

Persons with Disabilities Designation Application Introduction

The personal information requested on this form is collected and used by the Ministry of Social Development and Poverty Reduction pursuant to sections 26(c) and 32(b) of the *Freedom of Information and Protection of Privacy Act* for the purpose of administering the *Employment and Assistance for Persons with Disabilities Act*. If you have any questions about the collection or use of this information, please contact the Ministry of Social Development and Poverty Reduction at 1-866-866-0800.

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 person who is applying for the Person with Disabilities designation.

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

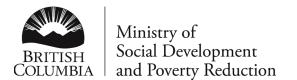
Section 3: Assessor Report (for completion by a Prescribed Professional – see Appendix for list)

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 their Physician or Nurse Practitioner for completion of the Medical Report.
- 3. The Applicant's Physician or Nurse Practitioner is to complete Section 2 Medical 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. Additional information/comments may be attached to this application as needed.
- 7. Applicant Please review the checklist on the next page to ensure your application is complete.
- 8. The Applicant will then mail the application to the Ministry of Social Development and Poverty Reduction.

Applicant Checklist						
☐ Have you completed Section 1 – Applicant Information?						
☐ Have you read and signed Section 1C − Declaration and Notification?						
☐ Has Section 2 – Medical Report been completed and signed?						
☐ Has Section 3 – Assessor Report 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 (if applicable)?						
☐ Please mail your completed application to:						
Ministry of Social Development and Poverty Reduction Health and Specialized Services PO Box 9971 Stn Prov Govt Victoria, BC V8W 9R5						

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You may have someone help you complete this Section of the Application.

Important Note: You **MUST** sign the "Declaration" on page 4 of this form in order for your application to be processed.

A – Applicant Information								
Last Name	First Name	Middle Name		Date of Birth (YYYY MMM DD)				
Social Insurance Number	(optional)	Personal Health Nu	mber	Telephone Number				
Street Address		City		Postal Code				
Do you need help comple	eting this application?		M.,					
Yes No	If yes, what help do you	ı need?						
B – Disabling Condition	1							
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 Sections 2 and 3 of this Application. I choose not to complete this self-report. (Please proceed to Declaration on page 4) Note - If more space is required, you may attach additional pages. 1. Please describe your disability:								

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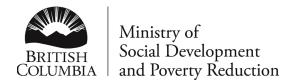
B – Disabling Condition (continued)

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B – Disabling Condition (continued)
2. How does your disability affect your life and your ability to take care of yourself?

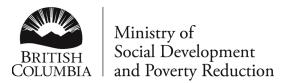
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C – Declaration and Notification	
I,, am ap set out in the <i>Employment and Assistance for Perso</i> information provided in Section 1A and 1B is true. It information in Section 1A, Section 2 and Section 3, a designation.	understand that the BC government may verify the
*Applicant Signature	Witness Signature
Date Signed (YYYY MMM DD)	Witness Name (Please print) Witness Address & Telephone
Property Act, a person acting under a power of attor	e Applicant under section 3 or 4 of the Freedom of guardian may act for a child if the authority to make de the declaration and acknowledgment set out or powers. A committee appointed under the <i>Patients</i> ney, a litigation guardian or a representative acting <i>Representation Agreement Act</i> may act for an adult his document and provide the declaration and

Note: Proof of Committee, Power of Attorney, Litigation Guardian, Representation Agreement, Representative or Guardian status must accompany this Application.

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This section is to be filled out by a Physician registered and licensed to practice medicine in British Columbia or a Nurse Practitioner registered to practice in British Columbia. The individual completing this Section of the Application may also complete Section 3 — Assessor Report.

The purpose of the Medical 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 **Persons 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 Poverty Reduction, 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 PWD designation; and
- the report may be reviewed by a Prescribed Professional consulting with the Ministry of Social Development and Poverty Reduction.

