Canada Revenue Agency | Agence du revenu du Canada

DISABILITY TAX CREDIT CERTIFICATE

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This form is separated into two sections: the introduction and the form itself. The introduction includes the following:

- general information about the disability amount;
- definitions;
- how to make adjustment requests for previous years;
- what to do if you disagree with our decision about your eligibility;
- a questionnaire to help you determine if you may be eligible for the disability tax credit; and
- tax centre addresses.

The form itself includes an **application** (**Part A**), and a **certification** (**Part B**). Both parts of the form must be completed.

Who uses this form – and why?

Individuals who have a severe and prolonged impairment in physical or mental functions (see "Definitions" on the next page), or their legal representative, use this form **to apply** for the disability tax credit (DTC) by completing Part A of the form.

Qualified practitioners use this form **to certify** the effects of the impairment by completing Part B of the form.

Note
For information to help qualified practitioners complete this form, go to **www.cra.gc.ca/qualifiedpractitioners**.

What is the disability amount?

The disability amount is a non-refundable tax credit used to reduce income tax payable on your income tax and benefit return. This amount includes a supplement for persons under 18 years of age at the end of the year. All or part of this amount may be transferred to your spouse or common-law partner, or another supporting person. For more information, go to **www.cra.gc.ca/disability** or see Guide RC4064, *Medical and Disability-Related Information*.

The disability amount is entered on **line 316** (self), **line 318** (transferred from a dependant), or **line 326** (transferred from your spouse or common-law partner) of your income tax and benefit return when you are eligible for the DTC.

Are you eligible?

You are eligible for the DTC only if we approve this form. A qualified practitioner has to complete and certify that you have a severe and prolonged impairment and its effects. To find out if you **may** be eligible for the DTC, use the self-assessment questionnaire in this introduction.

If you receive Canada Pension Plan or Quebec Pension Plan disability benefits, workers' compensation benefits, or other types of disability or insurance benefits, **it does not necessarily mean you are eligible for the DTC**. These programs have other purposes and different criteria, such as an individual's inability to work.

The Canada Revenue Agency must validate this certificate for you to be eligible for the DTC. If we have already told you that you are eligible, do not send another form unless you are advised that one is required. **However, you must tell us if your condition improves.**

You can send the form to us at any time during the year. By sending us your form before you file your income tax and benefit return, you may prevent a delay in your assessment. We will review your application before we assess your return. Keep a copy of the completed form for your records. **We do not accept photocopies or facsimile copies of this form.**

Fees – You are responsible for any fees that the qualified practitioner charges to complete this form or to give us more information. However, you may be able to claim these fees as medical expenses on line 330 or line 331 of your income tax and benefit return.

Related programs

If a child under 18 years of age is eligible for the DTC, that child is also eligible for the **Child Disability Benefit**, an amount available under the Canada Child Tax Benefit. For more information, go to **www.cra.gc.ca/benefits** or see Booklet T4114, *Canada Child Benefits*.

If you are eligible for the DTC and you have working income, you may be eligible for the **working income tax benefit disability supplement**. For more information, go to **www.cra.gc.ca/witb** or see line 453 in the *General Income Tax and Benefits Guide*.

If you are eligible for the DTC, you may be eligible to open a **registered disability savings plan (RDSP)**. For more information, go to **www.cra.gc.ca/RDSP** or see Guide RC4460, *Registered Disability Savings Plan*.

For more information

If you need help, go to **www.cra.gc.ca/disability** or call **1-800-959-8281**.

To get our forms or publications, go to **www.cra.gc.ca/forms** or call **1-800-959-2221**.

Do you use a teletypewriter (TTY) operator-assisted relay service? – If you use a TTY, an agent at our bilingual enquiry service (**1-800-665-0354**) can help you. Agents are available Monday to Friday (except holidays) from 8:15 a.m. to 5:00 p.m. From February 20 to April 30, these hours are extended to 9:00 p.m. on weekdays, and from 9:00 a.m. to 5:00 p.m. on Saturdays (except Easter weekend).

We need your written permission to discuss your information with the TTY relay operator when you contact us through our regular telephone enquiry lines. We need a letter from you giving us your name, address and social insurance number, the name of the telephone company you use, your signature, and the date you signed the letter.

