Ministry of Social Development and Social Innovation

PERSONS WITH DISABILITIES DESIGNATION APPLICATION

INTRODUCTION

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance for Persons With Disabilities Act.* The collection, use and disclosure of personal information is subject to the provisions of the *Freedom of Information and Protection of Privacy Act.* If you have any questions about the collection, use or disclosure of this information, please contact your local Employment and Assistance Centre.

The purpose of this form is to collect the information necessary to determine eligibility for the Person with Disabilities designation under the *Employment and Assistance for Persons with Disabilities Act*.

This Application has three Sections:

Section 1: **Applicant Information** (for completion by the Applicant) - The term "Applicant" used throughout the form means a client who is applying for the Person with Disabilities designation.

Section 2: **Physician Report** (for completion by the Applicant's Physician) - References to "Physician" in this application have the same meaning as "Medical Practitioner".

Section 3: **Assessor Report** (for completion by a prescribed professional)

PLEASE DO NOT TAKE THIS BOOKLET FORM APART - PLEASE KEEP TOGETHER

Instructions for completion

1. The above sections of the Application Form need to be completed in the order listed.
2. The Applicant is to complete Section 1, Applicant Information, sign the Declaration, and take the form to his/her physician for completion of the Physician Report.
3. The Applicant's Physician is to complete Section 2, Physician Report, and return the Application Form to the Applicant.
4. The Applicant will then take the form to a Prescribed Professional (as defined in Section 3) for completion of Section 3, Assessor Report.
5. The Prescribed Professional is to complete Section 3, Assessor Report, and return the Application Form to the Applicant.
6. Applicant - please review the checklist at the end of this booklet to ensure your application is complete.
7. The Applicant will then mail the application to the Health Assistance Branch, Ministry of Social Development and Social Innovation using the enclosed self-addressed envelope.

Office Use Only

The following must be signed in order for the application to be processed

The Applicant intends to apply for disability assistance and may meet the financial eligibility requirements for Disability Assistance under the *Employment and Assistance for Persons with Disabilities (PWD) Act.*

Ministry Signing Authority (Print Name)	Signature
Employment and Assistance Centre Stamp	Date Signed (YYYY MMM DD)

You may have someone help you complete this Section of the Application.
Important Note: *You MUST sign the "Declaration" on page 5 of this form in order for your application to be processed.*

A - PERSONAL INFORMATION

Last Name	First Name	Middle Name	Date of Birth (YYYY MMM DD)

Personal Health Number	Social Insurance Number (optional)	Telephone Number

Street Address	City	Postal Code

Do you need help completing this application?

☐ Yes ☐ No If yes, what help do you need?

B - DISABLING CONDITION

This section provides you with an opportunity to describe your disability and the impact it has on your life. You are not required to complete this section. If you do not complete this Section, your application will be considered based on information provided in the Physician and Assessor Sections of this Application.

☐ **I choose not to complete this self-report.** (Please proceed to Declaration on page 5)

Note - If more space is required, you may attach additional pages.

1. Please describe your disability.

B - DISABLING CONDITION (cont'd)

2. How does your disability affect your life and your ability to take care of yourself?

B - DISABLING CONDITION (cont'd)

C - DECLARATION AND NOTIFICATION

I, _____ , am applying for designation as a person with disabilities as set out in the Employment and Assistance for Persons with Disabilities Act and I declare that the information provided in Section 1A and 1B is true and complete. I understand that I will have the opportunity to review completed Section 2, Physician Report and Section 3, Assessor Report before submitting the completed designation application form to the Ministry of Social Development and Social Innovation. I understand that the BC government may verify the information in Section 1A, Section 2 and Section 3, as necessary to determine and confirm my eligibility for the designation.

_____
*Applicant Signature

_____
Witness Signature

_____
Date Signed (YYYY MMM DD)

_____
Witness Name (Please Print)

_____
Witness Address & Telephone

* If the Applicant is incapable of signing this Application, it may be signed by a person who has legal authority to act on behalf of the Applicant as applicable under provisions of relevant BC legislation, for example, a committee, or a person with an enduring power of attorney. If you are signing on behalf of the Applicant, you must state your legal authority to act on behalf of the Applicant and you must attach proof of that legal authority (for example, a copy of the court order naming you as Committee) to this Application.

My legal authority to act for the applicant is _____ .

NOTE: Proof of Committee, Power of Attorney and/or Parent/Guardian status must accompany this Application.

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance for Persons With Disabilities Act.* The collection, use and disclosure of personal information is subject to the provisions of the *Freedom of Information and Protection of Privacy Act.* If you have any questions about the collection, use or disclosure of this information, please contact your local Employment and Assistance Centre.