Fee

Physicians: Fees for physicians completing this section are paid through the Medical Services Plan under fee code 96501. Payment will be made in accordance with the rate established by the Ministry of Social Development and Poverty Reduction provided that the Physician has fully completed Section 2 of the Application.

Nurse Practitioners: Nurse Practitioners completing this section, where service contract permits billing 3rd parties outside of 1680 deliverable hours, may submit an invoice in the amount of \$130.00 to the Ministry of Social Development and Poverty Reduction at the following address (please use tear-off invoice on last page.)

Ministry of Social Development and Poverty Reduction Accounts Payable PO Box 5051 Stn Terminal Vancouver BC V6B 4A9

Or by fax at 1-866-399-9350

Please keep a copy of the completed Section 2 of this form until such time as you receive payment for your fee. You may contact the Ministry of Social Development and Poverty Reduction at 1-888-221-7711 if you have questions regarding this application.

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APPENDIX

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 is in a prescribed class of persons or that the person has a severe mental or physical IMPAIRMENT that
 - (a) in the opinion of a medical practitioner or nurse 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.

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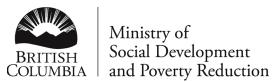
PROGRAM DEFINITIONS

- 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.

Alternative grounds for designation under section 2 of the Act

- 2.1 The following classes of persons are prescribed for the purposes of section 2(2) of the Act:
 - (a) a person who is enrolled in Plan P (Palliative Care) under the Drug Plans Regulation;
 - (b) a person who has at any time been determined to be eligible to be the subject of payments made through the Ministry of Children and Family Development's At Home Program;
 - (c) a person who has at any time been determined by Community Living British Columbia to be eligible to receive community living support under the Community Living Authority Act;
 - (d) a person whose family has at any time been determined by Community Living British Columbia to be eligible to receive community living support under the Community Living Authority Act to assist them in caring for the person;
 - (e) a person who is considered to be disabled under section 42(2) of the Canada Pension Plan (Canada).





To be completed by the Applicant's Physician or Nurse Practitioner only

A – Applican	t Informati	on				
Last Name	Personal Hea	lth Number				
D D:						
B – Diagnose						
"Impairment" is a I	oss or abnorma	e Applicant's impairment un ality of psychological, anatom effectively, appropriately or fo	ical or physiological	structure or function		tion in the
Diagnostic	Specific I	Diagnosis (e.g. location o			Date of ons	
Code		or heart condition, typ	oe of hepatitis, etc	;.)	Month	Year
Comments - Ple	ease include a	dditional information as rec	quired:			
C – Health Hi	story					
does the n		everity of the medical dition impair this person opriate.			•	
2. Height and Height	d Weight (if	relevant to the impair Weigh	•			



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
- 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

- 4.0 Other diseases of the blood
- 4.1 Anemia
- 4.2 Hemophilia

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

Diagnostic Codes

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 Quadriplegia
- 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 Emphysema

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 spondylitis
- 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 Thalidomide syndrome
- 14.4 Spina Bifida

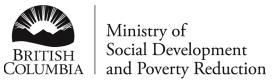
Injury and poisoning

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

Other conditions

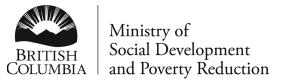
- 16.0 Other
- 16.1 Myalgic Encephalomyelitis
- 16.2 Sleep apnea
- 16.3 Environmental sensitivities

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C.	– Health History (continued)
3.	Has the Applicant been prescribed any medications and/or treatments that interfere with their
	ability to perform daily living activities?
	If yes, please explain:
	If yes, what is the anticipated duration of the medications and/or treatments:
4.	Does the Applicant require any prostheses or aids for their impairment?
	If yes, please explain:
	in yes, produce criprianii
D.	- Degree and Course of Impairment
	Is the impairment likely to continue for two years or more from today?
	What is the estimated duration of the impairment and are there remedial treatments that may
	resolve or minimize the impairment? Please explain:

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E – 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
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) Memory (ability to learn and recall information) Other Specify
Functional Skills Comments (regarding questions 1 to 6 above)

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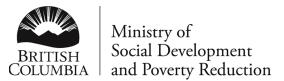


COLUMBIA and Poverty Reduct	ion		Sect	ion 2 - Medi	ical Report			
F – Daily Living Activities								
Note: If you are completing the Report, do not complete this pa		port – Secti	on 3, in addit	ion to this Me	dical			
Does the impairment directly restr	rict the person	's ability to pe	erform Daily L	iving Activities	?			
Yes No	Jnknown	If yes, please	e complete the	e following tabl	e:			
Daily Living Activities Is activity restricted? (check one) If yes, the restriction is: (check one) restriction in "comments" below								
	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 impacte	d, please exp	lain:						
	'							
Please provide additional commer	nts 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.								

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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.



G – Additional Comments							
Please provide any additional info							
significance of the person's medical condition, the nature and extent of this person's impairment and							
the impact these have on their daily functioning (e.g. hospitalization related to the impairment).							
H – Frequency of Contact							
How long has the Applicant been	your patient?						
Prior to today, how often have you	seen the Applic	cant in the past 12	? months?				
□ 0 □ Once	□ 2-10 ti		or more times				
Comments:							
estimente.							
I – Certification		N					
am a Physician registered with the	College of	am a Nurse Pra c	ctitioner and am registered to				
Physicians and Surgeons of British			BC College of Nurses and				
licensed to practice clinical medicin		Midwives.	· ·				
☐ I am a General Practitioner							
☐ I am a specialist in							
Medical Practitioner Number		Registration Nur	nber				
		_					
This report (and attached documen	ts) contains my fi	ndings and consid	•				
Signature			Date Signed (YYYY MMM DD)				
Telephone Number	Fax Number		Email Address (Optional)				
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Print/Stamp Address			1				

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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 Poverty Reduction, 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 Physician or Nurse Practitioner 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 Poverty Reduction.

Fee

Physicians: Fees for physicians completing this section are paid through the Medical Services Plan under fee code 96502. Payment will be made in accordance with the rate established by the Ministry of Social Development and Poverty Reduction provided that the Physician has fully completed Section 3 of the Application.

Nurse Practitioners where service contract permits billing 3rd parties outside of 1680 deliverable hours, and other Prescribed Professionals, may submit an invoice in the amount of \$75.00 to the Ministry of Social Development and Poverty Reduction at the following address (please use tear-off invoice on last page.)

Ministry of Social Development and Poverty Reduction Accounts Payable PO Box 5051 Stn Terminal Vancouver BC V6B 4A9

Or by fax at 1-866-399-9350

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APPENDIX

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 is in a prescribed class of persons or that the person has a severe mental or physical IMPAIRMENT that
 - in the opinion of a medical practitioner or nurse 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.

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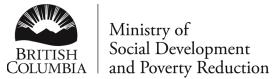
PROGRAM DEFINITIONS

- 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.

Alternative grounds for designation under section 2 of the Act

- 2.1 The following classes of persons are prescribed for the purposes of section 2(2) of the Act:
 - (a) a person who is enrolled in Plan P (Palliative Care) under the Drug Plans Regulation;
 - (b) a person who has at any time been determined to be eligible to be the subject of payments made through the Ministry of Children and Family Development's At Home Program;
 - (c) a person who has at any time been determined by Community Living British Columbia to be eligible to receive community living support under the Community Living Authority Act;
 - (d) a person whose family has at any time been determined by Community Living British Columbia to be eligible to receive community living support under the Community Living Authority Act to assist them in caring for the person;
 - (e) a person who is considered to be disabled under section 42(2) of the Canada Pension Plan (Canada).

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A – Applicant Informati	A – Applicant Information									
Last Name	First Na	me		Dat	e of Birth (Y	YYY MMM DD)	Personal Health Number			
B – Living Environment										
1. Does the Applicant liv	1. Does the Applicant live ☐ Alone? ☐ With family, friends or caregiver? ☐ In a care facility?									
Comments:										
C – Mental or Physical Impairment										
"Impairment" is a loss or abnorestriction in the ability to fund		•	•							
1. What are the Application manage Daily Living				_		hat impac	ct their ability to			
2. Ability to Communic	rato									
2. Ability to Communic	ale	>								
Please indicate the level		actol		Φ	Explain /	Describe				
of ability in the following areas:	g poog	Satisfactory	Poor	Unable						
Speaking										
Reading				7						
Writing										
Hearing										
3. Mobility and Physic	al 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 z from another person or unable	Uses Assistive device	Takes significantly longer than typical (describe how much longer)	Explain device(s	and specify assistive			
Walking indoors										
Walking outdoors										
Climbing stairs										
Standing										
Lifting										
Carrying and holding										

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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.

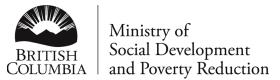
C – Mental or Physical Impairment (continued)

4. **Cognitive and Emotional Functioning** - only complete this if the Applicant has an identified mental impairment, including brain injury

For each item indicate to what degree the Applicant's mental impairment or brain injury restricts or impacts their functioning. Provide details/comments below.

If impact is episodic or impact varies over	Impact on Daily Functioning					
time, please explain in the comment section below.	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)	T					
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)						
Comments:						

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D – Daily Living Activities	S					
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 Include a description of the type and amount of assistance required
Personal Care						
Dressing						
Grooming						
Bathing						
Toileting						
Feeding self						
Regulating diet 5						
Transfers (in/out of bed)						
Transfers (on/off chair)						
Basic Housekeeping						
Laundry						
Basic Housekeeping						
Shopping						
Going to and from stores						
Reading prices and labels						
Making appropriate choices						
Paying for purchases						
Carrying purchases home						
Additional comments (incluidentification of any safety			otion of t	he type	e and amo	unt of assistance required and
- David dia analytic and the state of the st		ifi a a sat la a la			f 11 - 1 - 1 - 1 - 1	

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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.

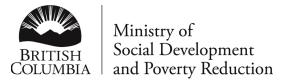
⁴ Continuous assistance - refers to needing significant help most or all of the time for an activity.

⁵ Regulating diet - for example, issues related to eating disorders characterized by major disturbances in eating behaviour.



s (cont	inued)								
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 Include a description of the type and amount of assistance required				
Meals									
•									
•		$\sqrt{\Lambda}$							
_		cription o	f the ty	pe and am	nount of assistance required and				
	ludebendent	Independent Periodic Assistance 3 from another person	Independent Supplies the periodic Assistance and the periodic Assistance and the person of the perso	Independent Independent Feriodic Assistance 3 from another person Continuous assistance 4 from another person or unable Uses Assistive device (Explain)	Independent Indepe				

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D - Daily Living Activities (continued)

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

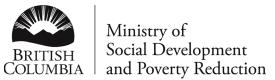
Indicate the support/supervision required, as related to restrictions in the following areas:	Independent	Periodic Support / Supervision	Continuous Support / Supervision	Explain / Describe Include a description of the degree and duration of support/supervision required		
Appropriate social decisions (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 Ap	plicant's	s relationship with their:		
immediate social network (par	tner, fa	mily, fri	ends)			
good functioning - positive relationsh	ips: ass	ertively o	ontribut	es to these relationships		
marginal functioning - little significant	marginal functioning - little significant participation/communication: relationships often minimal and fluctuate in quality					
very disrupted functioning - aggression	n or ab	use: maj	or withd	rawn: often rejected by others		
Comments						
extended social networks (nei	ghbour	hood co	ntacts,	acquaintances, storekeepers, public officials, etc.)		
			•	en participates in activities with others		
marginal functioning - little more than	minima	ıl acts to	fulfill ba	sic needs		
very disrupted functioning - overly dis	sruptive	behavio	ur; majoı	r social isolation		
Comments						
If the Applicant requires help, as indicated help to maintain them in the community		oove, ple	ease des	scribe the support/supervision required which would		
Additional Comments (including identif	ication o	of any sa	fety iss	ues):		

