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Canada Revenue Agency | Agence du revenu du Canada

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Disability Tax Credit Certificate

Help
canada.ca/disability-tax-credit
1-800-959-8281

The information provided in this form will be used by the Canada Revenue Agency (CRA) to determine the eligibility of the individual applying for the disability tax credit (DTC). For more information, see the general information on page 16.

Part A – Individual's section

1) Tell us about **the person with the disability**

First name: _____

Last name: _____

Social insurance number: | | | | | | | | | |

Mailing address: _____

City: _____

Province or territory: _____

Postal code: | | | | | | Date of birth: | | | | | | | | |
Year Month Day

2) Tell us about **the person intending to claim the disability amount** (if different from above)

This person must be a supporting family member of the person with the disability (the spouse or common-law partner of the person with the disability, or a parent, grandparent, child, grandchild, brother, sister, uncle, aunt, nephew, or niece of that person or their spouse or common-law partner).

First name: _____

Last name: _____

Relationship: _____

Social insurance number: | | | | | | | | | | Does the person with the disability live with you? ☐ Yes ☐ No

Indicate which of the basic necessities of life have been regularly and consistently provided to the person with the disability, and the years for which it was provided:

☐ Food _____ Year(s)

☐ Shelter _____ Year(s)

☐ Clothing _____ Year(s)

Provide details regarding the support you provide to the person with the disability (regularity of the support, proof of dependency, if the person lives with you, etc.):

If you and another person support the same dependant, you may split the claim for that dependant. However, the total amount of your claim and the other person's claim cannot be more than the maximum amount allowed for that dependant. If you want to provide more information than the space allows, or another supporting family member would like to add information about the support they provide, use a separate sheet of paper, sign it, and attach it to this form. Make sure to provide all identifying information, including social insurance numbers and signatures from all supporting family members.

As the supporting family member intending to claim the disability amount, I confirm the above information is accurate. This authorization will not result in automatic adjustments to my previous tax returns.

Signature: _____

Canada

Part A – Individual's section (continued)

3) Previous tax return adjustments

Are you the person with the disability or their legal representative (or if the person is under 18, their legal guardian)?

☐ Yes ☐ No

Note: If no, or more than one person is claiming the disability amount, you will need to send a Form T1-ADJ for each year to be adjusted or a letter with the details of your request(s).

If eligibility for the disability tax credit is approved, would you like the CRA to apply the credit to your previous tax returns?

☐ Yes, adjust my previous tax returns for all applicable years.

☐ No, do not adjust my previous tax returns at this time.

4) Individual's authorization (**mandatory**)

As the person with the disability or their legal representative:

- I certify that the above information is correct.
- I give permission for my medical practitioner(s) to provide the CRA with information from their medical records in order for the CRA to determine my eligibility.
- I authorize the CRA to adjust my returns, as applicable, if I opted to do so in question 3.

Signature: _____

If this form is not signed by the person with the disability or their legal representative (or if the person is under 18, their legal guardian), **the CRA will not process this form**.

Telephone number: _____ Date: Year Month Day

Personal information (including the SIN) is collected and used to administer or enforce the Income Tax Act and related programs and activities including administering tax, benefits, audit, compliance, and collection. The information collected may be disclosed to other federal, provincial, territorial, aboriginal, or foreign government institutions to the extent authorized by law. Failure to provide this information may result in paying interest or penalties, or in other actions. Under the Privacy Act, individuals have a right of protection, access to and correction of their personal information, or to file a complaint with the Privacy Commissioner of Canada regarding the handling of their personal information. Refer to Personal Information Bank CRA PPU 218 on Info Source at **canada.ca/cra-info-source**.

This marks the end of the individual's section of the form. Ask a medical practitioner to fill out Part B (pages 3-16). Once the medical practitioner certifies the form, it is ready to be submitted to the CRA for assessment.

Next steps:

Step 1 – Ask your medical practitioner(s) to fill out the remaining pages of this form.

Note
Your medical practitioner provides the CRA with your medical information but does not determine your eligibility for the DTC.

