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Canada Revenue Agency | Agence du revenu du Canada

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Disability Tax Credit Certificate

Use this form to apply for the disability tax credit (DTC). Being eligible for this credit may reduce your income tax and open the door to other programs. For more information, go to **www.cra.gc.ca/dtc**.

Step 1: Complete **only** the sections of Part A that apply to you. Remember to sign this form.

Step 2: Ask a medical practitioner to complete and certify Part B.

Step 3: Send us the completed and signed form.

For more information, see the General information on page 6. For definitions, examples of impairments that may qualify for the DTC, and a self-assessment questionnaire, see Guide RC4064, *Disability-Related Information*.

Part A – To be completed by the person with the disability

Section 1 – Information about the person with the disability

First name and initial | Last name | ☐ Female ☐ Male

Mailing address (Apt No – Street No Street name, PO Box, RR) | Social insurance number

City | Province or territory | Postal code | Date of birth: Year Month Day

Section 2 – Information about the person claiming the disability amount (if different from above)

First name and initial | Last name | Social insurance number

The person with the disability is: ☐ my spouse/common-law partner ☐ my dependant (specify): _____

Answer the following questions for **all** of the years that you are claiming the disability amount for the person with the disability.

1. Does the person with the disability live with you? Yes ☐ No ☐

   If **yes**, for which year(s)? _____

2. If you answered **no** to Question 1, does the person with the disability depend on you for regular and consistent support for one or more of the basic necessities of life such as food, shelter, or clothing? Yes ☐ No ☐

   If **yes**, for which year(s)? _____

Give details about the regular and consistent support you provide for food, shelter or clothing to the person with the disability (if you need more space, attach a separate sheet of paper). We may ask you to provide receipts or other documents to support your request for the transfer of the disability amount.

Section 3 – Adjust your income tax and benefit return

In most cases, the Canada Revenue Agency (CRA) can adjust your income tax returns for all applicable years to include the disability amount for **yourself** or your **dependant under the age of 18**. For more information, see Guide RC4064, *Disability-Related Information*.

☐ Yes, I want the CRA to adjust my returns, if possible. ☐ No, I do not want an adjustment.

Section 4 – Authorization

As the **person with the disability** or their **legal representative**, I authorize the medical practitioner having relevant clinical records to provide or discuss the information contained in those records or on this certificate with the CRA for the purpose of determining eligibility for the disability tax credit or other related programs.

Sign here: _____ | Telephone | Year Month Day

Personal information is collected under the *Income Tax Act* to administer tax, benefits, and related programs. It may also be used for any purpose related to the administration or enforcement of the Act such as audit, compliance and the payment of debts owed to the Crown. It may be shared or verified with other federal, provincial/territorial government institutions to the extent authorized by law. Failure to provide this information may result in interest payable, penalties or other actions. Under the *Privacy Act*, individuals have the right to access their personal information and request correction if there are errors or omissions. Refer to Info Source at **www.cra.gc.ca/gncy/tp/nfsrc/nfsrc-eng.html**, Personal Information Bank CRA PPU 218.

(Vous pouvez obtenir ce formulaire en français à **www.arc.gc.ca/formulaires** ou en composant le **1-800-959-7383**.)

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Patient's name: _____

Part B – Must be completed by the medical practitioner

Step 1: Complete **only** the section(s) on pages 2 to 4 that apply to your patient. Each category states which medical practitioner(s) can certify the information on this form.

Note
Whether completing this form for a child or an adult, assess your patient compared to someone of similar age with no impairment.

Step 2: Complete the "**Effects of impairment**", "**Duration**", and "**Certification**" sections on pages 5 and 6. If more information is needed, the Canada Revenue Agency may contact you.

For definitions and examples of impairments that may qualify for the DTC, see Guide RC4064, *Disability-Related Information*. For more information, go to **www.cra.gc.ca/dtcmedicalpractitioners**.

Vision – Medical doctor or optometrist

Your patient is considered **blind** if, even with the use of corrective lenses or medication:

- visual acuity in **both** eyes is 20/200 (6/60) or less, with the Snellen Chart (or an equivalent); **or**
- the greatest diameter of the field of vision in **both** eyes is 20 degrees or less.

1. Is your patient **blind**, as described above? Yes ☐ No ☐

If **yes**, when did your patient become blind (this is not necessarily the year of the diagnosis, as it is often the case with progressive diseases)? Year ____

2. What is your patient's visual acuity **after correction**? Right eye _____ Left eye _____

3. What is your patient's visual field **after correction** (in degrees if possible)? Right eye _____ Left eye _____

Speaking – Medical doctor or speech-language pathologist

Your patient is considered **markedly restricted** in speaking if, even with appropriate therapy, medication, and devices:

- he or she is **unable** or takes an **inordinate amount of time** to speak so as to be understood by another person familiar with the patient, in a quiet setting; **and**
- this is the case **all or substantially all of the time** (at least 90% of the time).

Is your patient **markedly restricted** in speaking, as described above? Yes ☐ No ☐

If **yes**, when did your patient's restriction in speaking become a marked restriction (this is not necessarily the year of the diagnosis, as it is often the case with progressive diseases)? Year ____

Hearing – Medical doctor or audiologist

Your patient is considered **markedly restricted** in hearing if, even with appropriate devices:

- he or she is **unable** or takes an **inordinate amount of time** to hear so as to understand another person familiar with the patient, in a quiet setting; **and**
- this is the case **all or substantially all of the time** (at least 90% of the time).

Is your patient **markedly restricted** in hearing, as described above? Yes ☐ No ☐

If **yes**, when did your patient's restriction in hearing become a marked restriction (this is not necessarily the year of the diagnosis, as it is often the case with progressive diseases)? Year ____

Walking – Medical doctor, occupational therapist, or physiotherapist

Your patient is considered **markedly restricted** in walking if, even with appropriate therapy, medication, and devices:

- he or she is **unable** or takes an **inordinate amount of time** to walk; **and**
- this is the case **all or substantially all of the time** (at least 90% of the time).

Is your patient **markedly restricted** in walking, as described above? Yes ☐ No ☐

If **yes**, when did your patient's restriction in walking become a marked restriction (this is not necessarily the year of the diagnosis, as it is often the case with progressive diseases)? Year ____

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Patient's name: _____

Eliminating (bowel or bladder functions) – Medical doctor

Your patient is considered **markedly restricted** in eliminating if, even with appropriate therapy, medication, and devices:

- he or she is **unable** or takes an **inordinate amount of time** to personally manage bowel or bladder functions; **and**
- this is the case **all or substantially all of the time** (at least 90% of the time).

Is your patient **markedly restricted** in eliminating, as described above? Yes ☐ No ☐

If **yes**, when did your patient's restriction in eliminating become a marked restriction (this is not necessarily the year of the diagnosis, as it is often the case with progressive diseases)? Year

Feeding – Medical doctor or occupational therapist

Your patient is considered **markedly restricted** in feeding if, even with appropriate therapy, medication, and devices:

- he or she is **unable** or takes an **inordinate amount of time** to feed himself or herself; **and**
- this is the case **all or substantially all of the time** (at least 90% of the time).

Feeding oneself **does not** include identifying, finding, shopping for, or otherwise obtaining food.

Feeding oneself **does** include preparing food, **except** when the time associated is related to a dietary restriction or regime, even when the restriction or regime is required due to an illness or health condition.

Is your patient **markedly restricted** in feeding, as described above? Yes ☐ No ☐

If **yes**, when did your patient's restriction in feeding become a marked restriction (this is not necessarily the year of the diagnosis, as it is often the case with progressive diseases)? Year

Dressing – Medical doctor or occupational therapist

Your patient is considered **markedly restricted** in dressing if, even with appropriate therapy, medication, and devices:

- he or she is **unable** or takes an **inordinate amount of time** to dress himself or herself; **and**
- this is the case **all or substantially all of the time** (at least 90% of the time).

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

Is your patient **markedly restricted** in dressing, as described above? Yes ☐ No ☐

If **yes**, when did your patient's restriction in dressing become a marked restriction (this is not necessarily the year of the diagnosis, as it is often the case with progressive diseases)? Year

Mental functions necessary for everyday life – Medical doctor or psychologist

Your patient is considered **markedly restricted** in performing the mental functions necessary for everyday life (described below) if, even with appropriate therapy, medication, and devices (for example, memory aids and adaptive aids):

- he or she is **unable** or takes an **inordinate amount of time** to perform these functions by himself or herself; **and**
- this is the case **all or substantially all of the time** (at least 90% of the time).