This section is to be filled out by a physician registered and licensed to practice in British Columbia. The Physician completing this Section of the application **may** also complete Section 3, Assessor Report.

The purpose of the Physician Report is to provide information to the ministry about the applicant's physical or mental impairments associated with diagnosed medical conditions relevant to this application for a ***Person with Disabilities (PWD)*** designation. The emphasis is on how the medical conditions and impairment affect the Applicant's ability to perform Daily Living Activities as defined in the *Regulations* pursuant to the *Employment and Assistance for Persons with Disabilities Act.* This Application is **not** intended to assess employability or vocational abilities.

Please answer all questions completely as this will assist the Ministry of Social Development and Social Innovation, Health Assistance Branch, in determining whether the Applicant meets the criteria for designation as a person with disabilities.

The contents of this report are confidential, but are subject to the following conditions:

- the report will be shared with the applicant;
- the report will be shared with the Prescribed Professional completing Section 3 of this Application;
- the report will be shared with the Employment and Assistance Appeal Tribunal if an appeal is initiated regarding eligibility for the Person with Disabilities (PWD) designation; and
- the report may be reviewed by a prescribed professional consulting with the Ministry of Social Development and Social Innovation

Fee

Payment of fees for completion of the Physician Report is provided through the Medical Services Plan. Payment will be made in accordance with the rate established by the Ministry of Social Development and Social Innovation provided that:

1. The Application process has been initiated by the Employment and Assistance Centre as indicated by the Office stamp and signature on the cover page of this Application; and
2. The Physician has fully completed Section 2 of the Application.

Please keep a copy of the completed Section 2 of this form until such time as you receive payment for your fee.

Physicians having questions regarding this application may contact the Health Assistance Branch, Ministry of Social Development and Social Innovation at 1-888-221-7711

PROGRAM DEFINITIONS

Designation of Persons with Disabilities (PWD)

Following is an extract of the section in the Employment and Assistance for Persons With Disabilities ACT that sets out the criteria for designation as a person with disabilities.

2 (1) In this section:
"prescribed professional" has the prescribed meaning;
"daily living activities" has the prescribed meaning;
"assistive device" means a device designed to enable a person to perform a daily living activity that, because of a severe mental or physical impairment, the person is unable to perform.

2(2) The minister may designate a person who has reached 18 years of age as a person with disabilities for the purposes of this ACT if the minister is satisfied that the person has a severe mental or physical IMPAIRMENT that
(a) in the opinion of a medical practitioner is likely to continue for at least 2 years, and
(b) in the opinion of a prescribed professional
(i) directly and significantly restricts the person's ability to perform DAILY LIVING ACTIVITIES either
(A) continuously, or
(B) periodically for extended periods, and
(ii) as a result of those restrictions, the person requires help to perform those activities.

2(3) For the purposes of subsection (2),
(a) a person who has a severe mental impairment includes a person with a mental disorder, and
(b) a person requires help in relation to a daily living activity if, in order to perform it, the person requires
(i) an assistive device,
(ii) the significant help or supervision of another person, or
(iii)the services of an assistance animal.

2(4) The minister may rescind a designation under subsection (2).

The following is an extract of a section in the Employment and Assistance for Persons with Disabilities REGULATIONS.

2 (1) For the purposes of the Act and this regulation, **"daily living activities",**
(a) In relation to a person who has a severe physical impairment or a severe mental impairment, means the following activities:
(i) prepare own meals;
(ii) manage personal finances;
(iii) shop for personal needs;
(iv) use public or personal transportation facilities;
(v) perform housework to maintain the person's place of residence in acceptable sanitary condition;
(vi) move about indoors and outdoors;
(vii) perform personal hygiene and self care;
(viii) manage personal medication, and

(b) In relation to a person which has a severe mental impairment, includes the following activities:
(i) make decisions about personal activities, care or finances;
(ii) relate to, communicate or interact with others effectively.

2 (2) For the purposes of the Act, **"prescribed professional"** means a person who is

(a) authorized under an enactment to practice the profession of

(i) medical practitioner,
(ii) registered psychologist,
(iii) registered nurse or registered psychiatric nurse,
(iv) occupational therapist,
(v) physical therapist,
(vi) social worker,
(vii) chiropractor, or
(viii) nurse practitioner; or

(b) acting in the course of the person's employment as a school psychologist by

(i) an authority, as that term is defined in section 1 (1) of the *Independent School Act*,
(ii) a board or a francophone education authority, as those terms are defined in section 1 (1) of the *School Act*,

if qualifications in psychology are a condition of such employment.