Step 2 – Make a copy of the filled out form for your own records.

Step 3 – Refer to page 16 for instructions on how to submit your form to the CRA.

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Part B – Medical practitioner's section

If you would like to use the digital application for medical practitioners to fill out your section of the T2201, it can be found at **canada.ca/dtc-digital-application**.

Important notes on patient eligibility

- Eligibility for the DTC is not based solely on the presence of a medical condition. It is based on the impairment resulting from a condition and the effects of that impairment on the patient. Eligibility, however, is not based on the patient's ability to work, to do housekeeping activities, or to engage in recreational activities.
- A person may be eligible for the DTC if they have a severe and prolonged impairment in physical or mental functions resulting in a marked restriction. A marked restriction means that, even with appropriate therapy, devices, and medication, they are unable or take an inordinate amount of time in one impairment category, **all or substantially all** (generally interpreted as 90% or more) of the time. If their limitations do not meet the criteria for one impairment category alone, they may still be eligible if they experience significant limitations in two or more categories.

For more information about the DTC, including examples and eligibility criteria, see Guide RC4064, Disability-Related Information, or go to **canada.ca/disability-tax-credit**.

Next steps

Step 1 – Fill out the sections of the form on pages 4-15 that are applicable to your patient.

When considering your patient's limitations, assess them compared to someone of similar age who does not have an impairment in that particular category. If your patient experiences limitations in more than one category, they may be eligible under the "Cumulative effect of significant limitations" section on page 14.

If you want to provide more information than the space allows, use a separate sheet of paper, sign it, and attach it to this form. Make sure to include the name of the patient at the top of all pages.

Step 2 – Fill out the "Certification" section on page 16 and sign the form.

Step 3 – You or your patient can send this form to the CRA when both Part A and Part B are filled out and signed (refer to page 16 for instructions).

The CRA will review the information provided to determine your patient's eligibility and advise your patient of its decision. If more information is needed, the CRA may contact you.

Clear Data

Patient's name: _____

Protected B when completed

If your patient has an impairment in vision, initial your professional designation and complete this section.

Vision

_____ Medical doctor _____ Nurse practitioner _____ Optometrist

1) List any medical conditions or diagnoses that impair your patient's ability to see, and provide the year of diagnosis (if available):

2) Indicate the aspect of vision that is impaired in each eye (visual acuity, field of vision, or both):

Left eye after correction	**Right eye** after correction
Visual acuity	**Visual acuity**
☐ Measurable on the Snellen chart (provide acuity)	☐ Measurable on the Snellen chart (provide acuity)
/ Example: 20/200, 6/60	/ Example: 20/200, 6/60
☐ Count fingers (CF)	☐ Count fingers (CF)
☐ No light perception (NLP)	☐ No light perception (NLP)
☐ Light perception (LP)	☐ Light perception (LP)
☐ Hand motion (HM)	☐ Hand motion (HM)
Field of vision (provide greatest diameter)	**Field of vision** (provide greatest diameter)
( ) degrees	( ) degrees

3) Does your patient meet at least one of the following criteria in both eyes, even with the use of corrective lenses or medication?

- The visual acuity is 20/200 (6/60) or less on the Snellen Chart (or an equivalent).
- The greatest diameter of the field of vision is 20 degrees or less.

☐ Yes ☐ No[1]

[1] If you answered no and your patient is impaired in two or more categories, they may be eligible under the "Cumulative effect of significant limitations" on page 14.

4) Provide the year that your patient became impaired based on your previous answers: ____ Year

5) Has your patient's impairment in vision lasted, or is it expected to last, for a continuous period of at least 12 months?

☐ Yes ☐ No

6) Has your patient's impairment in vision improved or is it likely to improve to such an extent that they would no longer be impaired?

☐ Yes (provide year) ____ Year ☐ No ☐ Unsure

Clear Data

Patient's name: _____

Protected B when completed

If your patient has an impairment in speaking, initial your professional designation and complete this section.

