# Treasury Health

## Disability Tax Credit Certificate

CRA Form T2201 – Patient Worksheet

Complete this form and return it to Treasury Health. Your answers will help your doctor accurately complete Part B of the T2201. You do not need to fill in sections that do not apply to you.

## Part A – Section 1: Person with the Disability

| | |
|---|---|
| **First Name** | |
| **Last Name** | |
| **Social Insurance Number** | |
| **Date of Birth (YYYY/MM/DD)** | |
| **Mailing Address** | |
| **City** | |
| **Province / Territory** | ON |
| **Postal Code** | |

## Part A – Section 2: Supporting Family Member (if applicable)

Only complete if someone OTHER than the person with the disability will claim the credit.

| | |
|---|---|
| **First Name** | |
| **Last Name** | |
| **Relationship to Person** | |
| **Social Insurance Number** | |

## Part A – Section 3: Authorization & Signature

You MUST sign this section. Without your signature the CRA will not process the form.

| | |
|---|---|
| **Signature** | |
| **Telephone Number** | |
| **Date (YYYY/MM/DD)** | |

# Treasury Health

Patient Form – Disability Tax Credit Certificate (T2201)

## Part B – Impairment Information for Your Doctor

Complete ONLY the sections that apply to you. Your notes here will help your doctor fill out Part B accurately. Be specific about HOW and HOW MUCH your conditions affect each function.

## Vision (Page 4)

| | |
|---|---|
| **Left Eye Acuity (after correction)** | |
| **Right Eye Acuity (after correction)** | |
| **Visual Field (degrees)** | |
| **Conditions / Diagnoses (include year of diagnosis for each)** | |
| **Medications** | |
| **Devices / Therapy used** | |
| **Examples of impact on daily life** | |
| **Takes 3x longer than typical?** | □ Yes □ No |
| **Occurs 90%+ of the time?** | □ Yes □ No |

# Treasury Health

Patient Form – Disability Tax Credit Certificate (T2201)

## Speaking (Page 5)

| | |
|---|---|
| **Conditions / Diagnoses (include year of diagnosis for each)** | |
| **Medications** | |
| **Devices / Therapy used** | |
| **Examples of impact on daily life** | |
| **Takes 3x longer than typical?** | ☐ Yes ☐ No |
| **Occurs 90%+ of the time?** | ☐ Yes ☐ No |

## Hearing (Page 6)

| | |
|---|---|
| **Left Ear Hearing Level** | |
| **Right Ear Hearing Level** | |
| **Conditions / Diagnoses (include year of diagnosis for each)** | |
| **Medications** | |
| **Devices / Therapy used** | |
| **Examples of impact on daily life** | |
| **Takes 3x longer than typical?** | ☐ Yes ☐ No |
| **Occurs 90%+ of the time?** | ☐ Yes ☐ No |

# Treasury Health

Patient Form – Disability Tax Credit Certificate (T2201)

## Walking (Page 7)

| | |
|---|---|
| **Conditions / Diagnoses (include year of diagnosis for each)** | |
| **Medications** | |
| **Devices / Therapy used** | |
| **Examples of impact on daily life** | |
| **Takes 3x longer than typical?** | □ Yes □ No |
| **Occurs 90%+ of the time?** | □ Yes □ No |

## Eliminating – Bowel / Bladder (Page 8)

| | |
|---|---|
| **Conditions / Diagnoses (include year of diagnosis for each)** | |
| **Medications** | |
| **Devices / Therapy used** | |
| **Examples of impact on daily life** | |
| **Takes 3x longer than typical?** | □ Yes □ No |
| **Occurs 90%+ of the time?** | □ Yes □ No |

## Feeding (Page 9)

| | |
|---|---|
| **Conditions / Diagnoses (include year of diagnosis for each)** | |
| **Medications** | |
| **Devices / Therapy used** | |
| **Examples of impact on daily life** | |
| **Takes 3x longer than typical?** | □ Yes □ No |
| **Occurs 90%+ of the time?** | □ Yes □ No |

## Dressing (Page 10)

| | |
|---|---|
| **Conditions / Diagnoses (include year of diagnosis for each)** | |
| **Medications** | |
| **Devices / Therapy used** | |
| **Examples of impact on daily life** | |
| **Takes 3x longer than typical?** | □ Yes □ No |
| **Occurs 90%+ of the time?** | □ Yes □ No |

# Treasury Health

Patient Form – Disability Tax Credit Certificate (T2201)

## Mental Functions Necessary for Everyday Life (Pages 11–13)

This section covers: adaptive functioning, attention, concentration, goal-setting, judgment, memory, perception of reality, problem-solving, regulation of behaviour/emotions, and verbal/non-verbal comprehension. Be as specific as possible about your daily limitations.

