Ontario
Ministry of Advanced Education and Skills Development
Student Financial Assistance Branch

2016-2017 Disability Verification Form: Ontario Student Assistance Program (OSAP)

Purpose of this Form

This form is used to obtain information and documentation related to your disability from your physician or other regulated health care professional.

Do You Need this Form?

Before going further, first determine if you need to use this form.

If you are going to a publicly-assisted college or university in Ontario:
Contact your school's Office for Students with Disabilities. They may have a different form that you will use instead of having this one completed.

If you have a learning disability:
You do not need to complete this form. Instead, you must provide a psycho-educational assessment conducted by a registered psychologist or psychological associate. To be considered, the assessment must have been completed either when you were at least 18 years of age or within the past 5 years.

If you are going to a private postsecondary school in Ontario or any postsecondary school outside of Ontario:
Use this form if you do not have documentation from your physician or other regulated health care Professional that clearly provides the following information:

- Your type of disability;
- The impact of your disability(ies) on your participation in postsecondary studies;
- The permanence of your disability (temporary or permanent); and,
- Your physician or health care professional's name and contact information.

If You Use this Form

This information provided will be used to assess your eligibility for disability-related assistance under OSAP. The documentation is also required so you can be considered as a person with a disability based on the minimum student loan course load requirement.

Note:

- This form is not an application. This form is used for the collection of information and documentation to support your being considered under disability-related eligibility criteria.
- You are responsible for covering any costs related to the completion of this form.

Programs Included

Disability-related funding under OSAP includes:

- Ontario Bursary for Students with Disabilities,
- Extended eligibility for the 30% Off Ontario Tuition grant,
- Canada Student Grant for Persons with Permanent Disabilities, and
- Canada Student Grant for Services and Equipment for Persons with Permanent Disabilities.

Who's Eligible?

To be eligible for disability-related Canada Student Grants, you must have a permanent disability, which is defined as a functional limitation:

- caused by a physical or mental impairment;
- that restricts your ability to perform the daily activities necessary to participate in studies at the postsecondary level or the labour force; and
- that is expected to remain with you for your whole life.

Students with temporary disabilities may be considered for the Ontario Bursary for Students with Disabilities. Talk to staff at your school's Office for Students with Disabilities for more information.

How Often is This Information Required?

Normally, you are only required to have this form completed once to confirm your disability and any related functional limitations and/or restrictions. However, you may be asked to provide additional documentation at any time by the ministry or your school to confirm or re-establish your disability status. The privacy of all disability documentation is protected by the ministry under the *Freedom of Information and Protection of Privacy Act.*

How to Complete this Form

Fill out Section A and sign the Notice, Declarations and Consents (page 3 and 4). Then forward Section B (pages 5, 6 and 7) to your physician or other regulated health care professional for their completion.

Where to Send Your Completed Form

Students attending an Ontario publicly-assisted college or university:
Contact your school's Office for Students with Disabilities or Financial Aid Office to find out which of these two offices you should send your completed form.

Students attending an Ontario private postsecondary school or any postsecondary school outside of Ontario:

Send your completed form to the ministry at:

Student Financial Assistance Branch
Ministry of Advanced Education and Skills Development
189 Red River Road, 4th Floor
Thunder Bay, ON P7B 6G9

Deadline

The completed form must be received no later than 40 days before the end of your current study period.

Section A: Student Information (to be completed by the student)

What is the name of the school you plan to attend?

Social Insurance Number:

Student number at your school:

Ontario Education Number (OEN), if assigned to you:

Last name:

First name:

Date of birth:
Month Day Year

Mailing Address

Street number and name, rural route, or post office box:

Apartment:

Street number and name, rural route, or post office box:

Province or state:

City, town, or post office:

Postal code or zip code:

Country:

Area code and telephone number:

Consent and Declarations of Student

- I agree that until my loans, overpayments, and repayments are assessed and repaid, the ministry can, without limitation, collect and exchange personal information about me that is relevant to the administration and financing of the Ontario Student Assistance Program (OSAP) and Canada Student Loans Program (CSLP) with: Employment and Social Development Canada (ESDC); Canada Revenue Agency (CRA); National Student Loans Service Centre (NSLSC); my postsecondary school and its authorized financial administration agents and auditors; bodies that administer programs identified on this form; other parties used by the ministry to administer and finance OSAP; ESDC's contractors and auditors; collection agencies operated or retained by the federal or provincial governments; and consumer reporting agencies.
- I certify that the information provided on this form is accurate and complete, to the best of my knowledge. I understand that it is an offence to make a false or misleading statement and furthermore, that the ministry may restrict me from receiving disability-related assistance under OSAP in the future, and may take legal action and may require me to repay any disability-related OSAP funding that I received as a result of any false or misleading statement.
- I authorize the physician or other regulated health care professional who has completed Section B of this form to provide the requested personal health information to the ministry and my postsecondary school and, if required by the ministry or my postsecondary school, to provide additional personal health information relating to my disability or disability-related needs.
- I authorize the ministry and my postsecondary school to contact the physician or other regulated health care professional if the personal health information provided by him or her is not clear or is illegible. This authorization is limited and does not extend to allow the ministry or my postsecondary school to gather any personal health information from my physician or other regulated health care professional that is not related to this form or any related documentation that I have submitted.
- I understand that information I provide, including the personal health information provided by my physician or other regulated health care professional, may be verified and audited and, for these purposes the ministry may conduct inspections and investigations.

