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

OSAP
Disability Verification Form

Purpose of this form

This form is used to collect information about your disability, including documentation from your health care provider (doctor or other regulated health care professional). This information is used to verify your status as a person with a disability for Ontario Student Assistance Program (OSAP) purposes.

If verified, you may get additional disability-related funding or the rules for getting OSAP may be adjusted (such as allowing a reduced course load). You may also qualify for other funding through the "Bursary for Students with Disabilities and the Canada Student Grant for Services and Equipment for Students with Disabilities". This program, which requires a separate application, helps students with the costs of their disability-related educational services and equipment, such as note-takers, tutors, or technical aids. A copy of the application is available on the OSAP website (ontario.ca/osap).

Help is available

The Office for Students with Disabilities or the financial aid office at your school can help you with any questions about this form. The Office for Students with Disabilities can also provide information about disability-related equipment, supports and services available at your school. For more information, see the "Questions?" section on page 2.

How to complete this form

There are two parts to this form: Section A and Section B.

- Fill out Section A, including the consents and declarations that you must sign and date.
- Section B is completed by your health care provider (doctor or other regulated health care professional) about your disability. Send all pages of Section B to your health care provider to complete.

Normally, you are only required to have this form completed once. Your health care provider may charge you a fee for completing the form. You are responsible for paying this fee yourself.

How to submit this form

Submit both Section A (completed by you) and Section B (completed by your health care provider).

Upload it online:
Log into your OSAP account at ontario.ca/osap and use the "Print/Upload" feature

Send the paper to:
If you're going to a school in Ontario
Send all sections of this form to the financial aid office at your school.

If you're going to a school outside of Ontario
Send all sections of this form to the ministry at:
Student Financial Assistance Branch, Ministry of Advanced Education and Skills Development,
PO Box 4500, 189 Red River Road, 4th Floor, Thunder Bay, Ontario, P7B 6G9

If you are sending in a paper copy, keep a copy of your form and related documents for your own records.

The privacy of all disability information is protected by the ministry under the *Freedom of Information and Protection of Privacy Act*.

Deadline to submit the form

The completed form must be received by your financial aid office or the ministry no later than 40 days before the end of your study period.

Questions?

If you need help with this form or have questions about assistance with your disability-related educational costs, contact the following offices:

If you're going to a school in Ontario
Contact the financial aid office or the Office for Students with Disabilities at your school.

If you're going to a school outside of Ontario
Contact the ministry at:

Student Financial Assistance Branch
Ministry of Advanced Education and Skills Development,
PO Box 4500
189 Red River Road, 4th Floor
Thunder Bay, Ontario, P7B 6G9
General inquiry telephone service is available Monday to Friday,
8:30 AM - 4:30 PM (Eastern Time)

Telephone: 807-343-7260.
Toll-free in North America: 1-877-OSAP- 411 or 1-877-672-7411
TTY: 1-800-465-3958

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:

Section A: Consents and declarations of student

Part 1: Required consents and declarations

- 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 signature:

Date:
Day Month Year

Part 2: Optional consent and declaration of student

Sign and date this section only if you:

- Plan to apply for assistance from the Bursary for Students with Disabilities and the Canada Student Grant for Services and Equipment
- Agree that your disability-related information can be shared with your school's Office for Students with Disabilities.

I authorize the financial aid office at my school and the Ministry of Advanced Education and Skills Development to disclose the personal information related to my disability (as provided on this form) to my school's Office for Students with Disabilities if it's required to determine my eligibility for the Bursary for Students with Disabilities and the Canada Student Grant for Services and Equipment.

Student's signature:

Date:
Day Month 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 Advanced Education and Skills Development 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 Advanced Education and Skills Development, PO Box 4500, 189 Red River Road, Thunder Bay, Ontario, P7B 6G9; 807-343-7260.

OSAP
Disability Verification Form

Section B: Verification of patient's disability

To be completed by the student's health care provider (doctor or other regulated health care professional).

The information provided on this form is used to determine your patient's status as a person with a disability and their eligibility for disability-related funding and/or accommodations under the Ontario Student Assistance Program (OSAP). 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.

Complete all pages in Section B. Provide clear statements about your patient's disability-related functional limitations and/or restrictions. Avoid such terms as "suggests" or "is indicative of". If more space is required, provide it on your official letterhead and attach it to this document.
Return the completed form and any attachments to your patient.

Patient information

First name:

Last name:

Date of birth:
Month Day Year

Part 1: Physician or regulated health care professional information

First name:

Area code and telephone number:

Last name:

Specialty:
Indicate all that apply:

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

Ontario Licence #:

Official stamp of facility name and address:
Note: If you do not have an office stamp, please sign and attach your letterhead to this form.

Patient first name: Last name:

Declaration of physician or regulated health care professional

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 regulated health care professional:

Date: Day Month Year

Part 2: Patient's disability status

For OSAP purposes, the federal government defines a permanent disability as a functional limitation:

- caused by a physical or mental impairment;
- that restricts a student's 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 the student for their whole life.

Does the patient have a disability (either permanent or temporary)?

- ☐ Yes
- ☐ No - See instructions below

If you answered "No" to the above question, no further information is required. Ensure the physician or regulated health care professional information section is completed. Return the form to the patient.

Choose ONE of the following statements that best describes the patient's disability status.

- ☐ Patient's disability (or disabilities) is **temporary**.
- ☐ Patient's disability (or disabilities) is **permanent** and expected to remain for their lifetime.

Does your patient's disability result in functional limitations that restricts their ability to perform daily activities necessary to study at the postsecondary level or participate in the labour force?

- ☐ Yes
- ☐ No - See instructions below

If you answered "No" to the above question, no further information is required. Ensure the physician or regulated health care professional information section is completed. Return the form to the patient.

Patient first name: _____ Last name: _____

Part 3: Nature of patient's disability

Check all that apply:

☐ **Acquired Brain Injury**

☐ **Attention Deficit Disorder (ADD) / Attention Deficit Hyperactivity Disorder (ADHD)**

☐ **Autism Spectrum Disorder**
(e.g. autism, Asperger's, pervasive developmental disorder, etc.)

☐ **Functional / mobility impairment**
(e.g. paraplegia, quadriplegia, muscular dystrophy, cerebral palsy, spinal cord injury, spina bifida, multiple sclerosis)

☐ **Hearing impairment**

☐ **Medical disability**
(e.g. epilepsy, chronic pain, heart condition)

☐ **Mental health disability**

☐ **Learning disability**

Answer the following questions:

Has an assessment been performed by a registered psychologist or psychiatrist?

☐ Yes

☐ No

If "Yes", enter the date of the most recent assessment:

Day Month Year

_ _ _ _ _ _ _ _

Was a learning disability confirmed?

☐ Yes

☐ No

☐ **Visual impairment**

☐ **Other disability not indicated above**

Specify: _____

Patient first name: _____ Last name: _____

Part 4: Mobility and movement impacts

Check all that apply:

☐ Ambulation ☐ Standing ☐ Sitting ☐ Stair climbing

☐ Lifting/carrying/reaching ☐ Grasping/gripping/dexterity

☐ Other - Specify: _____

Describe impact(s):

☐ No mobility and movement impacts

Part 5: 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):

☐ No cognitive and/or behavioural impacts

Part 6: Recommended accommodations or supports for postsecondary studies

Based on patient's disability and impact of that disability, which accommodations or supports do you recommend that will facilitate their participation in postsecondary studies.

Check all that apply:

☐ Reduced course load

☐ Specialized equipment. Specify:

☐ Specialized services. Specify:

☐ None