Speaking

_____ Medical doctor _____ Nurse practitioner _____ Speech-language pathologist

1) List any medical conditions or diagnoses that impair your patient's ability to speak, so as to be understood by a familiar person in a quiet setting, and provide the year of the diagnosis (if available):

2) Does your patient take medication to help manage their impairment in speaking?

☐ Yes ☐ No ☐ Unsure

3) Describe if your patient uses any devices or therapy to help manage their impairment in speaking (for example, voice amplifier, behaviour therapy).

4) Provide examples that describe how your patient's ability to speak – so as to be understood by a familiar person in a quiet setting – is impaired even with appropriate therapy, medication, and devices – this is **mandatory**.

For example, they require repetition to be understood, have difficulty with articulation, require more time for word retrieval or to respond to verbal information, experience mutism, or use sign language as their primary means of communicating.

5) Is your patient unable to speak, or do they take an inordinate amount of time to speak so as to be understood (at least three times longer than someone of similar age without an impairment in speaking) by a familiar person in a quiet setting, even with the use of appropriate therapy, medication, and devices?

☐ Yes ☐ No[1]

[1] If you answered no and your patient is impaired in two or more categories, they may be eligible under the "Cumulative effect of significant limitations" on page 14.

6) Is this the case all or substantially all of the time (see page 3)?

☐ Yes ☐ No

7) Provide the year when your patient became impaired based on your previous answers: ____ Year

8) Has your patient's impairment in speaking lasted, or is it expected to last, for a continuous period of at least 12 months?

☐ Yes ☐ No

9) Has your patient's impairment in speaking improved or is it likely to improve to such an extent that they would no longer be impaired?

☐ Yes (provide year) ____ Year ☐ No ☐ Unsure

Clear Data

Patient's name: _____

Protected B when completed

If your patient has an impairment in hearing, initial your professional designation and complete this section.

Hearing

_____ Medical doctor _____ Nurse practitioner _____ Audiologist

1) List any medical conditions or diagnoses that impair your patient's ability to hear so as to understand a familiar person in a quiet setting, and provide the year of the diagnosis (if available):

2) Indicate the level that best describes your patient's hearing loss in each ear (normal: 0-25dB, mild: 26-40dB, moderate: 41-55dB, moderate-to-severe: 56-70dB, severe: 71-90dB, profound: 91dB+, or unknown):

Left ear

Right ear

3) Describe if your patient uses any devices or therapy to help manage their impairment in hearing (for example, cochlear implant, hearing aid):

4) Provide examples that describe how your patient's ability to hear a familiar person in a quiet setting is impaired despite the use of appropriate therapy, medication, and devices – this is **mandatory**.

For example, they require repetition when listening to others, have poor word discrimination, or need to use lip-reading or sign-language to understand verbal communication.

5) Is your patient unable to hear, or do they take an inordinate amount of time to hear so as to understand (at least three times longer than someone of similar age without an impairment in hearing) a familiar person in a quiet setting, even with the use of appropriate therapy, medication, and devices?

☐ Yes ☐ No[1]

[1] If you answered no and your patient is impaired in two or more categories, they may be eligible under the "Cumulative effect of significant limitations" on page 14.

6) Is this the case all or substantially all of the time (see page 3)?

☐ Yes ☐ No

7) Provide the year when your patient became impaired based on your previous answers: ____ Year

8) Has your patient's impairment in hearing lasted, or is it expected to last, for a continuous period of at least 12 months?

☐ Yes ☐ No

9) Has your patient's impairment in hearing improved or is it likely to improve to such an extent that they would no longer be impaired?

☐ Yes (provide year) ____ Year ☐ No ☐ Unsure

Clear Data

Patient's name: _____

Protected B when completed

If your patient has an impairment in walking, initial your professional designation and complete this section.

Walking

_____ Medical doctor _____ Nurse practitioner _____ Occupational therapist _____ Physiotherapist

1) List any medical conditions or diagnoses that impair your patient's ability to walk, and provide the year of the diagnosis (if available):

2) Does your patient take medication to help manage their impairment in walking?