TO BE COMPLETED BY THE APPLICANT'S PHYSICIAN ONLY

A - DIAGNOSES

Specify diagnoses related to the Applicant's impairment using the diagnostic codes below.
"Impairment" is a loss or abnormality of psychological, anatomical or physiological structure or function causing a restriction in the ability to function independently, effectively, appropriately or for a reasonable duration. **Please include additional information as required.**

	Diagnostic Code	Specific Diagnosis (e.g. location of paralysis, type of respiratory or heart condition, type of hepatitis, etc.)	Date of onset, If known: Month	Date of onset, If known: Year
1.				
2.				
3.				
4.				
5.				

Comments:

DIAGNOSTIC CODES

Infectious and parasitic diseases
1.0 Other
1.1 HIV
1.2 AIDS
1.3 Hepatitis
1.4 Hepatitis C

Neoplasms
2.0 Neoplastic disorders - other
2.1 Lip, oral cavity & pharynx
2.2 Digestive organs & peritoneum
2.3 Respiratory & intrathoracic organs
2.4 Bone, connective tissue, skin and breast
2.5 Genitourinary organs
2.6 Leukemia

Endocrine, nutritional and metabolic diseases, and immunity disorders
3.0 Endocrine disorders - other
3.01 Immune disorders - other
3.02 Metabolic disorders - other
3.1 Thyroid disorders
3.2 Diabetes

Diseases of the blood and blood-forming organs
4.0 Other diseases of the blood
4.1 Anemia
4.2 Hemophillia

Mental disorders
5.0 Other mental (please specify)
5.1 Delirium, dementia & amnestic & other cognitive disorders
5.2 Schizophrenia & other Psychotic disorders
5.3 Mood disorders
5.4 Developmental disability
5.5 Anxiety disorders
5.6 Somatoform disorders
5.7 Personality disorders
5.8 Substance-related disorders
5.9 Pervasive developmental disorders
5.10 Eating disorders

Diseases of the nervous system & sense organs - Neurological
6.0 Neurological disorders - other
6.1 Epilepsy
6.3 Brain tumors
6.4 Parkinson's disease
6.5 Cerebral palsy
6.6 Paraplegia
6.7 Quadraplegia
6.9 Other paralysis
6.10 Myasthenia Gravis
6.11 Muscular dystrophy
6.12 ALS
6.13 Alzheimer's disease
6.14 Huntington's Chorea
6.15 Friedreich's Ataxia
6.16 Multiple sclerosis

Conditions of the nervous system & sense organs - Sensory
7.00 Sensory disorders - other
7.01 Blindness
7.02 Visually impaired
7.03 Deafness
7.04 Hearing impaired
7.05 Organic speech loss

Diseases of the circulatory system
8.0 Cardiovascular - other
8.1 Ischemic heart disease
8.2 Recurrent Arrhythmias
8.3 Valvular heart disease
8.4 Congenital heart disease
8.5 Cardiomyopathy
8.6 Chronic venous insufficiency
8.7 Peripheral arterial disease
8.8 Cerebral vascular accident

Diseases of the respiratory system
9.0 Respiratory disorders - other
9.1 Cystic fibrosis
9.2 COPD
9.3 Asthma
9.4 Emphysemia

Diseases of the digestive system
10.0 Digestive disorders - other
10.1 Peptic ulcer
10.2 Chronic liver disease
10.3 Cirrhosis
10.4 Crohn's disease
10.5 Colitis

Diseases of the genitourinary system
11.0 Genitourinary disorders - other
11.1 Kidney disease

Diseases of the skin and subcutaneous tissue
12.0 Skin disorders - other
12.1 Psoriasis

Diseases of the musculoskeletal system and connective tissue
13.0 Musculoskeletal system - other
13.1 Lupus
13.2 Rheumatoid arthritis
13.3 Arthritis
13.4 Osteoporosis
13.5 Ankylosing spondolitis
13.6 Degenerative disc disease
13.7 Scoliosis
13.8 Fibromyalgia
13.9 Scleroderma

Congenital anomalies
14.0 Congenital anomalies - other
14.1 Chromosomal abnormalities
14.2 Fetal alcohol syndrome
14.3 Thaldomide syndrome
14.4 Spina Bifida

Injury and poisoning
15.0 Injury and poisoning - other
15.1 Traumatic brain injury
15.2 Amputations

Other conditions
16.0 Other
16.1 Chronic fatigue syndrome
16.2 Sleep apnea
16.3 Environmental sensitivities

B - HEALTH HISTORY

1. Please indicate the severity of the medical conditions relevant to this person's impairment. How does the medical condition impair this person? Test results and other reports or findings may be used here where appropriate.

