Canada Revenue Agency | Agence du revenu du Canada

Protected B
when completed

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 claiming the disability amount**

☐ The person with the disability is claiming the disability amount

or

☐ A supporting family member is claiming the disability amount (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 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 person with the disability.

As the supporting family member claiming the disability amount, I confirm that the information provided is accurate.

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

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

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: _____

Telephone number: _____ Date: Year Month Day

Personal information (including the SIN) is collected 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 used or disclosed for purposes of other federal acts that provide for the imposition and collection of a tax or duty. It may also be disclosed to other federal, provincial, territorial, 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 Information about Programs and Information Holdings at **canada.ca/cra-information-about-programs**.

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.

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

Initial your designation if this category is applicable to your patient:

_____ medical doctor _____ nurse practitioner _____ optometrist

Vision

1) 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

2) Is the patient considered blind in both eyes according to at least one of the following criteria:

- 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 (provide the year they became blind) |____|____|____|____| Year

or

☐ No (provide the year the vision limitations began) |____|____|____|____| Year

Medical doctors and nurse practitioners only: If your patient experiences limitations in more than one category, tell us more about the patient's limitations in vision. They may be eligible under the "Cumulative effect of significant limitations" section on page 14.

Provide examples of how their limited vision impacts other activities of daily living (for example, walking, feeding). Also provide any other relevant details such as devices the patient uses to aid their vision (for example, cane, magnifier, service animal).

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

☐ Yes ☐ No

4) Has the 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

Initial your designation if this category is applicable to your patient:

_____ medical doctor _____ nurse practitioner _____ speech-language pathologist

Speaking

1) List any medical conditions that impact the patient's ability to speak so as to be understood and provide the year of diagnosis (if available):

2) Does the patient take medication that aids their speaking limitations?

☐ Yes ☐ No ☐ Unsure

3) Describe if the patient uses any devices or therapy to aid their speaking limitations (for example, voice amplifier, behavioural therapy):

4) Provide examples of the factors that limit the patient's ability to speak using the severity and frequency scales provided as a guide (for example, they often require repetition to be understood, always experience mild difficulty with articulation, selective mutism, they use sign language as their primary means of communicating):

Severity

Mild | Mild to moderate | Moderate | Moderate to severe | Severe

Frequency

Rarely | Occasionally | Often | Usually | Always

5) Tell us in the table below about the patient's ability to speak so as to be understood by a familiar person in a quiet setting (more than one answer may apply, given that the patient's ability may change over time). Evaluate their ability to speak so as to be understood when using the medication, devices, and therapy listed above, if applicable.

Limitations in speaking	Is this the case all or substantially all of the time (see page 3)?	Year this began
☐ The patient is unable to speak or takes an inordinate amount of time to speak so as to be understood (at least three times longer than someone of similar age without a speech impairment) by a familiar person in a quiet setting.	☐ Yes ☐ No	
☐ The patient has difficulty, but does not take an inordinate amount of time to speak so as to be understood by a familiar person in a quiet setting.[1]	☐ Yes ☐ No	

[1] 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.

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

☐ Yes ☐ No

7) Has the 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

Initial your designation if this category is applicable to your patient:

_____ medical doctor _____ nurse practitioner _____ audiologist

Hearing

1) Indicate the option that best describes the patient's level of hearing loss in each ear with any applicable devices (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

2) Provide the patient's overall word discrimination score in both ears:

% ☐ Unknown

3) Describe if the patient uses any devices to aid their hearing (for example, cochlear implant, hearing aid):

4) Provide the medical condition causing hearing loss and examples of the impacts of hearing loss on your patient using the severity and frequency scales as a guide (for example, they often require the use of repetition, lip-reading or sign-language to understand verbal communication, they have severely impaired awareness of risks to personal safety):

Severity

Mild | Mild to moderate | Moderate | Moderate to severe | Severe

Frequency

Rarely | Occasionally | Often | Usually | Always

5) Tell us in the table below about the patient's ability to hear so as to understand a familiar person in a quiet setting (more than one answer may apply, given that the patient's ability may change over time). Evaluate their ability to hear when using the devices listed above, if applicable.