If you have a visual impairment, you can get our publications in braille, large print, etext (CD), or MP3 by going to **www.cra.gc.ca/alternate** or by calling **1-800-959-2221**. You can also get your personalized correspondence in these formats by calling **1-800-959-8281**.

Vous pouvez obtenir ce formulaire en français à **www.arc.gc.ca** ou au **1-800-959-3376**.

Canada

Definitions

Life-sustaining therapy – Life-sustaining therapy must meet the following conditions:

- You receive the therapy to support a vital function, even if it alleviates the symptoms. Examples of this therapy are chest physiotherapy to facilitate breathing and kidney dialysis to filter blood. However, implanted devices such as a pacemaker, or special programs of diet, exercise, or hygiene do **not** qualify.
- You have to dedicate time for the therapy – at least **3 times a week**, for an average of at least **14 hours a week** (do not include time needed to recuperate after therapy, for travel, medical appointments, or shopping for medication). Time dedicated to therapy means that you must be required to take time away from normal, everyday activities in order to receive the therapy. The time it takes for a portable or implanted device to deliver therapy is not considered to be time dedicated to therapy.

Note

For 2005 and later years, where the life-sustaining therapy requires a regular dosage of medication that needs to be adjusted on a daily basis:

- the activities directly related to determining and administering the dosage are considered part of the therapy (except for those activities related to exercise or following a dietary regime, such as carbohydrate calculation); and
- the time spent by primary caregivers performing and supervising the activities related to the therapy of a child because of his or her age is considered to be time dedicated to this therapy.

Markedly restricted – You are markedly restricted if, **all or substantially all the time**, you are unable (or it takes you an inordinate amount of time) to perform one or more of the basic activities of daily living (see Question 4 on the next page), even with therapy (other than life-sustaining therapy to support a vital function) and the use of appropriate devices and medication.

Prolonged – An impairment is prolonged if it has lasted, or is expected to last, for a continuous period of at least 12 months.

Qualified practitioner – Qualified practitioners are medical doctors, optometrists, audiologists, occupational therapists, physiotherapists, psychologists, and speech-language pathologists. The table on page 2 of the form lists which sections of the form each can certify.

Significantly restricted – means that although you do not **quite** meet the criteria for markedly restricted, your ability to perform a basic activity of daily living (see Question 4 on next page) or your vision is still substantially restricted.

Adjustment requests

If you want us to adjust a tax year to allow a claim for the disability amount, include Form T1-ADJ, *T1 Adjustment Request*, or a letter containing the details of your request, with your completed Form T2201.

If a representative is acting on your behalf you must provide us with Form T1013, *Authorizing or Cancelling a Representative*, or a signed letter authorizing the representative to make this request.

What if you disagree with our decision?

If we do not approve your form, we will send you a notice of determination to explain why your application was denied. Check your copy of the form against the reason given, since we base our decision on the information provided by the qualified practitioner.

If you have additional information from a qualified practitioner that we did not have in our first review of the form, send that information to the Disability Tax Credit Unit of your tax centre and we will review your file again.

You also have the right to file a formal objection to appeal the decision. The time limit for filing an objection is 90 days after we mail the notice of determination.

Note

Asking your tax centre to review your file again does not extend the time limit for filing an objection.

If you choose to file a formal objection, your file will be reviewed by the Appeals Branch. You should send either a completed Form T400A, *Objection – Income Tax Act*, or a signed letter to:

Chief of Appeals
Sudbury Tax Services Office
1050 Notre Dame Avenue
Sudbury ON P3A 5C1

You may also file an objection electronically through our secure Web page at **www.cra.gc.ca/myaccount**.

For more information, visit **www.cra.gc.ca** or see Pamphlet P148, *Resolving Your Dispute: Objections and Appeal Rights Under the Income Tax Act*.

Self-assessment questionnaire

Answer these questions to determine if you **may** be eligible for the DTC. **This questionnaire does not replace the form itself.**

Note

If your answers indicate you **are not eligible** for the DTC, and you still feel that you should be able to claim it, see page 1 of the form for instructions on how to apply.

1. Has your impairment in physical or mental functions lasted, or is it expected to last, for a continuous period of at least 12 months?

Yes ☐ No ☐

If you answered **yes**, answer Questions 2 to 5 below.

If you answered **no**, you **are not eligible** for the DTC. To claim the disability amount, the impairment has to be **prolonged** (defined on the previous page).

2. Are you blind?

Yes ☐ No ☐

3. Do you receive **life-sustaining therapy** (defined on the previous page)?

Yes ☐ No ☐

4. Do the effects of your impairment cause you to be **markedly restricted** (defined on the previous page) in one of the following basic activities of daily living, even with the appropriate therapy, medication, and devices?

- speaking
- hearing
- walking
- elimination (bowel or bladder functions)
- feeding
- dressing
- mental functions necessary for everyday life

Yes ☐ No ☐

5. Do you meet **all** the following conditions?

- Because of the impairment, you are **significantly restricted** (defined on the previous page) in two or more of the basic activities of daily living listed in Question 4, or you are **significantly restricted** in vision and at least one of the basic activities of daily living listed in Question 4, even with appropriate therapy, medication, and devices.
- These significant restrictions exist together, all or substantially all the time.
- The cumulative effect of these significant restrictions is equivalent to being **markedly restricted** (defined on the previous page) in a **single** basic activity of daily living.

Yes ☐ No ☐

If you answered **yes** to Question 1 and to any one of Questions 2 to 5, you **may be eligible** for the DTC. To apply for the DTC, complete Part A of the form. Then, take the form to a qualified practitioner who can certify the effects of the impairment for you. If the qualified practitioner certifies the form, send it to us for approval. We will review the form and advise you in writing if you are eligible for the DTC.

If you answered **no** to all of Questions 2 to 5, you **are not eligible** for the DTC. For you to be eligible for the DTC, you have to answer **yes** to at least one of these questions. Even if you cannot claim the disability amount, you may have expenses you can claim on your income tax and benefit return. For more information, see Guide RC4064, *Medical and Disability-Related Information.*

Where do I send this form?

Complete and send the original certified form to the **Disability Tax Credit Unit** of your tax centre. Use the chart below to identify the address.

If you are normally served by the tax services office in:	Send this form to the following address:
British Columbia, Regina, or Yukon	Surrey Tax Centre 9755 King George Boulevard Surrey BC V3T 5E6
Alberta, London, Manitoba, Northwest Territories, Saskatoon, Thunder Bay, or Windsor	Winnipeg Tax Centre PO Box 14006, Station Main Winnipeg MB R3C 0E5
Barrie, Sudbury (the area of Sudbury/Nickel Belt only), Toronto Centre, Toronto East, Toronto North, or Toronto West	Sudbury Tax Centre 1050 Notre Dame Avenue Sudbury ON P3A 5C1
Laval, Montréal, Nunavut, Ottawa, Rouyn-Noranda, Sherbrooke, or Sudbury (other than the Sudbury/ Nickel Belt area)	Shawinigan-Sud Tax Centre PO Box 4000, Station Main Shawinigan QC G9N 7V9
Chicoutimi, Montérégie-Rive-Sud, Outaouais, Québec, Rimouski, or Trois-Rivières	Jonquière Tax Centre 2251 René-Lévesque Blvd Jonquière QC G7S 5J2
Kingston, New Brunswick, Newfoundland and Labrador, Nova Scotia, Peterborough, or St. Catharines	St. John's Tax Centre PO Box 12071, Station A St. John's NL A1B 3Z1
Belleville, Hamilton, Kitchener/Waterloo, or Prince Edward Island	Summerside Tax Centre 275 Pope Road Summerside PE C1N 6A2
International Tax Services Office (deemed residents, non-residents, and new or returning residents of Canada)	International Tax Services Office PO Box 9769, Station T Ottawa ON K1G 3Y4

DISABILITY TAX CREDIT CERTIFICATE

PROTECTED B
(when completed)

6729

Part A – To be completed by the person with the disability (or a legal representative)

Step 1: Complete Part A (**please print**). Remember to sign, where applicable, at the bottom of this page.

Step 2: Take this form to a qualified practitioner (use the table on the next page to find out who can certify the sections that apply). The qualified practitioner completes Part B.

Step 3: Complete and send the original certified form (Part A and Part B) to your tax centre (see the chart on the previous page). **This form must be submitted in its entirety.**

When reviewing your application, if we need more information, we may contact you or a qualified practitioner (named on this certificate or any attached document) who knows about your impairment.