Mental functions necessary for everyday life include:

- adaptive functioning (for example, abilities related to self-care, health and safety, abilities to initiate and respond to social interactions, and common, simple transactions);
- memory (for example, the ability to remember simple instructions, basic personal information such as name and address, or material of importance and interest); and
- problem-solving, goal-setting, **and** judgment, taken together (for example, the ability to solve problems, set and keep goals, and make appropriate decisions and judgments).

Note
A restriction in problem-solving, goal-setting, or judgement that markedly restricts adaptive functioning, all or substantially all of the time (at least 90% of the time), would qualify.

Is your patient **markedly restricted** in performing the mental functions necessary for everyday life, as described above? Yes ☐ No ☐

If **yes**, when did your patient's restriction in performing the mental functions necessary for everyday life become a marked restriction (this is not necessarily the year of the diagnosis, as it is often the case with progressive diseases)? Year

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Patient's name: _____

Life-sustaining therapy – Medical doctor

Life-sustaining therapy for your patient must meet **both** of the following criteria:

- your patient needs this therapy to support a vital function, even if this therapy has eased the symptoms; **and**
- your patient needs this therapy at least 3 times per week, for an average of at least 14 hours per week.

The 14-hour per week requirement

Include only the time your patient must dedicate to the therapy – that is, the patient has to take time away from normal, everyday activities to receive it.

If a child cannot perform the activities related to the therapy because of his or her age, **include** the time spent by the child's primary caregivers performing and supervising these activities.

Do not include the time spent on activities related to dietary restrictions or regimes (such as carbohydrate calculation) or exercising (even when these activities are a factor in determining the daily dosage of medication), travel time to receive therapy, medical appointments (other than appointments where the therapy is received), shopping for medication, or recuperation after therapy.

1. Does your patient need this therapy **to support a vital function**? Yes ☐ No ☐

2. Does your patient need this therapy at least **3 times per week**? Yes ☐ No ☐

3. Does this therapy take an average of at least **14 hours per week**? Yes ☐ No ☐

   If **yes**, when did your patient's therapy begin to meet the above criteria (this is not necessarily the year of the diagnosis, as it is often the case with progressive diseases)? Year ☐☐☐☐

It is **mandatory** that you describe how the therapy meets the criteria as stated above. If you need more space, attach a separate sheet of paper.

Cumulative effect of significant restrictions – Medical doctor or occupational therapist

Note: An occupational therapist can only certify limitations for walking, feeding and dressing.

Answer **all** the following questions to certify the cumulative effect of your patient's significant restrictions.

1. Even with appropriate therapy, medication, and devices, does your patient have a **significant restriction**, that is not quite a **marked restriction**, in **two** or more basic activities of daily living or in **vision** and **one** or more of the basic activities of daily living? Yes ☐ No ☐

   If **yes**, tick at least **two** of the following, as they apply to your patient.

   ☐ vision ☐ speaking ☐ hearing ☐ walking

   ☐ eliminating (bowel or bladder functions) ☐ feeding ☐ dressing ☐ mental functions necessary for everyday life

   Note
   You **cannot** include the time spent on life-sustaining therapy.

2. Do these significant restrictions exist together, **all or substantially all of the time** (at least 90% of the time)? Yes ☐ No ☐

3. Is the cumulative effect of these significant restrictions equivalent to being **markedly restricted** in **one** basic activity of daily living? Yes ☐ No ☐

4. When did the cumulative effect described above begin (this is not necessarily the year of the diagnosis, as it is often the case with progressive diseases)? Year ☐☐☐☐

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Patient's name: _____

Effects of impairment – Mandatory

The effects of your patient's impairment must be those which, even with therapy and the use of appropriate devices and medication, cause your patient to be restricted **all or substantially all of the time** (at least 90% of the time).

Note
Working, housekeeping, managing a bank account, and social or recreational activities are **not** considered basic activities of daily living. Basic activities of daily living are limited to walking, speaking, hearing, dressing, feeding, eliminating (bowel or bladder functions), and mental functions necessary for everyday life.

It is **mandatory** that you describe the effects of your patient's impairment on his or her ability to perform **each** of the basic activities of daily living that you indicated are or were markedly or significantly restricted. If you need more space, attach a separate sheet of paper. You may include copies of medical reports, diagnostic tests, and any other medical information, if needed.

