Canada Customs and Revenue Agency | Agence des douanes et du revenu du Canada

DISABILITY TAX CREDIT CERTIFICATE

Use this form to apply for the disability amount.

What is the disability amount?

This is a non-refundable tax credit that you can use to reduce the amount of income tax you have to pay. You may be able to transfer part or all of this amount to your spouse or common-law partner, or another supporting person.

Supplement

A person who was under 18 at the end of the year and who qualifies for the disability amount may be able to claim an additional amount, or transfer the unused amount to a spouse or common-law partner or another supporting person. Child care expenses and attendant care expenses anyone claimed for the person may reduce the claim. The supplement can only be claimed for 2000 and later years.

Who can claim the disability amount?

You may be able to claim the disability amount if a **qualified person** certifies **any** of the following:

- You are blind all or almost all the time, even with the use of corrective lenses or medication, and the impairment is **prolonged**.
- You have a severe mental or physical impairment which causes you to be **markedly restricted** in any of the **basic activities of daily living**, and the impairment is **prolonged**.
- You need, and dedicate time specifically for, **life-sustaining therapy** to support a vital function, as defined on this page.

Not all people with disabilities can claim the disability amount. **If you receive Canada or Quebec Pension Plan disability benefits, workers' compensation benefits, or other types of disability or insurance benefits, it does not necessarily mean you can claim the disability amount.** These programs are based on other criteria, such as an individual's inability to work.

When do we need Form T2201?

If you are making a new application for this amount, you have to file a completed Form T2201, *Disability Tax Credit Certificate*. If you have already qualified, do not file another form unless your previous period of approval has ended or we ask you to send in a new form. You must also tell us if your circumstances change. For example, if we advised you in 2000 that your claim would need to be re-evaluated for the 2002 tax year, you will need to file a new Form T2201 with your 2002 return. However, there is no need to file another Form T2201 if you will not be claiming the disability amount for 2002 and later years.

Definitions

Qualified person

Qualified persons are medical doctors, optometrists, audiologists, occupational therapists, psychologists, and speech-language pathologists.

What impairments can they certify?	
Medical doctors	all
Optometrists	seeing
Audiologists	hearing
Occupational therapists	walking, feeding, and dressing
Psychologists	perceiving, thinking, and remembering
Speech-language pathologists	speaking

Prolonged

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

Basic activities of daily living

These are:

- walking
- speaking
- perceiving, thinking, and remembering
- hearing
- feeding and dressing
- eliminating bodily waste

Basic activities of daily living do not include general activities such as working, housekeeping, or social or recreational activities.

Markedly restricted

You may be markedly restricted if, all or almost all the time, you are unable (or it takes you an extremely long time) to perform a basic activity of daily living, even with therapy (other than life-sustaining therapy) and the use of appropriate devices and medication.

Life-sustaining therapy

Life-sustaining therapy includes clapping therapy to help in breathing, or kidney dialysis to filter your blood. Life-sustaining therapy does not include implanted devices, such as a pacemaker, or special programs of diet, exercise, hygiene, or medication. A medical doctor must certify that you need, and dedicate time specifically for, this therapy—at least three times per week, to an average of at least 14 hours per week. The need for this therapy must have lasted, or be expected to last, for a continuous period of at least 12 months. Eligibility under this criteria applies only to 2000 and later years.

(Ce formulaire existe en français.)

Canada

Part A – To be completed by the applicant or his or her representative

If you meet the conditions outlined on the previous page, complete Part A of this form. **Be sure to complete all areas, including the social insurance number and date of birth.** Then, take the form to a qualified person who can complete and certify Part B.

Attach the completed form to your return or, if you have already filed your return, send it to your tax centre. We will accept a photocopy only if the qualified person's signature is an original.

Keep a copy of this form for your records.

We will review your claim **before** we assess your return. Giving incomplete or incorrect information may delay the processing of your return and any disability amount to which you may be entitled. We may ask our medical advisors to review your claim to determine if you meet the eligibility criteria, and they may contact you or the qualified person for more information.

Any fees that a qualified person may charge to complete Part B, or to give us more information, are your responsibility. These fees are not covered by the Canada Customs and Revenue Agency or by provincial medicare plans.

6729

6730 **The person with the disability is:**

1. ☐ Me **2.** ☐ My spouse or common-law partner **3.** ☐ Other (indicate relationship) _____

Information about the person with the disability

Name and address

Date of birth (Year Month Day) 6732 _____ Social insurance number 6734 _____ Maiden name _____

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

Name _____ Social insurance number _____

Does the person with the disability reside with you? . . . . . **yes** ☐ **no** ☐

Give the **name**, **address**, and **telephone number** of any qualified person (defined on the previous page) who knows about the individual's impairment. If you need more space, attach a separate sheet of paper.

Authorization

As the person with the disability or an authorized representative, I authorize any qualified person having medical records to disclose the information contained in those records to the Canada Customs and Revenue Agency for the purpose of determining if the person with the disability meets the eligibility requirements for the disability amount.

Sign here _____ Telephone _____ Date _____

6744 ☐ **DO NOT USE THIS AREA**

Part B – To be completed by a qualified person who is familiar with the patient's impairment

Be sure to review the eligibility requirements on page 1.

Eligibility for the disability amount is based on the functional impairment of your patient, and not on the medical diagnosis.