2. Height and Weight *(if relevant to the impairment):*

Height: _____ Weight: _____

3. Has the applicant been prescribed any medication and/or treatments that interfere with his/her ability to perform daily living activities? ☐ Yes ☐ No

If yes, please explain:

If yes, what is the anticipated duration of the medications/treatments:

4. Does the applicant require any prostheses or aids for his/her impairment? ☐ Yes ☐ No

If yes, please explain:

C - DEGREE AND COURSE OF IMPAIRMENT

1. Is the impairment likely to continue for two years or more from today? ☐ Yes ☐ No
   What is the estimated duration of the impairment and are there remedial treatments that may resolve or minimize the impairment?

Please explain:

D - FUNCTIONAL SKILLS

Note: For the purposes of questions #1 and #2, "unaided" means without the assistance of another person, assistive device or assistance animal

1. How far can this person **walk** unaided on a flat surface?

☐ 4+ blocks ☐ 1 to 2 blocks ☐ Unknown
☐ 2 to 4 blocks ☐ Less than 1 block ☐ Not at all

2. How many **stairs** can this person climb unaided?

☐ 5+ steps ☐ 2 to 5 steps ☐ None ☐ Unknown

3. What are the person's limitations in **lifting**?

☐ No limitations ☐ 2 to 7 kg (5 to 15 lbs) ☐ No lifting
☐ 7 to 16 kg (15 to 35 lbs) ☐ Under 2 kg (Under 5 lbs) ☐ Unknown

4. How long can this person remain **seated**?

☐ No limitation ☐ 1 to 2 hours ☐ Unknown
☐ 2 to 3 hours ☐ Less than 1 hour

5. Are there difficulties with **communication** other than a lack of fluency in English? ☐ Yes ☐ No

If yes, what is the cause: ☐ Cognitive ☐ Motor ☐ Sensory ☐ Other

Comments:

6. Are there any significant deficits with **cognitive and emotional function?** ☐ Yes ☐ No ☐ Unknown
   If yes, check those areas where the deficits are evident and provide details below:

☐ Consciousness *(orientation, confusion)*
☐ Executive *(planning, organizing, sequencing, calculations, judgement)*
☐ Language *(oral, auditory, written comprehension or expression)*
☐ Memory *(ability to learn and recall information)*
☐ Perceptual psychomotor *(visual spatial)*
☐ Psychotic symptoms *(delusions, hallucinations, thought disorders)*
☐ Emotional disturbance *(e.g. depression, anxiety)*
☐ Motivation *(loss of initiative or interest)*
☐ Impulse control
☐ Motor activity *(goal oriented activity, agitation, repetitive behaviour)*
☐ Attention or sustained concentration
☐ Other *(specify)*

Comments:

E - DAILY LIVING ACTIVITIES

Note: If you are completing the Assessor Report, Section 3, in addition to this Physician Report, do not complete this page, (Part E)

Does the impairment directly restrict the person's ability to perform Daily Living Activities?

☐ Yes ☐ No ☐ Unknown

If yes, please complete the following table:

Daily Living Activities	*Is Activity Restricted? (check one) If yes, describe extent of restriction in "comments" below*			If yes, the restriction is: (check one)	
	Yes	No	Unknown	Continuous[1]	Periodic*[2]
Personal self care	☐	☐	☐	☐	☐
Meal preparation	☐	☐	☐	☐	☐
Management of medications	☐	☐	☐	☐	☐
Basic housework	☐	☐	☐	☐	☐
Daily shopping	☐	☐	☐	☐	☐
Mobility inside the home	☐	☐	☐	☐	☐
Mobility outside the home	☐	☐	☐	☐	☐
Use of transportation	☐	☐	☐	☐	☐
Management of finances	☐	☐	☐	☐	☐
Social functioning** - daily decision making; interacting, relating and communicating with others *(this category only applies for persons with an identified mental impairment or brain injury).* **If yes, please provide details**	☐	☐	☐	☐	☐

* If "Periodic", please explain:

_____

_____

** If Social Functioning is impacted, please explain:

_____

_____

Please provide additional comments regarding the degree of restriction:

_____

_____

What assistance does your patient need with Daily Living Activities? *("Assistance" includes help from another person, equipment and assistance animals.)* Please be specific regarding the nature and extent of assistance required.

_____

_____

_____

[1] **Continuous assistance** - refers to needing significant help most or all of the time for an activity.

[2] **Periodic assistance** - refers to the need for significant help for an activity some of the time as would be the case where a person required help due to the episodic nature of the impairment.

F - ADDITIONAL COMMENTS

Please provide any additional information that you consider relevant to an understanding of the significance of the person's medical condition, the nature and extent of this person's impairment and the impact these have on his/her daily functioning. *(e.g., hospitalization related to the impairment.)*

G - FREQUENCY OF CONTACT

How long has the Applicant been your patient? _____

Prior to today, how often have you seen the Applicant in the past 12 months?

☐ 0 ☐ Once ☐ 2 - 10 ☐ 11 or more

Comments:

H - CERTIFICATION

I, _____, am a physician registered with the College of Physicians and Surgeons of British Columbia and licensed to practice clinical medicine in BC.

☐ I am a General Practitioner

☐ I am a specialist in _____

Medical Practitioner Number: _____

This report (and attached documents) contains my findings and considered opinion at this time.

Signature	Date (YYYY MMM DD)	Telephone

Fax	E-mail Address (optional)

Print / Stamp Address

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This Assessor Report is to be completed by one of the following prescribed professionals: Medical Practitioner, Registered Psychologist, Certified School Psychologist, Registered Nurse or Registered Psychiatric Nurse, Occupational Therapist, Physical Therapist, Social Worker, Chiropractor or Nurse Practitioner.

The purpose of the Assessor Report is to document the Applicant's impairments and their impact on performance of Daily Living Activities as defined in the *Regulations* pursuant to the *Employment and Assistance for Persons With Disabilities Act*. The Application is **not** intended to assess employability or vocational abilities.

This section should be completed by a prescribed professional having a history of contact and recent experience with the applicant. **Please complete this section based on your knowledge of the Applicant, observations, clinical data and experience.**

Please answer all questions completely as this will assist the Ministry of Social Development and Social Innovation, Health Assistance Branch, in determining whether the applicant meets the criteria for designation as a person with disabilities.

The contents of this report are confidential, but are subject to the following understandings:

- the report will be shared with the applicant;
- the report may be shared with the Physician completing Section 2 of this application;
- the report will be shared with the Employment and Assistance Appeal Tribunal if an appeal is initiated regarding eligibility for the Persons with Disabilities (PWD) designation; and
- the report may be reviewed by a prescribed professional consulting with the Ministry of Social Development and Social Innovation.

Fee :

Payment will be made in accordance with the rate established by the Ministry of Social Development and Social Innovation provided that:

1. The Application process has been initiated by the Employment and Assistance Centre as indicated by the Office stamp and signature on the cover page of this Application; and

2. The Prescribed Professional has fully completed Section 3 of the Application.

Fees for physicians completing this section are paid through the Medical Services Plan. Other Prescribed Professionals completing this section may submit an invoice in the amount of $75 to the Ministry of Social Development and Social Innovation at the following address (please use tear-off invoice on page 23):

Ministry of Social Development and Social Innovation
Health Assistance Branch
PO Box 9971 Stn Prov Govt
Victoria, B.C. V8W 9R5

Please keep a copy of the fully completed Section 3 of this form until such time as you receive payment for your fee.

Assessors having questions regarding this application may contact the Health Assistance Branch, Ministry of Social Development and Social Innovation at 1-888-221-7711

PROGRAM DEFINITIONS

Designation of Persons with Disabilities (PWD)

Following is an extract of the section in the Employment and Assistance for Persons With Disabilities ACT that sets out the criteria for designation as a person with disabilities.

2 (1) In this section:
"prescribed professional" has the prescribed meaning;
"daily living activities" has the prescribed meaning;
"assistive device" means a device designed to enable a person to perform a daily living activity that, because of a severe mental or physical impairment, the person is unable to perform.

2(2) The minister may designate a person who has reached 18 years of age as a person with disabilities for the purposes of this ACT if the minister is satisfied that the person has a severe mental or physical IMPAIRMENT that
(a) in the opinion of a medical practitioner is likely to continue for at least 2 years, and
(b) in the opinion of a prescribed professional
(i) directly and significantly restricts the person's ability to perform DAILY LIVING ACTIVITIES either
(A) continuously, or
(B) periodically for extended periods, and
(ii) as a result of those restrictions, the person requires help to perform those activities.

2(3) For the purposes of subsection (2),
(a) a person who has a severe mental impairment includes a person with a mental disorder, and
(b) a person requires help in relation to a daily living activity if, in order to perform it, the person requires
(i) an assistive device,
(ii) the significant help or supervision of another person, or
(iii)the services of an assistance animal.

2(4) The minister may rescind a designation under subsection (2).

The following is an extract of a section in the Employment and Assistance for Persons with Disabilities REGULATIONS.

2 (1) For the purposes of the Act and this regulation, **"daily living activities",**
(a) In relation to a person who has a severe physical impairment or a severe mental impairment, means the following activities:
(i) prepare own meals;
(ii) manage personal finances;
(iii) shop for personal needs;
(iv) use public or personal transportation facilities;
(v) perform housework to maintain the person's place of residence in acceptable sanitary condition;
(vi) move about indoors and outdoors;
(vii) perform personal hygiene and self care;
(viii) manage personal medication, and

(b) In relation to a person which has a severe mental impairment, includes the following activities:
(i) make decisions about personal activities, care or finances;
(ii) relate to, communicate or interact with others effectively.

PROGRAM DEFINITIONS

2 (2) For the purposes of the Act, **"prescribed professional"** means a person who is

(a) authorized under an enactment to practice the profession of

(i) medical practitioner,
(ii) registered psychologist,
(iii) registered nurse or registered psychiatric nurse,
(iv) occupational therapist,
(v) physical therapist,
(vi) social worker,
(vii) chiropractor, or
(viii) nurse practitioner; or

(b) acting in the course of the person's employment as a school psychologist by

(i) an authority, as that term is defined in section 1 (1) of the *Independent School Act*,
(ii) a board or a francophone education authority, as those terms are defined in section 1 (1) of the *School Act*,

if qualifications in psychology are a condition of such employment.

A -LIVING ENVIRONMENT

1. Does the Applicant live ☐ Alone? ☐ With Family, Friends, or Caregiver? ☐ In a Care Facility?

Comment:

B - MENTAL OR PHYSICAL IMPAIRMENT

"Impairment" is a loss or abnormality of psychological, anatomical or physiological structure or functioning causing a restriction in the ability to function independently, effectively, appropriately or for a reasonable duration.

1. What are the applicant's mental or physical impairments that impact his/her ability to manage Daily Living activities? *(brief summary)*

2. Ability to Communicate **Please indicate the level of ability in the following areas:**	*Good*	*Satisfactory*	*Poor*	*Unable*	Explain / Describe
Speaking					
Reading					
Writing					
Hearing					

Comments:

3. Mobility and Physical Ability **Indicate the assistance required related to impairment(s) that directly restrict the applicant's ability to manage in the following areas. Check all that apply.**	Independent	Periodic assistance [1] from another person	Continuous assistance [2] from another person or unable	Uses Assistive device	Takes significantly longer than typical (describe how much longer)	Explain and specify assistive device/s
Walking indoors						
Walking outdoors						
Climbing stairs						
Standing						
Lifting						
Carrying and holding						

Comments:

[1] **Periodic assistance** - refers to the need for significant help for an activity some of the time as would be the case where a person required help due to the episodic nature of the impairment.

[2] **Continuous assistance** - refers to needing significant help most or all of the time for an activity.

B - MENTAL OR PHYSICAL IMPAIRMENT (cont'd)

Complete item #4 for an Applicant with an identified mental impairment or brain injury.

4. Cognitive and Emotional Functioning

For each item indicate to what degree the applicant's mental impairment or brain injury restricts or impacts his/her functioning.

If impact is episodic or impact varies over time, please explain in the comment section below.	***Impact on Daily Functioning***			
	No impact	**Minimal impact**	**Moderate impact**	**Major impact**
Bodily functions *(e.g., eating problems, toileting problems, poor hygiene, sleep disturbance)*	☐	☐	☐	☐
Consciousness *(e.g., orientation, alert/drowsy, confusion)*	☐	☐	☐	☐
Emotion *(e.g., excessive or inappropriate anxiety, depression, etc.)*	☐	☐	☐	☐
Impulse control *(e.g., inability to stop doing something or failing to resist doing something)*	☐	☐	☐	☐
Insight and judgement *(e.g., poor awareness of self and health condition(s), grandiosity, unsafe behaviour)*	☐	☐	☐	☐
Attention/concentration *(e.g., distractible, unable to maintain concentration, poor short term memory)*	☐	☐	☐	☐
Executive *(e.g., planning, organizing, sequencing, abstract thinking, problem-solving, calculations)*	☐	☐	☐	☐
Memory *(e.g., can learn new information, names etc. and then recall that information; forgets over-learned facts)*	☐	☐	☐	☐
Motivation *(e.g., lack of initiative; loss of interest)*	☐	☐	☐	☐
Motor activity *(e.g., increased or decreased goal-oriented activity; co-ordination, lack of movement, agitation, ritualistic or repetitive actions; bizarre behaviours, extreme tension)*	☐	☐	☐	☐
Language *(e.g., expression or comprehension problems - e.g. inability to understand, extreme stuttering, mute, racing speech, disorganization of speech)*	☐	☐	☐	☐
Psychotic symptoms *(e.g., delusions, hallucinations, disorganized thinking, etc.)*	☐	☐	☐	☐
Other neuropsychological problems *(e.g., visual/spatial problems; psychomotor problems, learning disabilities, etc.)*	☐	☐	☐	☐
Other emotional or mental problems *(e.g., hostility, explain below)*	☐	☐	☐	☐