☐ Yes ☐ No ☐ Unsure

3) Describe if your patient uses any devices or therapy to help manage their impairment in walking (for example: cane, occupational therapy):

4) Provide examples that describe how your patient's ability to walk (for example, a short distance such as 100 metres) is impaired despite the use of appropriate therapy, medication, and devices – this is **mandatory**.

For example, they need assistance when they walk, they have impaired balance, or as a result of pain or shortness of breath they require frequent breaks when walking.

5) Is your patient unable to walk, or do they take an inordinate amount of time to walk (at least three times longer than someone of similar age without an impairment in walking), for example a short distance such as 100 metres, even with appropriate therapy, medication and devices?

☐ Yes ☐ No[1]

[1] If you answered no and your patient is impaired in two or more categories, they may be eligible under the "Cumulative effect of significant limitations" on page 14.

6) Is this the case all or substantially all of the time (see page 3)?

☐ Yes ☐ No

7) Provide the year when your patient became impaired based on your previous answers: ____ Year

8) Has your patient's impairment in walking lasted, or is it expected to last, for a continuous period of at least 12 months?

☐ Yes ☐ No

9) Has your patient's impairment in walking improved or is it likely to improve to such an extent that they would no longer be impaired?

☐ Yes (provide year) ____ Year ☐ No ☐ Unsure

Clear Data

Patient's name: _____

Protected B when completed

If your patient has an impairment in eliminating, initial your professional designation and complete this section.

Eliminating

_____ Medical doctor _____ Nurse practitioner

1) List any medical conditions or diagnoses that impair your patient's ability to personally manage bowel or bladder functions, and provide the year of the diagnosis (if available):

2) Does your patient take medication to help manage their impairment in bowel or bladder functions?

☐ Yes ☐ No ☐ Unsure

3) Describe if your patient uses any devices or therapy to help manage their impairment in bowel or bladder functions (for example, ostomy, biological therapy):

4) Provide examples that describe how your patient's ability to personally manage bowel or bladder functions is impaired, despite the use of appropriate therapy, medication, and devices – this is **mandatory**.

For example, they require assistance from another person, they rely on enemas due to chronic constipation, they wear incontinence briefs to manage fecal or urinary incontinence, or they require intermittent catheterization.

5) Is your patient unable to personally manage bowel or bladder functions, or do they take an inordinate amount of time to personally manage bowel or bladder functions (at least three times longer than someone of similar age without an impairment in eliminating), even with appropriate therapy, medication, and devices?

☐ Yes ☐ No[1]

[1]If you answered no and your patient is impaired in two or more categories, they may be eligible under the "Cumulative effect of significant limitations" on page 14.

6) Is this the case all or substantially all of the time (see page 3)?

☐ Yes ☐ No

7) Provide the year when your patient became impaired based on your previous answers: ____ Year

8) Has your patient's impairment in bowel or bladder functions lasted, or is it expected to last, for a continuous period of at least 12 months?

☐ Yes ☐ No

9) Has your patient's impairment in bowel or bladder functions improved or is it likely to improve to such an extent that they would no longer be impaired?

☐ Yes (provide year) ____ Year ☐ No ☐ Unsure

Clear Data

Patient's name: _____

Protected B when completed

If your patient has an impairment in feeding, initial your professional designation and complete this section.

Feeding

_____ Medical doctor _____ Nurse practitioner _____ Occupational therapist

1) List any medical conditions or diagnoses that impair your patient's ability to feed themselves, and provide the year of the diagnosis (if available):

2) Does your patient take medication to help manage their impairment in feeding themselves?

☐ Yes ☐ No ☐ Unsure

3) Describe if your patient uses any devices or therapy to help manage their impairment in feeding themselves (for example, assistive utensils, occupational therapy):

4) Provide examples that describe how your patient's ability to feed themselves is impaired, despite the use of appropriate therapy, medication, and devices – this is **mandatory**.

Feeding oneself includes preparing food (except when the time spent preparing food is related to a dietary restriction or regime). It does not include identifying, finding, shopping for, or obtaining food.

For example, they cannot hold utensils, they rely exclusively on tube feeding, or they require assistance from someone else to prepare their meals or feed themselves.

5) Is your patient unable to feed themselves, or do they take an inordinate amount of time to feed themselves (at least three times longer than someone of similar age without an impairment in feeding), even with the use of appropriate therapy, medication and devices?

☐ Yes ☐ No[1]

[1] If you answered no, and your patient is impaired in two or more categories, they may be eligible under the "Cumulative effect of significant limitations" on page 14.

6) Is this the case all or substantially all of the time (see page 3)?

☐ Yes ☐ No

7) Provide the year when your patient became impaired based on your previous answers: ____ Year

8) Has your patient's impairment in feeding themselves lasted, or is it expected to last, for a continuous period of at least 12 months?

☐ Yes ☐ No

9) Has your patient's impairment in feeding themselves improved or is it likely to improve to such an extent that they would no longer be impaired?

☐ Yes (provide year) ____ Year ☐ No ☐ Unsure

Clear Data

Patient's name: _____

Protected B when completed

If your patient has an impairment in dressing, initial your professional designation and complete this section.

Dressing

_____ Medical doctor _____ Nurse practitioner _____ Occupational therapist

1) List any medical conditions or diagnoses that impair your patient's ability to dress themselves, and provide the year of the diagnosis (if available):

2) Does your patient take medication to help manage their impairment in dressing?

☐ Yes ☐ No ☐ Unsure

3) Describe if your patient uses any devices or therapy to help manage their impairment in dressing themselves (for example, button hook, occupational therapy):

4) Provide examples that describe how your patient's ability to dress themselves is impaired, despite the use of appropriate therapy, medication, and devices – this is **mandatory**.

Dressing oneself does not include identifying, shopping for, or obtaining clothing.

For example, they experience pain in their upper extremities, they have a limited range of motion, or they require assistance from someone else to dress themselves.

5) Is your patient unable to dress themselves, or do they take an inordinate amount of time to dress themselves (at least three times longer than someone of similar age without an impairment in dressing), even with the use of appropriate therapy, medication and devices?

☐ Yes ☐ No[1]

[1]If you answered no, and your patient is impaired in two or more categories, they may be eligible under the "Cumulative effect of significant limitations" on page 14.

6) Is this the case all or substantially all of the time (see page 3)?

☐ Yes ☐ No

7) Provide the year when your patient became impaired based on your previous answers: ____ Year

8) Has your patient's impairment in dressing themselves lasted, or is it expected to last, for a continuous period of at least 12 months?

☐ Yes ☐ No

9) Has your patient's impairment in dressing themselves improved or is it likely to improve to such an extent that they would no longer be impaired?

☐ Yes (provide year) ____ Year ☐ No ☐ Unsure

Clear Data

Patient's name: _____

Protected B when completed

Mental functions necessary for everyday life

If your patient has an impairment in mental functions necessary for everyday life, initial your professional designation and complete this section.

_____ Medical doctor _____ Nurse practitioner _____ Psychologist

Mental functions necessary for everyday life include adaptive functioning, attention, concentration, goal-setting, judgment, memory, perception of reality, problem-solving, regulation of behaviour and emotions, and verbal and non-verbal comprehension.

1) List any medical conditions or diagnoses that impair your patient's ability to perform mental functions necessary for everyday life, and provide the year of diagnosis (if available):

2) Does your patient take medication to help manage their impairment in mental functions necessary for everyday life?

☐ Yes ☐ No ☐ Unsure

Does your patient require supervision or reminders from another person to take their medication?
This question is not applicable to children.

☐ Yes ☐ No ☐ Unsure

Select the option that best describes how effectively the medication helps manage their impairment in mental functions necessary for everyday life:

☐ Effective ☐ Moderately effective ☐ Mildly effective ☐ Ineffective ☐ Unsure

3) Describe any devices or therapy your patient uses to help manage their impairment in mental functions necessary for everyday life (for example, memory aids, assistive technology, cognitive-behavioural therapy):

4) Does your patient have an impaired capacity to live independently (or to function at home or at school in the case of a child under 18) without daily supervision or support from others?