Student's Social Insurance Number:

Student's signature:

Date :

Month Day Year

The personal information you and your physician or other regulated health care professional provide in connection with this form, including your Social Insurance Number (SIN), is collected and used by the ministry to determine your eligibility for disability-related assistance under OSAP.

Your personal information will be used to administer and finance the Ontario Student Assistance Program (OSAP) as set out in the notice of Collection and Use of Personal Information on your OSAP application form and in accordance with the consents you signed on your OSAP application form. The Ministry of Training, Colleges and Universities administers and finances OSAP under the legal authority set out on your OSAP application form. If you have any questions about the collection, use and disclosure of your personal information, contact the Director, Student Financial Assistance Branch, Ministry of Training, Colleges and Universities, PO Box 4500, 189 Red River Road, Thunder Bay, ON P7B 6G9; (807) 343-7260.

Section B: Disability Information

To be completed by a physician or other regulated health care professional.

Purpose and Instructions

This form is used to determine your patient's eligibility for assistance under the Ontario Student Assistance Program (OSAP) for students with disabilities. Eligibility is based on the functional impact of the disability on the patient's ability to participate in a postsecondary educational environment and, in some instances, the permanence of their disability.

Section B includes 3 pages. Ensure that you complete all 3 pages. If you require additional space, please attach a letter (on your official letterhead) with the additional information. Provide clear statements about your patient's disability-related functional limitations and/or restrictions, avoiding such terms as "suggests" or "is indicative of". Once completed, please return all 3 pages to the patient.

Patient Information

First name:

Last name:

Date of Birth:
Month Day Year

Physician or Health Care Professional Information

First name:

Last name:

Area code and telephone number:

ext.

Specialty (indicate all that apply)

- ☐ Audiologist
- ☐ Chiropractor
- ☐ Neurologist
- ☐ Occupational Therapist
- ☐ Optometrist
- ☐ Ophthalmologist
- ☐ Physician – family
- ☐ Physician – Psychiatrist
- ☐ Physiotherapist
- ☐ Psychologist or Psychological Associate
- ☐ Rheumatologist
- ☐ Other - Specify:

Ontario Licence #:

I certify that the information provided on this form is accurate and the patient identified above experiences the disability-related educational barrier(s) indicated.

Signature of Physician or Health Care Professional:

Date:
Month Day Year

Official stamp of facility name and address:

Note: If you don't have an office stamp, please sign and attach your letterhead to this form.

Section B: cont'd Patient First Name: _____ Last Name: _____

Type of Disability (check all that apply)

☐ **Functional/Mobility Impairment** (e.g., paraplegia, quadriplegia, muscular dystrophy, cerebral palsy, spinal cord injury, spina bifida, multiple sclerosis)
If your patient consents, please identify the diagnosis:

☐ **Visual Impairment**
Visual acuity: _____ Visual field: _____
If your patient consents, please identify the diagnosis:

☐ **Hearing Impairment**
Please indicate hearing loss in better ear:
☐ Mild ☐ Moderate ☐ Severe ☐ Congenital ☐ Profound
If your patient consents, please identify the diagnosis:

☐ **Medical Disability** (e.g., epilepsy, chronic pain, heart condition)
If your patient consents, please identify the diagnosis:

☐ **Acquired Brain Injury** Provide date of injury: Month Day Year
If your patient consents, please identify the diagnosis:

☐ **Autism Spectrum Disorder** (e.g., autism, Asperger's, pervasive developmental disorder, etc.)
If your patient consents, please identify the diagnosis:

☐ **Mental Health Disability**
If your patient consents, please identify the diagnosis:

☐ **Attention Deficit Disorder (ADD) / Attention Deficit Hyperactivity Disorder (ADHD)**
Psycho-educational assessment performed?
☐ Yes - Attach a copy of the assessment. ☐ No ☐ Unknown
If your patient consents, please identify the diagnosis:

☐ **Other** (specify) : _____
If applicable, include copy of assessment (e.g., medical, psycho-educational, psychological, etc.)
If your patient consents, please identify the diagnosis:

Permanence of Disability

To be eligible for disability-related Canada Student Grants, your patient must have a permanent disability. Choose ONE of the following statements that best describes the patient.

☐ Patient's disability (or disabilities) is **temporary**.
Anticipated duration of disability:

☐ Patient's disability (or disabilities) is **permanent** with ongoing (chronic or episodic) symptoms that will restrict his/her ability to perform the daily activities necessary to fully participate in postsecondary studies or in the labour force, and the disability is expected to remain for his/her lifetime.

Disability Impacts on Daily Functioning

Check all that apply:

☐ Ambulation ☐ Standing ☐ Sitting ☐ Stair Climbing ☐ Lifting/Carrying/Reaching

☐ Grasping/Gripping/Dexterity ☐ Other - Specify:

Describe impact(s):

Cognitive and/or Behavioural Impacts

Check all that apply:

☐ Attention and Concentration ☐ Memory ☐ Information Processing (verbal and written)

☐ Stress Management ☐ Organization and Time Management ☐ Social Interactions

☐ Communication ☐ Other - Specify:

Describe impact(s):

Medication

Is the patient currently taking any prescription medications that may affect the patient's participation in an educational environment?

☐ Yes If "Yes", indicate any side effects (alertness, concentration, nausea):

☐ No

Recommended Supports

Optional - Check all that apply.

☐ The patient is advised to take a reduced course load.

☐ The patient requires specialized equipment in order to participate in postsecondary education.

Specify equipment required:

☐ The patient requires specialized services in order to participate in postsecondary education.

Specify services required: