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). The Canada Revenue Agency (CRA) will use this information to make a decision on eligibility for the DTC. See the "General information" on page 6 for more information.

Step 1: Fill out and sign the sections of Part A that apply to you.
Step 2: Ask a medical practitioner to fill out and certify Part B.
Step 3 – Send the form to the CRA.

Part A – To be filled out by the taxpayer

Section 1 – Information about the person with the disability

First name and initial	Last name	Social insurance number

Mailing address (Apt No. – Street No. Street name, PO Box, RR)

PO Box	RR

City	Prov./Terr.	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 or 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 regularly and consistently depend on you 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.

Section 3 – Adjust your income tax and benefit return

Once eligibility is approved, the CRA can adjust your 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 following actions:

- Medical practitioner(s) can give information to the CRA from their medical records or discuss the information on this form.
- The CRA can adjust my returns, as applicable, if the "Yes" box has been ticked in Section 3.

Sign here:	Telephone number ( ) -	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 enforcement of the Act such as audit, compliance and collection activities. It may be shared or verified with other federal, provincial, territorial or foreign government institutions to the extent authorized by law. Failure to provide this information may result in interest payable, penalties or other actions. The social insurance number is collected under section 237 of the Act and is used for identification purposes. Under the Privacy Act, individuals have the right to access, or request 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 at **canada.ca/cra-info-source**.

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Patient's name: _____

Part B – Must be filled out by the medical practitioner

Step 1: Fill out **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 in this part.

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

Step 2: Fill out the "**Effects of impairment**", "**Duration**", and "**Certification**" sections on page 5. If more information is needed, the Canada Revenue Agency (CRA) may contact you.

Eligibility for the DTC is based on the effects of the impairment, not on the medical condition itself. For definitions and examples of impairments that may qualify for the DTC, see Guide RC4064, *Disability-Related Information*. For more information, go to **canada.ca/disability-tax-credit**.

Vision – Medical doctor, nurse practitioner, or optometrist

Your patient is considered **blind** if, even with the use of corrective lenses or medication, their vision meets any of the following criteria:
- The visual acuity in **both** eyes is 20/200 (6/60) or less, with the Snellen Chart (or an equivalent).
- 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, as described above (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, nurse practitioner, or speech-language pathologist

Your patient is considered **markedly restricted** in speaking if, even with appropriate therapy, medication, and devices, they meet both of the following criteria:
- They are **unable** or take an **inordinate amount of time** to speak so as to be understood by another person familiar with the patient, in a quiet setting.
- 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 is often the case with progressive diseases)? Year ____

Hearing – Medical doctor, nurse practitioner, or audiologist

Your patient is considered **markedly restricted** in hearing if, even with appropriate devices, they meet both of the following criteria:
- They are **unable** or take an **inordinate amount of time** to hear so as to understand another person familiar with the patient, in a quiet setting.
- 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, nurse practitioner, occupational therapist, or physiotherapist

Your patient is considered **markedly restricted** in walking if, even with appropriate therapy, medication, and devices, they meet both of the following criteria:
- They are **unable** or take an **inordinate amount of time** to walk.
- 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 is often the case with progressive diseases)? Year ____

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Eliminating (bowel or bladder functions) – Medical doctor or nurse practitioner

Your patient is considered **markedly restricted** in eliminating if, even with appropriate therapy, medication, and devices, they meet both of the following criteria:

- They are **unable** or take an **inordinate amount of time** to personally manage bowel or bladder functions.
- This is the case **all or substantially all of the time** (at least 90% of the time).

Is your patient **markedly restricted** in elimination, 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 is often the case with progressive diseases)? Year

Feeding – Medical doctor, nurse practitioner, or occupational therapist

Your patient is considered **markedly restricted** in feeding if, even with appropriate therapy, medication, and devices, they meet both of the following criteria:

- They are **unable** or take an **inordinate amount of time** to feed themselves.
- This is the case **all or substantially all of the time** (at least 90% of the time).