☐ No ☐ Yes

Select all types of support received by the adult or child under 18:

Adult

☐ Assisted living or long-term facility
☐ Community-based health services
☐ Hospitalization
☐ Support from family members

Child under 18

☐ Adult supervision at home beyond an age-appropriate level
☐ Additional support from educational staff at school

Provide additional details about support received (optional):

The Mental functions section continues on pages 12 and 13.

Mental functions necessary for everyday life (continued)

5) Select the box that best describes the extent of your patient's impairment, if any, for each of the mental functions listed below, compared to someone of similar age without an impairment in mental functions necessary for everyday life.

Note: For a child, you can indicate either their current or anticipated impairment.

		No limitations	Some limitations	Severe limitations
Adaptive functioning	Adapt to change	☐	☐	☐
	Express basic needs	☐	☐	☐
	Go out into the community	☐	☐	☐
	Initiate common, simple transactions	☐	☐	☐
	Perform basic hygiene or self-care activities	☐	☐	☐
	Perform necessary, everyday tasks	☐	☐	☐
Attention	Demonstrate awareness of danger and risks to personal safety	☐	☐	☐
	Demonstrate basic impulse control	☐	☐	☐
Concentration	Focus on a simple task for any length of time	☐	☐	☐
	Absorb and retrieve information in the short-term	☐	☐	☐
Goal-setting	Make and carry out simple day-to-day plans	☐	☐	☐
	Self-direct to begin everyday tasks	☐	☐	☐
Judgment	Choose weather-appropriate clothing	☐	☐	☐
	Make decisions about their own treatment and welfare	☐	☐	☐
	Recognize risk of being taken advantage of by others	☐	☐	☐
	Understand consequences of their actions or decisions	☐	☐	☐
Memory	Remember basic personal information such as date of birth and address	☐	☐	☐
	Remember material of importance and interest to themselves	☐	☐	☐
	Remember simple instructions	☐	☐	☐
Perception of reality	Demonstrate an accurate understanding of reality	☐	☐	☐
	Distinguish reality from delusions and hallucinations	☐	☐	☐
Problem-solving	Identify everyday problems	☐	☐	☐
	Implement solutions to simple problems	☐	☐	☐
Regulation of behaviour and emotions	Behave appropriately for the situation	☐	☐	☐
	Demonstrate appropriate emotional responses for the situation	☐	☐	☐
	Regulate mood to prevent risk of harm to self or others	☐	☐	☐
Verbal and non-verbal comprehension	Understand and respond to non-verbal information or cues	☐	☐	☐
	Understand and respond to verbal information	☐	☐	☐

The Mental functions section continues on page 13.

Mental functions necessary for everyday life (continued)

Mental functions necessary for everyday life include adaptive functioning, attention, concentration, goal-setting, judgment, memory, perception of reality, problem-solving, regulation of behaviour and emotions, and verbal and non-verbal comprehension.

6) Provide examples that describe your patient's impairment if you indicated they have "some limitations" on page 12, or if you have additional examples related to your patient's ability to perform mental functions necessary for everyday life.

7) Is your patient unable to, or do they take an inordinate amount of time to perform mental functions necessary for everyday life (at least three times longer than someone of similar age without an impairment in mental functions), even with the use of appropriate therapy, medication and devices?

☐ Yes ☐ No[1]

[1] If you answered no, and your patient is impaired in two or more categories, they may be eligible under the "Cumulative effect of significant limitations" on page 14.

8) Is this the case all or substantially all of the time (see page 3)?

☐ Yes ☐ No

9) Provide the year when your patient became impaired based on your previous answers: ____ Year

10) Has your patient's impairment in performing mental functions necessary for everyday life lasted, or is it expected to last, for a continuous period of at least 12 months?

☐ Yes ☐ No

11) Has your patient's impairment in performing mental functions necessary for everyday life improved or is it likely to improve to such an extent that they would no longer be impaired?