Comments:

C - DAILY LIVING ACTIVITIES

Indicate the assistance required related to impairment(s) that directly restrict the applicant's ability to manage in the following areas. Check all that apply.	Independent	Periodic assistance [3] from another person	Continuous assistance [4] from another person or unable	Uses Assistive device (Explain)	Takes significantly longer than typical (describe how much longer)	Explain / Describe
Personal Care						
1. Dressing						
2. Grooming						
3. Bathing						
4. Toileting						
5. Feeding self 6. Regulate diet[5]						
7. Transfers (in/out of bed)						
8. Transfers (on/off of chair)						
Basic Housekeeping						
1. Laundry						
2. Basic Housekeeping						
Shopping						
1. Going to and from stores						
2. Reading prices and labels						
3. Making appropriate choices						
4. Paying for purchases						
5. Carrying purchases home						

Additional comments *(including a description of the type and amount of assistance required and identification of any safety issues)*:

[3] **Periodic assistance** - refers to the need for significant help for an activity some of the time as would be the case where a person required help due to the episodic nature of the impairment.

[4] **Continuous assistance** - refers to needing significant help most or all of the time for an activity.

[5] For example, issues related to eating disorders characterized by major disturbances in eating behaviour.

C - DAILY LIVING ACTIVITIES (cont'd)

Indicate the assistance required related to impairment(s) that directly restrict the applicant's ability to manage in the following areas. Check all that apply.	Independent	Periodic assistance from another person	Continuous assistance from another person or unable	Uses Assistive device (Explain)	Takes significantly longer than typical (describe how much longer)	Explain / Describe
Meals						
1. Meal planning						
2. Food preparation						
3. Cooking						
4. Safe storage of food (ability, not environmental circumstances)						
Pay Rent and Bills						
1. Banking						
2. Budgeting						
3. Pay rent and bills						
Medications						
1. Filling/Refilling prescriptions						
2. Taking as directed						
3. Safe handling and storage						
Transportation						
1. Getting in and out of a vehicle						
2. Using public transit *(where available)*						
3. Using transit schedules and arranging transportation						

Additional comments *(including a description of the type and amount of assistance required and identification of any safety issues):*

C - DAILY LIVING ACTIVITIES (cont'd)

Social Functioning Only complete this if the Applicant has an identified mental impairment, including brain injury.

Indicate the support/supervision required, as related to restrictions in the following areas:	Independent	Periodic Support/Supervision	Continuous Support/Supervision	Explain / Describe (include a description of the degree and duration of support/supervision required)
Appropriate social decisions (incl. avoiding situations dangerous to self or others, good social judgement)				
Able to develop and maintain relationships				
Interacts appropriately with others (e.g., understands and responds to social cues; problem solves in social context)				
Able to deal appropriately with unexpected demands				
Able to secure assistance from others				
Other (specify) _____				

Describe how the mental impairment impacts the applicant's relationship with his/her:

- **immediate social network (partner, family, friends)**

☐ good functioning - positive relationships: assertively contributes to these relationships

☐ marginal functioning - little significant participation/communication: relationships often minimal and fluctuate in quality

☐ very disrupted functioning - aggression or abuse: major withdrawn: often rejected by others

Comments:

- **extended social networks (neighbourhood contacts, acquaintances, storekeepers, public officials, etc.)**

☐ good functioning - positive interacts in community: often participates in activities with others

☐ marginal functioning - little more than minimal acts to fulfill basic needs

☐ very disrupted functioning - overly disruptive behaviour: major social isolation

Comments:

If the applicant requires help, as indicated above, please describe the support/supervision required which would help to maintain him/her in the community.