### General Information

| | |
|---|---|
| **Conditions / Diagnoses (include year of diagnosis for each)** | |
| **Medications (name, dose, frequency)** | |
| **Need reminders to take medications?** | □ Yes □ No □ Unsure |
| **Medication effectiveness** | □ Effective □ Moderately effective □ Mildly effective □ Ineffective |
| **Devices / Therapy / Supports used** | |
| **Can you live independently?** | □ Yes □ No |
| **Type of support received** | □ Family □ Assisted living □ Community services □ Other |
| **Support details (who, what, how often)** | |

### Rate Your Limitation for Each Mental Function

For each sub-function below, mark the box that best describes your limitation. Then use the example area to describe in your own words how this affects your daily life. The more specific your examples, the better your doctor can document your case.

| | Sub-Function | No limitations | Some limitations | Severe limitations |
|---|---|---|---|---|
| **Adaptive Functioning** | | | | |
| | Adapt to change | □ | □ | □ |
| | Express basic needs | □ | □ | □ |
| | Go out into the community | □ | □ | □ |
| | Initiate simple transactions | □ | □ | □ |

| | | | | |
|---|---|---|---|---|
| | Perform basic hygiene / self-care | ☐ | ☐ | ☐ |
| | Perform necessary everyday tasks | ☐ | ☐ | ☐ |

Examples – How does this affect your daily life? (optional but helpful):

| Attention | | | | |
|---|---|---|---|---|
| | Awareness of danger / safety | ☐ | ☐ | ☐ |
| | Basic impulse control | ☐ | ☐ | ☐ |

Examples – How does this affect your daily life? (optional but helpful):

| Concentration | | | | |
|---|---|---|---|---|
| | Focus on a simple task | ☐ | ☐ | ☐ |
| | Absorb and retrieve short-term information | ☐ | ☐ | ☐ |

Examples – How does this affect your daily life? (optional but helpful):

| Goal-Setting | | | | |
|---|---|---|---|---|
| | Make and carry out day-to-day plans | ☐ | ☐ | ☐ |
| | Self-direct to begin everyday tasks | ☐ | ☐ | ☐ |

Examples – How does this affect your daily life? (optional but helpful):

| Judgment | | | | |
|---|---|---|---|---|
| | Choose weather-appropriate clothing | ☐ | ☐ | ☐ |
| | Decisions about treatment and welfare | ☐ | ☐ | ☐ |
| | Recognize risk of being taken advantage of | ☐ | ☐ | ☐ |
| | Understand consequences of actions | ☐ | ☐ | ☐ |

Examples – How does this affect your daily life? (optional but helpful):

| Memory | | | | |
|---|---|---|---|---|
| | Remember personal info (date of birth, address) | ☐ | ☐ | ☐ |
| | Remember material of importance | ☐ | ☐ | ☐ |
| | Remember simple instructions | ☐ | ☐ | ☐ |

Examples – How does this affect your daily life? (optional but helpful):

| Perception of Reality | | | | |
|---|---|---|---|---|
| | Accurate understanding of reality | ☐ | ☐ | ☐ |
| | Distinguish reality from delusions / hallucinations | ☐ | ☐ | ☐ |

Examples – How does this affect your daily life? (optional but helpful):

| Problem-Solving | | | | |
|---|---|---|---|---|
| | Identify everyday problems | ☐ | ☐ | ☐ |
| | Implement solutions to simple problems | ☐ | ☐ | ☐ |

Examples – How does this affect your daily life? (optional but helpful):

| Regulation of Behaviour and Emotions | | | | |
|---|---|---|---|---|
| | Behave appropriately for situation | ☐ | ☐ | ☐ |
| | Appropriate emotional responses | ☐ | ☐ | ☐ |
| | Regulate mood to prevent harm to self or others | ☐ | ☐ | ☐ |

Examples – How does this affect your daily life? (optional but helpful):

| Verbal and Non-Verbal Comprehension | | | | |
|---|---|---|---|---|
| | Understand and respond to non-verbal cues | ☐ | ☐ | ☐ |
| | Understand and respond to verbal information | ☐ | ☐ | ☐ |

Examples – How does this affect your daily life? (optional but helpful):

## Cumulative Effect (Page 14)

If no single impairment qualifies on its own, two or more significant limitations may combine to create eligibility. Complete this section if this applies to you.

| | |
|---|---|
| **Conditions involved** | |
| **Combined impact on daily life** | |
| **Takes 3x longer than typical?** | ☐ Yes ☐ No |
| **Occurs 90%+ of the time?** | ☐ Yes ☐ No |

## Life-Sustaining Therapy (Page 15)

Complete this section only if you require therapy that must be administered at least twice weekly (at least 14 hours/week), such as dialysis or chest physiotherapy for cystic fibrosis.

| | |
|---|---|
| **Type of therapy** | |
| **Frequency per week** | |
| **Hours per session** | |
| **Who administers it?** | |

# Treasury Health

Patient Form – Disability Tax Credit Certificate (T2201)

## Patient Acknowledgment

| | |
|---|---|
| **Patient Name** | |
| **Signature** | |
| **Date (YYYY/MM/DD)** | |