☐ Yes (provide year) ____ Year ☐ No ☐ Unsure

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If your patient is impaired in two or more categories, initial your professional designation and complete this section.

_____ Medical doctor _____ Nurse practitioner _____ Occupational therapist[2]

[2]An occupational therapist can only certify limitations for walking, feeding, and dressing.

Cumulative effect of significant limitations

When a person is impaired in two or more categories, they may be eligible under "cumulative effect of significant limitations" if the combined effect of their significant limitations is equivalent to a marked restriction (see page 3).

1) Select all categories in which your patient has significant limitations, even with appropriate therapy, medication, and devices:

- ☐ Vision
- ☐ Hearing
- ☐ Eliminating (bowel or bladder functions)
- ☐ Dressing
- ☐ Speaking
- ☐ Walking
- ☐ Feeding
- ☐ Mental functions necessary for everyday life

2) Provide examples that describe your patient's significant limitations in the categories of impairment you selected above, despite the use of appropriate therapy, medication, and devices – this is **mandatory**.

3) Do your patient's limitations in at least two of the categories selected above exist together all or substantially all of the time (see page 3)?

Note: Although a person may not engage in the activities simultaneously, "together" in this context means that they are affected by the significant limitations during the same period of time.

☐ Yes ☐ No

4) Is the cumulative effect of these limitations equivalent to being unable or taking an inordinate amount of time in one single category of impairment, all or substantially all of the time (see page 3)?

☐ Yes ☐ No

5) Provide the year the cumulative effect of the limitations described above began: ____ Year

6) Have your patient's impairments in two or more of the categories selected lasted, or are they expected to last, for a continuous period of at least 12 months?

☐ Yes ☐ No

7) Have your patient's impairments improved, or are they expected to improve to such an extent that your patient would no longer be impaired in at least two of the categories selected?

☐ Yes (provide year) ____ Year ☐ No ☐ Unsure

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Life-sustaining therapy

Initial your professional designation if this category is applicable to your patient:
_____ Medical doctor _____ Nurse practitioner

Life-sustaining therapy – for type 1 diabetes (2021 and later years)

People with type 1 diabetes are deemed to meet the eligibility criteria under life-sustaining therapy for 2021 and later years.

1) Indicate when your patient was diagnosed with type 1 diabetes:

☐ Prior to 2021 – continue to question 2

☐ 2021 and later – provide the year and skip to the Certification section: 2 0 2 _

Life-sustaining therapy – for all conditions & therapies

Eligibility criteria for life-sustaining therapy are as follows:

- The therapy **supports a vital function**.
- The therapy is needed at least **2 times per week** (3 times a week for years prior to 2021).
- The therapy is needed for an average of at least **14 hours per week** including only the time that your patient or another person must dedicate to the therapy. This means that the time they spend on activities to administer the therapy requires them to take time away from normal everyday activities. The following table includes some examples of eligible and ineligible activities:

Eligible activities that count towards the 14 hours per week:

- Activities directly related to adjusting and administering dosage of medication or determining the amount of a compound that can be safely consumed
- Maintaining a log related to the therapy
- Managing dietary restrictions or regimes related to therapy requiring daily consumption of a medical food or formula to limit intake of a particular compound or requiring a regular dosage of medication that needs to be adjusted on a daily basis
- Receiving life-sustaining therapy at home or at an appointment
- Setting up and maintaining equipment used for the therapy

Ineligible activities that do not count towards the 14 hours per week:

- Exercising
- Managing dietary restrictions or regimes other than in the situations described in the eligible activities
- Medical appointments that do not involve receiving the therapy or determining the daily dosage of medication, medical food, or medical formula
- Obtaining medication
- Recuperation after therapy (unless medically required)
- Time a portable or implanted device takes to deliver therapy
- Travel to receive therapy

2) Indicate your patient's life-sustaining therapy and medical conditions:

Life-sustaining therapy:
☐ Multiple daily insulin injections ☐ Insulin pump ☐ Hemodialysis ☐ Peritoneal dialysis
☐ Intermittent oxygen therapy ☐ 24-hour oxygen therapy ☐ Tube feeding ☐ Chest physiotherapy
☐ Other (specify) _____

