

How to apply for the Disability Tax Credit

The Disability Tax Credit (DTC) is a non-refundable tax credit that helps people with impairments, or their supporting family member, reduce the amount of income tax they may have to pay.

Who qualifies?

Beginning for tax year 2021, people with type 1 diabetes are now eligible for the Disability Tax Credit (DTC) based on their need for life sustaining therapy. This means:

- Claimants no longer need to document 14 hours of therapy for tax years 2021 and forward.
- All that is required is that insulin therapy for type 1 diabetes is reported, along with the year when insulin was started (usually the year of diagnosis).

How to apply

The form can also be downloaded from the [CRA website](#).

Part A is completed by the applicant. Be sure to add your name at the top of each page.

Part B can be completed by your family doctor (they only need to complete Pages 15 and 16). You can give your doctor the attached example showing which boxes need to be checked and what information they need to insert.

Make a copy of the form and mail the original to the applicable taxation centre indicated on page 16.

Once approved for the DTC, you can apply for other federal, provincial, or territorial programs, including:

1. The **Registered Disability Savings Plan (RDSP)** – save for future expenses in a tax protected RDSP, which also attracts government grants and bonds (similar to a Registered Education Savings Program).
2. The **Child Disability Benefit** – a tax-free monthly payment made to caregivers of children under age 18 who qualify for the DTC.

Individuals with type 2 diabetes may qualify for the DTC if they can demonstrate that they spend at least 14 hours per week on the activities specified by the CRA that are related to administering insulin. The permitted activities for years 2020 and earlier years, as well as the expanded list of activities applicable starting the 2021 tax year, can be found on the [CRA website](#).



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:

- 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

Examples of ineligible activities:

- 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: Insulin therapy

Specify the medical condition: Type 1 Diabetes

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: _____ enter year of diagnosis

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) _____ No Unsure

Patient's name: _____

Certification – Mandatory

1) For which year(s) has the person with the disability been your patient?

X _____ 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.

X
Signature: _____

It is a serious offence to make a false statement.

Name (print): _____

Medical license or registration number (optional): _____

Telephone number: _____

X
Date: _____
 Year Month Day

Address