Information about the person with the disability

First name and initial	Last name	☐ Female ☐ Male
Mailing address (Apt No – Street No Street name, PO Box, RR)		Social insurance number
City	Province or territory / Postal code	Date of birth (Year Month Day)

Information about the person claiming the disability amount (if different from above)

First name and initial	Last name	Social insurance number

The person with the disability is: ☐ my spouse or common-law partner ☐ other (specify) _____

Answer the following questions for **all** of the years that you are claiming the disability amount for the person with the disability.

1. Does the person with the disability live with you? ☐ Yes ☐ No

   If **yes**, for which year(s)? _____

2. If you answered **no** to Question 1, does the person with the disability depend on you for one or more of the basic necessities of life such as food, shelter, or clothing? ☐ Yes ☐ No

   If **yes**, for which year(s)? _____

Give details about the support you provide for the person with the disability (if you need more space, attach a separate sheet of paper):

_____

_____

_____

As the person claiming the disability amount, I certify that the information given on this form is, to the best of my knowledge, correct and complete.

Signature	Telephone number – –	Date (Year Month Day)

Authorization

As the person with the disability or their legal representative, I authorize the qualified practitioner(s) having relevant clinical records to provide or discuss the information contained in those records on or with this certificate to the Canada Revenue Agency for the purpose of determining eligibility for the disability tax credit or other related programs.

Signature	Telephone number – –	Date (Year Month Day)

Privacy Act, Personal Information Bank number CRA PPU 218

Part B – Must be completed by the qualified practitioner

PROTECTED B
(when completed)

Before completing this form, read the instructions below.
For more information, go to **www.cra.gc.ca/qualifiedpractitioners**.

Your patient must have an impairment in physical or mental functions which is both severe and prolonged. You must assess the following two criteria of your patient's impairment **separately**:

- **Duration** of the impairment – The impairment must be prolonged (it must have lasted, or be expected to last, for a continuous period of at least 12 months).
- **Effects** of the impairment – The effects of your patient's impairment must be such that, even with therapy and the use of appropriate devices and medication, your patient is restricted all or substantially all of the time. The effects of your patient's impairment must fall into one of the following categories:
  - – Vision
  - – Markedly restricted in a basic activity of daily living
  - – Life-sustaining therapy
  - – The cumulative effect of **significant restrictions** (for patients who are significantly restricted in two or more of the basic activities of daily living, including vision, but do not quite meet the criteria for **markedly restricted**)

Step 1: Complete **only** the section(s) on pages 3 to 8 that apply to your patient. See the table below to find out which page(s) to complete and to determine which sections you can certify.

Note
Whether completing this form for a child or an adult, assess your patient relative to someone of a similar chronological age who does not have the marked or significant restriction.

	Section:	Go to:	To certify the applicable section, you have to be a:
	Vision	Page 3	Medical doctor or optometrist
Markedly restricted in a basic activity of daily living	• Speaking	Page 3	Medical doctor or speech-language pathologist
	• Hearing	Page 3	Medical doctor or audiologist
	• Walking	Page 4	Medical doctor, occupational therapist, or physiotherapist (physiotherapist can certify only for 2005 and later years)
	• Elimination (bowel or bladder functions)	Page 4	Medical doctor
	• Feeding	Page 5	Medical doctor or occupational therapist
	• Dressing	Page 5	Medical doctor or occupational therapist
	• Performing the mental functions necessary for everyday life	Page 6	Medical doctor or psychologist
	Life-sustaining therapy to support a vital function	Page 7	Medical doctor
	Cumulative effects of significant restrictions in two or more basic activities of daily living, including vision (applies to 2005 and later years)	Page 8	Medical doctor or occupational therapist (occupational therapist can only certify for walking, feeding and dressing)

Step 2: Complete the "**Effects of impairment**," "**Duration**," and "**Certification**" sections on page 9.

Definition

Markedly restricted – means that **all or substantially all the time**, and even with therapy (other than life-sustaining therapy to support a vital function) and the use of appropriate devices and medication, either:

- your patient is unable to perform at least one of the basic activities of daily living (see above); or
- it takes your patient an inordinate amount of time to perform at least one of the basic activities of daily living.

Patient's name: _____

Vision (Complete this section if applicable, and **all sections on page 9**.)

Not applicable ☐

Your patient is considered **blind** if, even with the use of corrective lenses or medication:

- visual acuity in **both** eyes is 20/200 (6/60) or less with the Snellen Chart (or an equivalent); or
- the greatest diameter of the field of vision in **both** eyes is 20 degrees or less.