Medical conditions:
☐ Type 1 diabetes ☐ Type 2 diabetes ☐ End-stage renal disease ☐ Phenylketonuria (PKU)
☐ Cystic fibrosis ☐ Other (specify) _____

3) List the eligible activities for which your patient or another person dedicates time to administer the life-sustaining therapy (see above reference list):

4) Does your patient need the therapy to support a vital function? ☐ Yes ☐ No

5) Provide the minimum number of times per week your patient needs to receive the life-sustaining therapy: _____ times per week

6) Provide the average number of hours per week your patient or another person needs to dedicate to activities in order to administer the life-sustaining therapy: _____ hours per week

7) Provide the year your patient began to need life-sustaining therapy as per your previous answers above: ____ Year

8) Has the impairment that necessitated the life-sustaining therapy lasted, or is it expected to last, for a continuous period of at least 12 months? ☐ Yes ☐ No

9) Has your patient's impairment that required the life-sustaining therapy improved, or is it likely to improve to such an extent that your patient would no longer be in need of the life-sustaining therapy?

☐ Yes (provide year) ____ Year ☐ No ☐ Unsure

Clear Data

Patient's name: _____

Protected B when completed

Certification (mandatory)

1) For which year(s) has the person with the disability been your patient? _____ to _____

2) Do you have medical information on file for all the year(s) you certified on this form? ☐ Yes ☐ No

Select the medical practitioner type that applies to you. Tick one box only:

☐ Medical doctor ☐ Nurse practitioner ☐ Optometrist ☐ Occupational therapist

☐ Audiologist ☐ Physiotherapist ☐ Psychologist ☐ Speech-language pathologist

As a **medical practitioner**, I certify that this information is correct to the best of my knowledge. I understand that this information will be used by the CRA to make a decision if my patient is eligible for the DTC.

Signature: _____

It is a serious offence to make a false statement.

Name (print): _____

Medical license or registration number (optional): _____

Telephone number: _____

Date: Year Month Day

Address

General information

Disability tax credit

The disability tax credit (DTC) is a non-refundable tax credit that helps persons with disabilities or their supporting persons reduce the amount of income tax they may have to pay.

For more information, go to **canada.ca/disability-tax-credit** or see Guide RC4064, Disability-Related Information.

Eligibility

A person with a severe and prolonged impairment in physical or mental functions **may be eligible** for the DTC. To find out if you may be eligible for the DTC, fill out the self-assessment questionnaire in Guide RC4064, Disability-Related Information.

After you send the form

Make sure to keep a copy of your application for your records. After we receive your application, we will review it and make a decision based on the information provided by your medical practitioner. We will then send you a notice of determination to inform you of our decision.

You are responsible for any fees that the medical practitioner charges to fill out this form or to give us more information. You may be able to claim these fees as medical expenses on line 33099 or line 33199 of your income tax and benefit return.

If you have questions or need help

If you need more information after reading this form, go to **canada.ca/disability-tax-credit** or call **1-800-959-8281**.

Forms and publications

To get our forms and publications, go to **canada.ca/cra-forms** or call **1-800-959-8281**.

How to send in your form

You can send your completed form at **any time** during the year online or by mail. Sending your form before you file your annual income tax and benefit return may help us assess your return faster.

Online

Submitting your form online is secure and efficient. You will get immediate confirmation that it has been received by the CRA. To submit online, scan your form and send it through the "Submit documents" service in My Account at **canada.ca/my-cra-account**. If you're a representative, you can access this service in Represent a Client at **canada.ca/taxes-representatives**.

By Mail

You can send your application to the tax centre closest to you:

Winnipeg Tax Centre
Post Office Box 14000, Station Main
Winnipeg MB R3C 3M2

Sudbury Tax Centre
Post Office Box 20000, Station A
Sudbury ON P3A 5C1

Jonquière Tax Centre
2251 René-Lévesque Blvd
Jonquière QC G7S 5J2

For internal use _____

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