Additional Comments *(including identification of any safety issues):*

D - ASSISTANCE PROVIDED FOR APPLICANT

Assistance provided by other people

The help required for daily living activities is provided by:

- ☐ Family
- ☐ Friends
- ☐ Health Authority Professionals (e.g., Nurse)
- ☐ Volunteers
- ☐ Community Service Agencies
- ☐ Other

Comments: _____

If help is required but there is none available, please describe what assistance would be necessary.

Assistance provided through the use of Assistive Devices

What equipment or devices does the Applicant routinely use to help compensate for his/her impairment?

Check (✓) appropriate item(s):

- ☐ **Cane**
- ☐ **Crutches**
- ☐ **Walker**
- ☐ **Manual Wheelchair**
- ☐ **Power Wheelchair**
- ☐ **Scooter**
- ☐ **Lifting device**
- ☐ **Hospital bed**
- ☐ **Prosthesis**
- ☐ **Splints**
- ☐ **Braces**
- ☐ **Feeding device**
- ☐ **Breathing device**
- ☐ **Commode**
- ☐ **Urological appliance**
- ☐ **Ostomy appliance**
- ☐ **Communication devices** _____
- ☐ **Interpretive services** _____
- ☐ **Toileting aids** _____
- ☐ **Bathing aids** _____
- ☐ **Other** _____
- ☐ **Specially designed adaptive housing**

Please provide details on any equipment or devices used by the applicant:

If equipment is required but is not currently being used, please describe the equipment or device that is needed:

Assistance provided by Assistance Animals

Does the applicant have an Assistance Animal? ☐ Yes ☐ No

If yes, please specify either the nature of the assistance provided by the animal or the need:

E - ADDITIONAL INFORMATION

Please provide any additional information that may be relevant to understanding the nature and extent of the applicant's impairment and its effect on daily living activities.

F - APPROACHES AND INFORMATION SOURCES

What approaches and information sources did you use to complete this form:

- ☐ office interview with applicant
- ☐ home assessment
- ☐ other assessments (specify) _____
- ☐ file/chart information (specify) _____
- ☐ family/friends/caregivers (specify) _____
- ☐ other professionals (specify) _____
- ☐ community services (specify) _____
- ☐ other (specify) _____

G - FREQUENCY OF CONTACT

1. Is this your first contact with the applicant? ☐ Yes ☐ No

2. How long have you known this applicant? _____

3. How often have you seen this person in the last year?

   ☐ Once ☐ 2 - 10 times ☐ 11 or more times

4. Briefly describe the type and duration of the program or services you or your organization are providing or have provided to the applicant.

_____

_____

_____

_____

_____

_____

_____

_____

H - CERTIFICATION

I, _____, am a _____ practicing in British Columbia.
(enter professional discipline)

I am registered with a professional regulatory body: ☐ Yes ☐ No

Name of regulatory body: _____

My registration number is: _____

I am employed by:

☐ self-employed; private practice ☐ A Health Authority

☐ Other employer (please specify) _____

This report *(and attached documents)* contains my findings and considered opinion at this time.

Signature	Date (YYYY MMM DD)	Telephone

Fax	E-mail Address (optional)

Print / Stamp Address

CHECKLIST ☑ APPLICANT CHECKLIST

- ☐ Have you completed Section 1, Applicant Information?
- ☐ Have you read and signed the declaration, Section 1C?
- ☐ Has the Physician Report, Section 2, been completed and signed?
- ☐ Has the Assessor Report, Section 3, been completed and signed?
- ☐ Did you keep a photocopy for your records?
- ☐ Did you remember to include any additional information you want considered?
- ☐ Has proof of legal authority to act on behalf of the applicant been attached?

☐ **Do you wish to be notified when your application is received by Health Assistance Branch?**

If so, please check here and complete the form below

☐ Using the enclosed self-addressed envelope, please mail your completed application to:

Health Assistance Branch
Ministry of Social Development and Social Innovation
PO Box 9999 Stn Prov Govt
Victoria, B.C. V8W 9W9

CONFIRMATION OF APPLICATION RECEIVED BY HEALTH ASSISTANCE BRANCH

Your Application was received on:

_____ Name
_____ Address
_____ City/Town
_____ Postal Code

SD2883(13/07/02)

ASSESSOR'S INVOICE

Invoice No. | Invoice Date

Applicant Name | Applicant DOB | Personal Health Number

Date of Service | Description of Service

Completion of PWD Assessors Section..... $75.00

Make cheque payable to:

Supplier Name

Address | Postal Code | Telephone

Supplier Signature

NOTES

NOTES

Ministry of Social Development and Social Innovation
Health Assistance Branch
P.O. Box 9971 Stn Prov Govt
Victoria, B.C. V8W 9R5