Effects of impairment:

Duration – Mandatory

Has your patient's impairment lasted, or is it expected to last, for a continuous period of at least 12 months? For deceased patients, was the impairment expected to last for a continuous period of at least 12 months? Yes ☐ No ☐

If **yes**, has the impairment improved, or is it likely to improve, to such an extent that the patient would no longer be blind, markedly restricted, in need of life-sustaining therapy, or have the equivalent of a marked restriction due to the cumulative effect of significant restrictions? Unsure ☐ Yes ☐ No ☐

If **yes**, enter the year that the improvement occurred or may be expected to occur. Year ____

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Patient's name: _____

Certification – Mandatory

1. For which year(s) have you been the attending medical practitioner for your patient? _____

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

Tick the box that applies to you:

☐ Medical doctor ☐ 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, to the best of my knowledge, correct and complete. I understand that this information will be used by the Canada Revenue Agency to determine if my patient is eligible for the disability tax credit or other related programs.

Sign here: _____

It is a serious offence to make a false statement.

Print your name

Date: Year Month Day

Telephone

Address

General information

What is the DTC?

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. An individual may claim the disability amount once they are eligible for the DTC. This amount includes a supplement for persons under 18 years of age at the end of the year.

For more information, go to **www.cra.gc.ca/dtc** or see Guide RC4064, *Disability-Related Information*.

Are you eligible?

You are eligible for the DTC only if we approve your application. A medical practitioner has to complete and certify that you have a severe and prolonged impairment and must describe its effects.

To find out if you **may be eligible** for the DTC, use the self-assessment questionnaire in Guide RC4064, *Disability-Related Information*. If we have already told you that you are eligible, do not send another form unless the previous period of approval has ended or if we tell you that we need one. **You should tell us if your medical condition improves.**

If you receive Canada Pension Plan or Quebec Pension Plan disability benefits, workers' compensation benefits, or other types of disability or insurance benefits, **it does not necessarily mean you are eligible for the DTC**. These programs have other purposes and different criteria, such as an individual's inability to work.

You can send the form to us at any time during the year. By sending us your form before you file your income tax and benefit return, you may prevent a delay in your assessment. We will review your form before we assess your return. Keep a copy of the completed form for your records.

Fees – You are responsible for any fees that the medical practitioner charges to complete this form or to give us more information. However, you may be able to claim these fees as medical expenses on line 330 or line 331 of your income tax and benefit return.

What happens after you send Form T2201?

Once the CRA has received the completed and signed Form T2201, we will assess your application to determine if you are eligible to the DTC. We will then send you a notice of determination to inform you of our decision. If your application is denied, we will explain why on the notice of determination. For more information, see Guide RC4064, *Disability-Related Information,* or go to **www.cra.gc.ca/dtc**.

Where do you send this form?

Send your completed and signed form to the Disability Tax Credit Unit of your tax centre. Use the chart below to get the address.

If your tax services office is located in:	**Send your correspondence to the following address:**
British Columbia, Regina or Yukon	Surrey Tax Centre 9755 King George Boulevard Surrey BC V3T 5E1
Alberta, London, Manitoba, Northwest Territories, Saskatoon, Thunder Bay, or Windsor	Winnipeg Tax Centre 66 Stapon Road Winnipeg MB R3C 3M2
Barrie, Sudbury (the area of Sudbury/Nickel Belt only), Toronto Centre, Toronto East, Toronto North, or Toronto West	Sudbury Tax Centre 1050 Notre Dame Avenue Sudbury ON P3A 5C1
Laval, Montréal, Nunavut, Ottawa, Rouyn-Noranda, Sherbrooke, or Sudbury (other than the Sudbury/Nickel Belt area)	Shawinigan-Sud Tax Centre 4695 12e Avenue Shawinigan-Sud QC G9P 5H9
Chicoutimi, Montérégie-Rive-Sud, Outaouais, Québec, Rimouski, or Trois-Rivières	Jonquière Tax Centre 2251 René-Lévesque Blvd Jonquière QC G7S 5J1
Kingston, New Brunswick, Newfoundland and Labrador, Nova Scotia, Peterborough, or St. Catharines	St. John's Tax Centre 290 Empire Avenue St. John's NL A1B 3Z1
Belleville, Hamilton, Kitchener/Waterloo, or Prince Edward Island	Summerside Tax Centre 275 Pope Road Summerside PE C1N 6A2
International and Ottawa Tax Services Office (deemed residents, non-residents, and new or returning residents of Canada)	International and Ottawa Tax Services Office PO Box 9769, Station T Ottawa ON K1G 3Y4 CANADA

What if you need help?

If you need more information after reading this form, go to **www.cra.gc.ca/dtc** or call **1-800-959-8281**.

Forms and publications

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