Is your patient **blind**, as described above? Yes ☐ No ☐

If **yes**, in what year did your patient's blindness begin (this is not necessarily the same as the year in which the diagnosis was made, as with progressive diseases)? Year ____

What is your patient's visual acuity **after correction**? Right eye _____ Left eye _____

What is your patient's visual field **after correction** (in degrees if possible)? Right eye _____ Left eye _____

Speaking (Complete this section if applicable, and **all sections on page 9**.)

Not applicable ☐

Your patient is considered **markedly restricted** in speaking if, all or substantially all the time, he or she is **unable** or takes an **inordinate amount of time** to speak so as to be understood by another person familiar with the patient, in a quiet setting, even with appropriate therapy, medication, and devices.

Notes

- Devices for speaking include tracheoesophageal prostheses, vocal amplification devices, and other such devices.
- An **inordinate amount of time** means that speaking so as to be understood takes **significantly** longer than for an average person who does not have the impairment.

Examples of markedly restricted in speaking (examples are not exhaustive):

- Your patient must rely on other means of communication, such as sign language or a symbol board, all or substantially all the time.
- In your office, you must ask your patient to repeat words and sentences several times, and it takes an inordinate amount of time for your patient to make himself or herself understood.

Is your patient **markedly restricted** in speaking, as described above? Yes ☐ No ☐

Is the marked restriction in speaking present **all or substantially all of the time**? Yes ☐ No ☐

If **yes**, when did your patient's marked restriction in speaking begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)? Year ____

Hearing (Complete this section if applicable, and **all sections on page 9**.)

Not applicable ☐

Your patient is considered **markedly restricted** in hearing if, all or substantially all the time, he or she is **unable** or takes an **inordinate amount of time** to hear so as to understand another person familiar with the patient, in a quiet setting, even with the use of appropriate devices.

Notes

- Devices for hearing include hearing aids, cochlear implants, and other such devices.
- An **inordinate amount of time** means that hearing so as to understand takes **significantly** longer than for an average person who does not have the impairment.

Examples of markedly restricted in hearing (examples are not exhaustive):

- Your patient must rely completely on lip reading or sign language, despite using a hearing aid, in order to understand a spoken conversation, all or substantially all the time.
- In your office, you must raise your voice and repeat words and sentences several times, and it takes an inordinate amount of time for your patient to understand you, despite the use of a hearing aid.

Is your patient **markedly restricted** in hearing, as described above? Yes ☐ No ☐

Is the marked restriction in hearing present **all or substantially all of the time**? Yes ☐ No ☐

If **yes**, when did your patient's marked restriction in hearing begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)? Year ____

Patient's name: _____

Walking (Complete this section if applicable, and **all sections on page 9**.)

Not applicable ☐

Your patient is considered **markedly restricted** in walking if, all or substantially all the time, he or she is **unable** or requires an **inordinate amount of time** to walk even with appropriate therapy, medication, and devices.

Notes

- Devices for walking include canes, walkers, and other such devices.
- An **inordinate amount of time** means that walking takes **significantly** longer than for an average person who does not have the impairment.

Examples of markedly restricted in walking (examples are not exhaustive):

- Your patient must always rely on a wheelchair, even for short distances outside of the home.
- Your patient can walk 100 metres (or approximately one city block), but only by taking an inordinate amount of time, stopping because of shortness of breath or because of pain, all or substantially all the time.
- Your patient experiences severe episodes of fatigue, ataxia, lack of coordination, and problems with balance. These episodes cause the patient to be incapacitated for several days at a time, in that he or she becomes unable to walk more than a few steps. Between episodes, your patient continues to experience the above symptoms, but to a lesser degree. Nevertheless, these symptoms cause him or her to require an inordinate amount of time to walk, all or substantially all the time.

Is your patient **markedly restricted** in walking, as described above? Yes ☐ No ☐

Is the marked restriction in walking present **all or substantially all of the time**? Yes ☐ No ☐

If **yes**, when did your patient's marked restriction in walking begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)? Year ____

Elimination – bowel or bladder functions (Complete this section if applicable, and **all sections on page 9**.)

Not applicable ☐

Your patient is considered **markedly restricted** in elimination if, all or substantially all the time, he or she is **unable** or requires an **inordinate amount of time** to personally manage bowel or bladder functions, even with appropriate therapy, medication, and devices.