Limitations in hearing	Is this the case all or substantially all of the time (see page 3)?	Year this began
☐ The patient is unable to hear or takes an inordinate amount of time to hear so as to understand (at least three times longer than someone of similar age without a hearing impairment) a familiar person in a quiet setting.	☐ Yes ☐ No	
☐ The patient has difficulty, but does not take an inordinate amount of time to hear so as to understand a familiar person in a quiet setting.[1]	☐ Yes ☐ No	

[1]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.

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

☐ Yes ☐ No

7) Has the 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

Initial your designation if this category is applicable to your patient:

_____ medical doctor _____ nurse practitioner _____ occupational therapist _____ physiotherapist

Walking

1) List any medical conditions that impact the patient's ability to walk and provide the year of diagnosis (if available):

2) Does the patient take medication to aid their limitations in walking?

☐ Yes ☐ No ☐ Unsure

3) Describe if the patient uses any devices or therapy to aid their limitation in walking (for example: cane, occupational therapy):

4) Provide examples of the factors that limit the patient's ability to walk using the severity and frequency scales provided as a guide (for example, they have severe pain in their legs, they often have moderately impaired balance, they experience shortness of breath upon mild exertion):

Severity

Mild | Mild to moderate | Moderate | Moderate to severe | Severe

Frequency

Rarely | Occasionally | Often | Usually | Always

5) Tell us in the table below about the patient's ability to walk, for example, a short distance such as 100 metres (more than one answer may apply, given that the patient's ability may change over time). Evaluate their ability to walk when using the devices and therapy listed above, if applicable.

Limitations in walking	Is this the case all or substantially all of the time (see page 3)?	Year this began
☐ The patient is unable or takes an inordinate amount of time to walk (at least three times longer than someone of a similar age without an impairment in walking).	☐ Yes ☐ No	
☐ The patient has difficulty, but does not take an inordinate amount of time to walk.[1]	☐ Yes ☐ No	

[1]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.

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

☐ Yes ☐ No

7) Has the 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

Initial your designation if this category is applicable to your patient:

_____ medical doctor _____ nurse practitioner

Eliminating

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

2) Does the patient take medication to aid their limitations in bowel or bladder functions?

☐ Yes ☐ No ☐ Unsure

3) Describe if the patient uses any devices or therapy to aid their limitations in bowel or bladder functions (for example, ostomy, biological therapy):

4) Provide examples of the factors that limit the patient's ability to personally manage their bowel or bladder functions using the severity and frequency scales provided as a guide (for example, they always require assistance from another person to manage bowel or bladder functions, they have chronic constipation or diarrhea, they often have fecal or urinary incontinence, they usually require intermittent catheterization):

Severity

Mild | Mild to moderate | Moderate | Moderate to severe | Severe

Frequency

Rarely | Occasionally | Often | Usually | Always

5) Tell us in the table below about the patient's ability to personally manage their bowel or bladder functions (more than one answer may apply, given that the patient's ability may change over time). Evaluate their ability to personally manage bowel or bladder functions when using the medication, devices, and therapy listed above, if applicable.

Limitations in eliminating	Is this the case all or substantially all of the time (see page 3)?	Year this began
☐ The patient is unable or takes 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 these functions).	☐ Yes ☐ No	
☐ The patient has difficulty, but does not take an inordinate amount of time to personally manage bowel or bladder functions.[1]	☐ Yes ☐ No	

[1] 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.

6) Has the 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

7) Has the 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) ____ ☐ No ☐ Unsure

Year

Initial your designation if this category is applicable to your patient:

_____ medical doctor _____ nurse practitioner _____ occupational therapist

Feeding

This impairment category includes the acts of feeding oneself as well as preparing food, except when the time spent on food preparation is related to a dietary restriction or regime. It does not include identifying, finding, shopping for, or obtaining food.

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

2) Does the patient take medication to aid their limitations in feeding themselves?