Your patient **does not qualify** if he or she receives therapy (other than life-sustaining therapy), uses appropriate devices, or takes medication that removes a marked restriction in a basic activity of daily living.

For information about **claims for children**, see the back of this form.

Patient's name _____

Answer the following questions as they apply to your patient's impairment.

■ Can your patient see?

Answer **no** only if, all or almost all the time, even with corrective lenses or medication, your patient cannot see. This means visual acuity in both eyes with proper refractive lenses is 20/200 (6/60) or less with the Snellen Chart or an equivalent, or when the greatest diameter of the field of vision in **both** eyes is 20 degrees or less . . . . . **yes** ☐ **no** ☐ 1

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

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

■ Can your patient walk?

Answer **no** only if, all or almost all the time, even with therapy, medication, or a device, your patient cannot walk 50 metres on level ground, or he or she takes an inordinate amount of time to do so . . . . . **yes** ☐ **no** ☐ 2

If you answered **no** and your patient is confined to a bed or a wheelchair, how many hours per day (excluding sleeping hours) does this apply? . . . . . _____

■ Can your patient speak?

Answer **no** only if, all or almost all the time, even with therapy, medication, or a device, your patient cannot speak so as to be understood in a quiet setting, or he or she takes an inordinate amount of time to do so (exclude language differences) . . . . . **yes** ☐ **no** ☐ 3

■ Can your patient perceive, think, and remember?

Answer **no** only if, all or almost all the time, even with therapy, medication, or a device, your patient cannot perceive, think, and remember. For example, answer **no** if he or she cannot manage or initiate personal care without constant supervision . . . . . **yes** ☐ **no** ☐ 4

■ Can your patient hear?

Answer **no** only if, all or almost all the time, even with therapy, medication, or a device, your patient cannot hear (without lip reading) so as to understand a spoken conversation in a quiet setting (exclude language differences) . . . . . **yes** ☐ **no** ☐ 6

■ Can your patient feed or dress himself or herself?

Answer **no** only if, all or almost all the time, even with therapy, medication, or a device, your patient cannot feed or dress himself or herself, or he or she takes an inordinate amount of time to do so . . . . . **Feeding** **yes** ☐ **no** ☐ 7

Dressing **yes** ☐ **no** ☐ 7

■ Can your patient personally manage bowel and bladder functions?

Answer **no** only if, all or almost all the time, even with therapy, medication, or a device, your patient cannot personally manage bowel or bladder functions, or he or she takes an inordinate amount of time to do so. For example, answer **no** if your patient needs help from another person on a daily basis to care for his/her ostomy . . . . . **yes** ☐ **no** ☐ 8

Life-sustaining therapy (applies to 2000 and later years)

If your patient needs life-sustaining therapy to support a vital function (see page 1), he or she may qualify for the disability amount, even if the therapy has alleviated the condition. Your patient must specifically dedicate the time needed for this therapy—at least three times per week, to an average of at least 14 hours per week (**do not** include time needed for travel, medical appointments, or to recuperate after therapy).

Does your patient meet these conditions for life-sustaining therapy? . . . . . **yes** ☐ 9 **no** ☐

If **yes**, please specify the type of therapy: _____

DO NOT USE THIS AREA 6742 BADLs 1 ☐ 2 ☐ 3 ☐ 4 ☐ 6 ☐ 7 ☐ 8 ☐ Life-sustaining therapy 9 ☐

Part B (continued) – Complete all three sections on this page.

Duration

Has your patient's marked restriction in a basic activity of daily living, blindness, or need for life-sustaining therapy lasted, or is it expected to last, for a continuous period of at least 12 months? . . . . . **yes** ☐ **no** ☐

If **yes**, give the date:

- your patient became markedly restricted or blind, **or**
- the life-sustaining therapy began . . . . . 6738 Year ____ Month ____

This is **not** necessarily the date your patient was diagnosed with his or her condition.

Is the impairment likely to improve sufficiently such that the patient may no longer be markedly restricted in a basic activity of daily living, blind, or need life-sustaining therapy?

If **yes**, give the year the marked restriction, blindness, or need for life-sustaining therapy ceased, or is expected to cease . . . . . 6740 Year ____

If **no**, check this box . . . . . ☐

Diagnosis

State the medical diagnosis related to the impairment and describe the restriction and devices used. **Please print.**
Attach any other information or documents that may be relevant to your patient's impairment.

Certification

As a **qualified person**, I certify that to the best of my knowledge the information given in Part B is correct and complete.

Sign here _____

Print your name _____

Telephone number _____

Fax number _____

Date _____

Address

Check whichever of the following applies to you:

☐ Medical doctor ☐ Optometrist ☐ Audiologist ☐ Occupational therapist ☐ Psychologist ☐ Speech-language pathologist

Claims for children

If the child is blind or needs life-sustaining therapy to support a vital function, complete Part B as you would for an adult.

For impairments affecting a basic activity of daily living for a child from birth to three years of age, assess the child's developmental progress in relation to the normal range of development. Basic activities of daily living for a child up to the age of three are normally performed with the help of a parent or legal guardian. However, if the impairment is obvious or medically proven, an assessment can be done at an early age. After the age of three, assess how the impairment affects the child's ability to perform the basic activities of daily living.

Fees

Your patient is responsible for any fees you may charge to complete this form.

These fees are not covered by the Canada Customs and Revenue Agency or by provincial medicare plans.

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