

LANGLEY LIONS HOUSING SOCIETY  
EMAIL: ADMIN@LLHS.CA (preferred)  
OFFICE: 5464 – 203<sup>rd</sup> STREET, Langley, BC V3A 0A4  
TELEPHONE: 604 530-7171 FAX: 604 530-7104

**APPLICANT TO COMPLETE**

I hereby authorize the Physician named below to disclose information contained in my medical records to Langley Lions Senior Citizens Housing Society Housing for the sole purpose of determining my eligibility for subsidized housing.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Name ( please print) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Dear Physician:

Your patient is applying for subsidized housing under our disabled client group. To confirm eligibility under this group, documentation is required from you, his/her medical physician, indicating that your patient suffers from a prolonged mental or physical disability which cannot be improved by medical treatment and causes a severe loss or impairment of normal physical and/or mental ability such that he/she is incapable of pursuing or maintaining any substantial gainful employment on a regular basis. To be eligible for subsidized housing, your patient's disability must be expected to continue permanently, or for a significant duration, i.e., for several years, that cannot be predicted with any certainty. He/She must also be able to live independently.

Please complete the Section at the bottom of the page and return this letter directly to the Housing Services Department at the address shown on our letterhead.

This information will be held in the strictest confidence.

<b>PHYSICIAN TO COMPLETE</b>		
Diagnosis: _____		
Relevant Medical History: _____		
Treatment/Medication: _____		
Summary and Prognosis: _____		
_____		
Is the Patient able to live independently at this time? _____		
In your opinion, is this patient capable of pursuing or maintaining any substantial gainful employment on a regular basis? _____		
_____		
Physician's Name (please print)	Signature	Date
Address		Phone Number
( ) GP	( ) Specialist: _____	