are you STILL significantly impaired even WITH those devices/medications? (circle one) **Y N**

What year did your difficulty with feeding or cooking become a SEVERE IMPAIRMENT? _________

How does your feeding impairment affect your day to day life? Please provide details in your response.

____
____
____
____
____
____

7) DRESSING

Are you UNABLE to dress yourself or do you take THREE TIMES LONGER than the average person to dress yourself? (circle one) **Y N**

Do you use any devices/medications to assist with dressing yourself? If so, are you STILL significantly impaired even WITH those devices/medications? (circle one) **Y N**

What year did your difficulty with dressing yourself become a SEVERE IMPAIRMENT? ________

How does your dressing impairment affect your day to day life? Please provide details in your response.

____
____
____
____
____
____

8) MENTAL FUNCTIONS NECESSARY FOR EVERYDAY LIFE

Are you SEVERELY RESTRICTED in everyday mental functions such as memory, judgment, goal-setting, problem-solving, simple interactions with others, or basic self-care? (circle one) **Y N**

Do you use any devices/medications to assist with everyday mental functions? If so, are you STILL significantly impaired even WITH those devices/medications? (circle one) **Y N**

What year did your mental disorder become a SEVERE IMPAIRMENT? ________

How does your impairment in everyday mental functions affect your day to day life? Please provide details in your response.

____
____
____
____
____

9) LIFE SUSTAINING THERAPY

Do you require life sustaining therapy at least THREE TIMES PER WEEK for an average of at least FOURTEEN HOURS PER WEEK? (circle one) **Y N**

What is the life sustaining therapy that you require?

____
____
____
____
____
____
____