☐ Yes ☐ No ☐ Unsure

3) Describe if the patient uses any devices or therapy to aid their limitations in feeding themselves (for example, assistive utensils, occupational therapy):

4) Provide examples of the factors that limit the patient's ability to feed themselves using the severity and frequency scales provided as a guide (for example, they often require assistance from another person to prepare their meals or feed themselves, their dexterity is always severely impaired, they have moderate tremors, they rely exclusively on tube feeding):

Severity

Mild | Mild to moderate | Moderate | Moderate to severe | Severe

Frequency

Rarely | Occasionally | Often | Usually | Always

5) Tell us in the table below about the patient's ability to feed themselves (more than one answer may apply, given that the patient's ability may change over time). Evaluate their ability to feed themselves when using the medication, devices, and therapy listed above, if applicable.

Limitations in feeding oneself	Is this the case all or substantially all of the time (see page 3)?	Year this began
☐ The patient is unable or takes an inordinate amount of time to feed themselves (at least three times longer than someone of similar age without an impairment in that ability).	☐ Yes ☐ No	
☐ The patient has difficulty, but does not take an inordinate amount of time to feed themselves.[1]	☐ Yes ☐ No	

[1] 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.

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

☐ Yes ☐ No

7) Has the 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

Initial your designation if this category is applicable to your patient:

_____ medical doctor _____ nurse practitioner _____ occupational therapist

Dressing

This impairment category does not include identifying, finding, shopping for, or obtaining clothing.

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

2) Does the patient take medication to aid their limitations in dressing?

☐ Yes ☐ No ☐ Unsure

3) Describe if the patient uses any devices or therapy to aid their limitations in dressing themselves (for example, button hook, occupational therapy):

4) Provide examples of the factors that limit the patient's ability to dress themselves using the severity and frequency scales provided as a guide (for example, they often require assistance from another person to dress themselves, they have severe pain in their upper extremities, they often have moderately limited range of motion):

Severity

Mild | Mild to moderate | Moderate | Moderate to severe | Severe

Frequency

Rarely | Occasionally | Often | Usually | Always

5) Tell us in the table below about the patient's ability to dress themselves (more than one answer may apply, given that the patient's ability may change over time). Evaluate their ability to dress themselves when using the medication, devices, and therapy listed above, if applicable.

Limitations in dressing oneself	Is this the case all or substantially all of the time (see page 3)?	Year this began
☐ The patient is unable or takes an inordinate amount of time to dress themselves (at least three times longer than someone of similar age without an impairment in that ability).	☐ Yes ☐ No	
☐ The patient has difficulty, but does not take an inordinate amount of time to dress themselves.[1]	☐ Yes ☐ No	

[1]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.

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

☐ Yes ☐ No

7) Has the 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

Mental functions necessary for everyday life

Initial your designation if this category is applicable to your patient:

_____ 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 that impact the patient's ability to perform mental functions necessary for everyday life and provide the year of diagnosis (if available):

2) Does the patient take medication that aids their ability to perform mental functions necessary for everyday life?

☐ Yes ☐ No ☐ Unsure

Does the 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 treats their condition:

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

3) Describe any devices or therapy the patient uses that aid their ability to perform mental functions necessary for everyday life (for example, memory aids, assistive technology, cognitive-behavioural therapy):

4) Does the 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) Indicate the extent of the patient's limitations **compared to someone of similar age** without an impairment in mental functions:

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

		No limitations	Some limitations	Very limited capacity
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	☐	☐	☐
	Other (optional): _____			
Attention	Demonstrate awareness of danger and risks to personal safety	☐	☐	☐
	Demonstrate basic impulse control	☐	☐	☐
	Other (optional): _____			
Concentration	Focus on a simple task for any length of time	☐	☐	☐
	Absorb and retrieve information in the short-term	☐	☐	☐
	Other (optional): _____			
Goal-setting	Make and carry out simple day-to-day plans	☐	☐	☐
	Self-direct to begin everyday tasks	☐	☐	☐
	Other (optional): _____			
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	☐	☐	☐
	Other (optional): _____			
Memory	Remember basic personal information such as date of birth and address	☐	☐	☐
	Remember material of importance and interest to themselves	☐	☐	☐
	Remember simple instructions	☐	☐	☐
	Other (optional): _____			

 The Mental functions section continues on page 13.