Notes

- Devices for elimination include catheters, ostomy appliances, and other such devices.
- An **inordinate amount of time** means that personally managing elimination takes **significantly** longer than for an average person who does not have the impairment.

Examples of markedly restricted in elimination (examples are not exhaustive):

- Your patient needs the assistance of another person to empty and tend to his or her ostomy appliance on a daily basis.
- Your patient is incontinent of bladder functions, all or substantially all the time, and requires an inordinate amount of time to manage and tend to his or her incontinence pads on a daily basis.

Is your patient **markedly restricted** in elimination, as described above? Yes ☐ No ☐

Is the marked restriction in elimination present **all or substantially all of the time**? Yes ☐ No ☐

If **yes**, when did your patient's marked restriction in elimination begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)? Year ____

Feeding (Complete this section if applicable, and **all sections on page 9**.) Not applicable ☐

Your patient is considered **markedly restricted** in feeding if, all or substantially all the time, he or she is **unable** or requires an **inordinate amount of time** to feed himself or herself, even with appropriate therapy, medication, and devices.

Notes

- Feeding oneself **does not** include identifying, finding, shopping for or otherwise procuring food.
- Feeding oneself **does** include preparing food, **except** when the time associated is related to a dietary restriction or regime, even when the restriction or regime is required due to an illness or health condition.
- Devices for feeding include modified utensils, and other such devices.
- An **inordinate amount of time** means that feeding takes **significantly** longer than for an average person who does not have the impairment.

Examples of markedly restricted in feeding (examples are not exhaustive):

- Your patient requires tube feedings, all or substantially all the time, for nutritional sustenance.
- Your patient requires an inordinate amount of time to prepare meals or to feed himself or herself, on a daily basis, due to significant pain and decreased strength and dexterity in the upper limbs.

Is your patient **markedly restricted** in feeding, as described above?	Yes ☐ No ☐
Is the marked restriction in feeding present **all or substantially all of the time**?	Yes ☐ No ☐
If **yes**, when did your patient's marked restriction in feeding begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)?	Year ____

Dressing (Complete this section if applicable, and **all sections on page 9**.) Not applicable ☐

Your patient is considered **markedly restricted** in dressing if, all or substantially all the time, he or she is **unable** or requires an **inordinate amount of time** to dress himself or herself, even with appropriate therapy, medication, and devices.

Notes

- Dressing oneself **does not** include identifying, finding, shopping for or otherwise procuring clothing.
- Devices for dressing include specialized buttonhooks, long-handled shoehorns, grab rails, safety pulls, and other such devices.
- An **inordinate amount of time** means that dressing takes **significantly** longer than for an average person who does not have the impairment.

Examples of markedly restricted in dressing (examples are not exhaustive):

- Your patient cannot dress without daily assistance from another person.
- Due to pain, stiffness, and decreased dexterity, your patient requires an inordinate amount of time to dress on a daily basis.

Is your patient **markedly restricted** in dressing, as described above?	Yes ☐ No ☐
Is the marked restriction in dressing present **all or substantially all of the time**?	Yes ☐ No ☐
If **yes**, when did your patient's marked restriction in dressing begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)?	Year ____

Mental functions necessary for everyday life

Not applicable ☐

(Complete this section if applicable, and **all sections on page 9**.)

Your patient is considered **markedly restricted** in performing the mental functions necessary for everyday life (described below) if, all or substantially all the time, he or she is **unable** or requires an **inordinate amount of time** to perform them by himself or herself, even with appropriate therapy, medication, and devices (for example, memory aids and adaptive aids).

Note
An **inordinate amount of time** means that your patient takes **significantly** longer than an average person who does not have the impairment.

Mental functions necessary for everyday life include:

- adaptive functioning (for example, abilities related to self-care, health and safety, abilities to initiate and respond to social interaction and common, simple transactions);
- memory (for example, the ability to remember simple instructions, basic personal information such as name and address, or material of importance and interest); and
- problem-solving, goal-setting, and judgement, taken together (for example, the ability to solve problems, set and keep goals, **and** make appropriate decisions and judgements).

Important – A restriction in problem-solving, goal-setting, or judgement that markedly restricts adaptive functioning, all or substantially all the time, would qualify.