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

Feeding yourself **does** include preparing food, **except** when the time spent is related to a dietary restriction or regime, even when the restriction or regime is needed due to an illness or medical 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 is often the case with progressive diseases)? Year

Dressing – Medical doctor, nurse practitioner, or occupational therapist

Your patient is considered **markedly restricted** in dressing if, even with appropriate therapy, medication, and devices, they meet both of the following criteria:

- They are **unable** or take an **inordinate amount of time** to dress themselves.
- This is the case **all or substantially all of the time** (at least 90% of the time).

Dressing yourself **does not** include identifying, finding, shopping for, or 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 is often the case with progressive diseases)? Year

Mental functions necessary for everyday life – Medical doctor, nurse practitioner, 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), they meet both of the following criteria:

- They are **unable** or take an **inordinate amount of time** to perform these functions by themselves.
- 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)
- problem-solving, goal-setting, **and** judgment taken together (for example, the ability to solve problems, set and keep goals, and make the appropriate decisions and judgments)

Note
A restriction in problem-solving, goal-setting, or judgment 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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Life-sustaining therapy – Medical doctor or nurse practitioner

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.
- 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 do the activities related to the therapy because of their age, **include** the time spent by the child's primary caregivers to do and supervise these activities.

Do not include the time a portable or implanted device takes to deliver the therapy, 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 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, use a separate sheet of paper, sign it and attach it to this form.

Cumulative effect of significant restrictions – Medical doctor, nurse practitioner, 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
   ☐ elimination (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 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 do **each** of the basic activities of daily living that you indicated are or were markedly or significantly restricted. If you need more space, use a separate sheet of paper, sign it and attach it to this form. You may include copies of medical reports, diagnostic tests, and any other medical information, if needed.

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

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 ☐ 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.

Sign here: _____
It is a serious offence to make a false statement.

Name

Date Year Month Day

Telephone ( ) -

Address

City Province / territory Postal Code

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Patient's name: _____

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. The disability amount may be claimed once the person with a disability is eligible for the DTC. This amount includes a supplement for persons under 18 years of age at the end of the year. Being eligible for this credit may open the door to other programs.

For more information, go to **canada.ca/disability-tax-credit** or see Guide RC4064, *Disability-Related Information*.

Are you eligible?

You are eligible for the DTC only if we approve your application. On this form, a medical practitioner has to indicate 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, fill out 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 at any time during the year. By sending 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 for your records.

Fees – You are responsible for any fees that the medical practitioner charges to fill out 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?

After we receive Form T2201, we will review your application. We will then send you a notice of determination to inform you of our decision. Our decision is based on the information given by the medical practitioner. 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 **canada.ca/disability-tax-credit**.

Where do you send this form?

Send your 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:
Alberta, British Columbia, Hamilton, Kitchener/Waterloo, London, Manitoba, Northwest Territories, Regina, Saskatoon, Thunder Bay, Windsor, or Yukon	Winnipeg Tax Centre Post Office Box 14000 Station Main Winnipeg MB R3C 3M2
Barrie, Belleville, Kingston, Montréal, New Brunswick, Newfoundland and Labrador, Nova Scotia, Nunavut, Ottawa, Outaouais, Peterborough, St. Catharines, Prince Edward Island, Sherbrooke, Sudbury, or Toronto	Sudbury Tax Centre Post Office Box 20000, Station A Sudbury ON P3A 5C1
Chicoutimi, Laval, Montérégie-Rive-Sud, Québec, Rimouski, Rouyn-Noranda, or Trois-Rivières	Jonquière Tax Centre 2251 René-Lévesque Blvd Jonquière QC G7S 5J2
Deemed residents, non-residents, and new or returning residents of Canada	Sudbury Tax Centre Post Office Box 20000, Station A Sudbury ON P3A 5C1 CANADA or Winnipeg Tax Centre Post Office Box 14000 Station Main Winnipeg MB R3C 3M2 CANADA

What if you 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**.