Mental functions necessary for everyday life (continued)

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

		No limitations	Some limitations	Very limited capacity
Perception of reality	Demonstrate an accurate understanding of reality	☐	☐	☐
	Distinguish reality from delusions and hallucinations	☐	☐	☐
	Other (optional): _____			
Problem-solving	Identify everyday problems	☐	☐	☐
	Implement solutions to simple problems	☐	☐	☐
	Other (optional): _____			
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	☐	☐	☐
	Other (optional): _____			
Verbal and non-verbal comprehension	Understand and respond to non-verbal information or cues	☐	☐	☐
	Understand and respond to verbal information	☐	☐	☐
	Other (optional): _____			

6) Tell us in the table below about the patient's ability to perform mental functions necessary for everyday life (more than one answer may apply, given that the patient's ability may change over time). Evaluate their ability to perform mental functions when using the medication, devices, and therapy listed above, if applicable.

Mental functions	Is this the case all or substantially all of the time (see page 3)?	Year this began
☐ The patient is unable to perform these functions by themselves or takes an inordinate amount of time compared to someone of similar age without an impairment in mental functions.	☐ Yes ☐ No	
☐ The patient has difficulty performing these functions, but does not take an inordinate amount of time.[1]	☐ Yes ☐ No	

[1] If your patient experiences limitations in more than one category, they may be eligible under the "Cumulative effect of significant limitations" section.

7) Has the 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

8) Has the 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

Cumulative effect of significant limitations

Initial your designation if this category is applicable to your patient:

_____ medical doctor _____ nurse practitioner _____ occupational therapist[2]

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

When a person's limitations in one category do not quite meet the criteria to qualify for the DTC, they may still qualify if they experience significant limitations in two or more categories.

1) Select all categories you completed in previous pages and in which your patient has significant limitations, even with therapy and the use of appropriate devices and medication:

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

Important: If you checked a box for a particular category on this page but did not complete the corresponding section on the applicable page of this form, fill out that section prior to completing this page. The CRA will need that information to determine your patient's eligibility under the cumulative effect of significant limitations.

2) Do the 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 limitations during the same period of time.

☐ Yes ☐ No

3) 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

4) Provide the year the cumulative effect of the limitations described above began:

Year

Initial your designation if this category is applicable to your patient:

_____ medical doctor _____ nurse practitioner

Life-sustaining therapy

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**.

  Note: For 2020 and previous years, the therapy had to be needed at least 3 times per week to be eligible.
- 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, that is, the time they spend on activities to administer the therapy requires them to take time away from normal everyday activities.

Refer to the following table as a guide for the types of activities to include in the 14-hour requirement.

Examples of eligible activities:	**Examples of ineligible activities:**
• 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	• 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

1) Which type of life-sustaining therapy is your patient receiving?

Specify the life-sustaining therapy: _____

Specify the medical condition: _____

Note: If the life-sustaining therapy indicated is for type 1 diabetes and you are filing this form for 2021 or later years only, you may skip to question 6. Individuals in this case are deemed to have met the criteria for life-sustaining therapy.

2) List the eligible activities for which the patient or another person dedicates time to administer the life-sustaining therapy:

_____

_____

_____

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

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

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

6) Enter the year the patient began to meet the eligibility criteria at the top of the page:

Year | **or** | ☐ Not applicable (provide the year life-sustaining therapy began) Year

7) 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

8) Has the impairment that necessitated the life-sustaining therapy improved or is it likely to improve to such an extent that they would no longer be in need of the life-sustaining therapy?

☐ Yes (provide year) Year ☐ No ☐ Unsure

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 the information given in Part B of this form is correct and complete. 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 _____