Examples of markedly restricted in the mental functions necessary for everyday life (examples are not exhaustive):

- Your patient is unable to leave the house, all or substantially all the time, due to anxiety, despite medication and therapy.
- Your patient is independent in some aspects of everyday living. However, despite medication and therapy, your patient needs daily support and supervision due to an inability to accurately interpret his or her environment.
- Your patient is incapable of making a common, simple transaction, such as a purchase at the grocery store, without assistance, all or substantially all the time.
- Your patient experiences psychotic episodes several times a year. Given the unpredictability of the psychotic episodes and the other defining symptoms of his or her impairment (for example, avolition, disorganized behaviour and speech), your patient continues to require **daily** supervision.
- Your patient is unable to express needs or anticipate consequences of behaviour when interacting with others.

Is your patient **markedly restricted** in performing the mental functions necessary for everyday life, as described above? Yes ☐ No ☐

Is the marked restriction in performing the mental functions necessary for everyday life present **all or substantially all of the time**? Yes ☐ No ☐

If **yes**, when did your patient's marked restriction in the mental functions necessary for everyday life begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)? Year ____

Life-sustaining therapy

Not applicable ☐

(Complete this section if applicable, and **all sections on page 9**.)

Your patient needs life-sustaining therapy to support a vital function, even if the therapy has alleviated the symptoms.
Your patient needs the therapy at least 3 times per week, for an average of at least 14 hours per week.

Notes

The following points apply in determining the time your patient spends on therapy:

- Your patient must dedicate the time for the therapy—that is, the patient has to take time away from normal, everyday activities to receive it. If your patient receives therapy by a portable device, such as an insulin pump, or an implanted device, such as a pacemaker, the time the device takes to deliver the therapy **does not** count towards the 14-hour per week requirement. However, the time your patient spends setting up a portable device **does** count.
- **Do not include** activities such as following a dietary restriction or regime, exercising, travelling to receive the therapy, attending medical appointments (other than appointments where the therapy is received), shopping for medication, or recuperating after therapy.

For 2005 and later years

- If your patient's therapy requires a regular dosage of medication that needs to be adjusted daily, the activities directly related to determining and administering the dosage **are** considered part of the therapy (for example, monitoring blood glucose levels, preparing and administering the insulin, calibrating necessary equipment, or maintaining a log book of blood glucose levels).
- Activities that are considered to be part of following a dietary regime, such as carbohydrate calculation, as well as activities related to exercise, **do not count** toward the 14-hour requirement (even when these activities or regimes are a factor in determining the daily dosage of medication).
- If a child is unable to perform the activities related to the therapy because of his or her age, the time spent by the child's primary caregivers performing and supervising these activities **can** be counted toward the 14-hour per week requirement. For example, in the case of a child with Type 1 diabetes, supervision includes having to wake the child at night to test his or her blood glucose level, checking the child to determine the need for additional blood glucose testing (during or after physical activity), or other supervisory activities that can reasonably be considered necessary to adjust the dosage of insulin (excluding carbohydrate calculation).

Examples of life-sustaining therapy (examples are not exhaustive):

- Chest physiotherapy to facilitate breathing
- Kidney dialysis to filter blood
- Insulin therapy to treat Type 1 diabetes in a child who cannot independently adjust the insulin dosage (for 2005 and later years)

Does your patient need **life-sustaining therapy to support a vital function**?	Yes ☐	No ☐
Does your patient need life-sustaining therapy at least 3 times per week?	Yes ☐	No ☐
Does the life-sustaining therapy take an average of at least 14 hours per week?	Yes ☐	No ☐

If **yes**, when did your patient's therapy begin to meet the above conditions (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)? Year ____

Provide details of the therapy (for example dialysis, or for persons with diabetes, insulin pump or multiple daily injections):

Cumulative effect of significant restrictions – applies to 2005 and later years
(Complete this section if applicable, and **all sections on page 9**. However, do **not** complete this section if your patient is markedly restricted under any of the previous sections.)

Not applicable ☐

Answer the following questions to determine if your patient may be eligible for the disability tax credit. Also answer the questions at the bottom of this page.

1. Does your patient have at least one impairment in physical or mental functions that has lasted, or is expected to last, for a continuous period of at least 12 months? Yes ☐ No ☐

2. Even with appropriate therapy, medication, and devices, has the impairment resulted in a **significant restriction**, that is not quite a **marked restriction** (defined below), in **two** or more basic activities of daily living? Yes ☐ No ☐

3. Do these significant restrictions exist together, all or substantially all the time? Yes ☐ No ☐

4. Is the cumulative effect of these significant restrictions equivalent to a marked restriction in a single basic activity of daily living (see examples below)? Yes ☐ No ☐

Notes

You **can** include vision in combination with the basic activities of daily living.