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E – Assistance Provided for Applicant	
Assistance provided by other people	
The help required for daily living activities is provided by	<i>r</i> :
Family Health Authority Professionals (e.g	. Nurse) Community Service Agencies
Friends Volunteers	Other
Comments:	
If help is required but there is none available, please de	scribe what assistance would be necessary.
Assistance provided through the use of Assistive D	evices
What equipment or devices does the Applicant routinely impairment? Check appropriate items:	use to help compensate for their
☐ Cane ☐ Lifting device ☐ Feeding device	☐ Communicative devices
☐ Crutches ☐ Hospital bed ☐ Breathing device	☐ Interpretive services
☐ Walker ☐ Prosthesis ☐ Commode	☐ Toileting aids
☐ Manual wheelchair ☐ Splints ☐ Urological applian	ce Bathing aids
☐ Power wheelchair ☐ Braces ☐ Ostomy appliance	☐ Other
☐ Scooter	☐ Specially designed adaptive housing
Please provide details on any equipment or devices use	ed by the Applicant:
If equipment is required but is not currently being used, is needed:	please describe the equipment or device that
Assistance provided by Assistance Animals	
Does the Applicant have an Assistance Animal?	∃ Yes □ No
If yes, please specify either the nature of the assistance p	provided by the assistance animal or the need:

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F – 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.	
G - Approaches and Informational 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)	

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Н -	- Frequency of Contact							
1.	Is this your first contact with the Applicant? Yes No							
2.	How long have you known this Applicant?							
3.	Prior to today, how often have you seen the Applicant in the past 12 months?							
	☐ None ☐ 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.							
I - (Certification							
Ι, _	am a							
nrs	acticing in British Columbia.							
	m registered with a professional regulatory body: Yes No							
	me of regulatory body:							
	registration number is:							
_	m employed by:							
	Self-employed; private practice							
	Other employer (please specify):							
	cuter empreyer (produce openny).							
	is report (and attached documents) contains my findings and considered opinion at this time.							
Sigr	pature Date Signed (YYYY MMM DD)							
Tele	phone Number Fax Number Email Address (Optional)							
Prin	t/Stamp Address							

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	Important: To avoid delay	in payment please c	omplete e	every field of the in	nvoice
Invoice #1	Inv	oice No.	Invoice [)ate	Date of Service
Select who is billing				Sate	Date of Service
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Your Employer (Self/Healt	th Authority/Other)			Registration Number	-
. , ,	,				
Your Name				Your Profession	
Applicant/Client Name		Applicant Date of Birth		Personal Heal	th Number
Description of Servic					
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	th Sections 2 and 3			(Only for Nurse F	ractitioner)
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Make cheque payabl	ie io:				
Payee Name					
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Signature					
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Invoice #2				,	
	Inv	oice No.	Invoice [Date	Date of Service
Select who is billing	Prescribed Professional	Nurse Pract	itioner		
Your Employer (Self/Heal	th Authority/Other)			Registration Number	
Yann Mana				Varia Bartarria	
Your Name				Your Profession	
Applicant/Client Name		Applicant Date of Birth		Personal Heal	th Number
Description of Service					
·	edical Report Section 2		\$130.00	(Only for Nurse F	Practitioner)
	th Sections 2 and 3				•
	sessors Report Section 3			. •	,
Make cheque payabl					
Payee Name					
Address				Postal Code	Telephone
Signature					

Ministry of Social Development and Poverty Reduction Accounts Payable PO Box 5051 Stn Terminal Vancouver BC V6B 4A9



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