You **cannot** include the time spent on life-sustaining therapy.

If you answered **yes** to all of the above questions, your patient may be eligible for the disability tax credit.

Definitions

Markedly restricted – means that **all or substantially all the time**, and even with therapy (other than life-sustaining therapy to support a vital function) and the use of appropriate devices and medication, either:

- your patient is unable to perform at least one of the basic activities of daily living; or
- it takes your patient an inordinate amount of time to perform at least one of the basic activities of daily living.

Significantly restricted – means that although your patient does not **quite** meet the criteria for markedly restricted, his or her ability to perform a basic activity of daily living or his or her vision is still substantially restricted.

Examples

Examples of cumulative effects equivalent to being markedly restricted in a basic activity of daily living (examples are not exhaustive):

- Your patient can walk for 100 metres, but then must take time to recuperate. He or she can perform the mental functions necessary for everyday life, but can concentrate on any topic for only a short period of time. The cumulative effect of these two significant restrictions is equivalent to being markedly restricted, such as being unable to perform one of the basic activities of daily living.
- Your patient always takes a long time for walking, dressing and feeding. The extra time it takes to perform these activities, when added together, is equivalent to being markedly restricted, such as taking an inordinate amount of time in a single basic activity of daily living.

Answer the following question(s) to certify your patient's condition:

Do you certify that your patient meets the four conditions described in the questions **above**? Yes ☐ No ☐

If **yes**, tick at least two of the following, as they apply to your patient.

☐ vision ☐ speaking ☐ hearing ☐ walking ☐ elimination (bowel or bladder functions)

☐ feeding ☐ dressing ☐ mental functions necessary for everyday life

If **yes**, when did the cumulative effect described above begin (this is not necessarily the same as the date of the diagnosis, as with progressive diseases)? Year ____

Part B – (continued)

Patient's name: _____

Complete **all areas** on this page.

Effects of impairment

The effects of your patient's impairment must be those which, even with therapy and the use of appropriate devices and medication, cause your patient to be restricted **all or substantially all of the time**.

Note
Basic activities of daily living are limited to walking, speaking, hearing, dressing, feeding, elimination, and mental functions necessary for everyday life. Working, housekeeping, managing a bank account, and social or recreational activities are **not** considered basic activities of daily living.

Examples of effects of impairment (examples are not exhaustive):

- For a patient with a walking impairment, you might state the number of hours spent in bed or in a wheelchair each day.
- For a patient with an impairment in mental functions necessary for everyday life, you might describe the degree to which your patient needs support and supervision.

Describe the effects of your patient's impairment(s) on his or her ability to perform each of the basic activities of daily living that you indicated are or were markedly or significantly restricted (include the diagnosis, if available). If you need more space, attach a separate sheet of paper.

Diagnosis: _____

_____

_____

Effects of impairment: _____

_____

_____

Duration

Has your patient's impairment lasted, or is it expected to last, for a continuous period of at least 12 months? For deceased patients, was the impairment expected to last for a continuous period of at least 12 months? Yes ☐ No ☐

If **yes**, has the impairment improved, or is it likely to improve, such that the patient would no longer be blind, markedly restricted, equivalent to markedly restricted due to the cumulative effect of significant restrictions, or in need of life-sustaining therapy? Yes ☐ No ☐ Unsure ☐

Note
Additional comments related to duration may be added to the "Effects of impairment" section.

If **yes**, enter the year that the improvement occurred or may be expected to occur. Year ☐☐☐☐

Certification

Tick the box that applies to you :

☐ Medical doctor ☐ Optometrist ☐ Occupational therapist ☐ Audiologist

☐ Physiotherapist ☐ Psychologist ☐ Speech-language pathologist

As a **qualified practitioner**, I certify that the information given in Part B of this form is, to the best of my knowledge, correct and complete and I understand that this information will be used by the Canada Revenue Agency (CRA) to determine if my patient is eligible for the disability tax credit or other related programs.

Sign here

_____

Print your name

_____

Date

_____

Telephone

_____

Address

Note
If more information is needed, the CRA may contact you.