

#### IMPORTANT NOTE TO HEALTH PROFESSIONALS and APPLICANTS

The BC Ministry of Social Development and Poverty Reduction ("Ministry") has published an electronic version of the Persons with Disabilities (PWD) Application Form (HR2883) on its website at <a href="https://www2.gov.bc.ca/PWDApp">https://www2.gov.bc.ca/PWDApp</a>. This provides applicants and health professionals an alternative method to access and fill out the form.

To receive provincial disability assistance, the person must be designated as PWD. Prior to applying for the PWD designation, the applicant should start an application for or be in receipt of income assistance with the Ministry. At the intake appointment, an eligibility assessment will be completed to determine if the applicant (and their family members, if applicable) meet residency, citizenship and identification requirements, as well as income and asset tests. More information on qualifying for financial assistance through the BCEA Program can be found at: <a href="https://myselfserve.gov.bc.ca/">https://myselfserve.gov.bc.ca/</a> or applicants can contact the Ministry of Social Development and Poverty Reduction at 1-866-866-0800.

#### Instructions:

- 1. **Before completing the PWD Application Form (HR2883), the applicant should start an application for or be in receipt of income assistance.** If they have not applied for or are not currently receiving income assistance, the applicant should contact the Ministry and complete an income assistance application (see section above).
- 2. **After completing the PWD Application Form**, return the form, along with any supporting documents, to the applicant for submission <u>or</u> submit it on the applicant's behalf:

Fax: 1-855-771-8785
 Mail: Health Assistance
 Ministry of Social Development and Poverty Reduction
 PO Box 9971 Stn Prov Govt
 Victoria, BC V8W 9R5

Note: if either Section 2 (Medical Report) or Section 3 (Assessor Report) of the Application Form needs to be completed by another health/prescribed professional, please contact the applicant to make specific arrangements.

3. **If the applicant is not able to attend your office in person** as part of the assessment and completion of the PWD Application Form, please attach a completed Certification of Authorization to Collect Information Form (HR4019) as an addendum (see next page).



# Certification of Authorization to Collect Information - PWD

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 Act* and 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*. Any questions regarding this form, please contact the Ministry of Social Development and Poverty Reduction at 1-866-860-0800

### Addendum to the Persons with Disabilities Application Form (HR2883)

Applicant Information			
Last Name	First Name		Middle Name
Date of Birth (YYYY MMM DD)	Personal Health Number	Case Number (For	Office use Only)
Purpose			
The purpose of this form is to ensure the Ministry of applicant, to collect personal information about the cannot provide written authorization to the Ministry	em from a third party. This form should	d only be used when the app	licant, or their legal representative
Certification			
1,	certify that the follow	wing is true and complete:	
(name of health professional)  • The above-named applicant has authori	zed me to initiate an application for the	e Persons with Disabilities d	esignation on their behalf.
<ul> <li>I have reviewed the information contains applicant or their legal representative be</li> </ul>		lication Form, and any assoc	ciated attachments, with the
I have received clear and express author     Poverty Reduction to collect from me, at     Disabilities Application Form, for the pur     and for assistance under the Employme	ny health and other personal informations of assisting the ministry to determ	ion about the applicant, as re mine if they qualify for design	quested in the Persons with
Signature		Date Signed (YYY	Y MMM DD)
Health Profession			
Telephone Number	Fax Number	Email Address	
Practitioner / College Registration Number	Print/Stamp Address	I	

\* If the Applicant does not have the necessary capacity to provide the authorization described above, it may be provided by a person who has legal authority to act on behalf of the Applicant under section 3 or 4, as applicable, of the Freedom of Information and Protection of Privacy Regulation. A guardian may act for an Applicant who is a minor if the authority to make the application described in this document and provide the authorization set out above are within the scope of the guardian's duties or powers. A committee appointed under the Patients Property Act, a person acting under a power of attorney, a litigation guardian or a representative acting under a representation agreement, as defined in the Representation Agreement Act, may act for an Applicant who is an adult if the authority to make the application described in this document and provide the authorization set out above are within the scope of that person's duties or powers.

If another person is acting on behalf of the Applicant, you must attach proof of that legal authority to this Form.

The required proof is a document or documents establishing that the person acting on behalf of the Applicant is:

- (a) a Committee appointed under the Patients Property Act;
- (b) acting under a Power of Attorney;
- (c) a Litigation Guardian;
- (d) a Representative acting under a Representation Agreement as defined in the Representation Agreement Act, or
- (e) if the Applicant is a minor, a Guardian of the Applicant who is acting within the scope of their duties or powers.

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# 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.* 

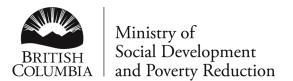
### This Application has three Sections:

- 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				



## 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	on		
Last Name	First Name	Middle Name	Date of Birth (YYYY MMM DD)
Social Insurance Number (optional)		Personal Health Number	Telephone Number
Street Address		City Postal Code	
Do you need help comple  Yes No	If yes, what help do you	ı need?	
B – Disabling Condition			
life. You are not required	to complete this section.	escribe your disability and If you do not complete this n provided in Sections 2 a	s Section, your
I choose not to co	mplete this self-report.	(Please proceed to De	claration on page 4)
Note - If more space is re	equired, you may attach a	dditional pages.	
1. Please describe your		. •	
	•		

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B – Disabling Condition (continued)	

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

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oplying for designation as a Person with Disabilities as ons with Disabilities Act and I declare that the understand that the BC government may verify the as necessary to determine my eligibility for the
Witness Signature
Witness Name (Please print)
Witness Address & Telephone
city to sign this Application, it may be signed by a ne Applicant under section 3 or 4 of the Freedom of guardian may act for a child if the authority to make ride the declaration and acknowledgment set out or powers. A committee appointed under the <i>Patients</i> rney, a litigation guardian or a representative acting a <i>Representation Agreement Act</i> may act for an adult this document and provide the declaration and pe of that person's duties or powers.

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

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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.

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).

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	o be completed by the Ap	ppiicant's	Physician or Nurse Pra	ctitioner only	
A – Applican	t Information				
Last Name	First Name		Date of Birth (YYYY MMM DD)	Personal Hea	alth Number
B – Diagnos			the diaments and a second		
"Impairment" is a	es related to the Applicant's impa oss or abnormality of psychological ndependently, effectively, appropria	l, anatomical c	or physiological structure or function		tion in the
Diagnostic				Date of ons	et if known
Code	or heart condi	ition, type of	f hepatitis, etc.)	Month	Year
Oamananta Di		4!	under ale		
Comments - Pi	ease include additional inform	nation as rec	quirea:		
_					
C – Health H					
	licate the severity of the m		•	•	
does the r	nedical condition impair thi	is person?	Test results and other re	ports or finding	gs may be
used here	where appropriate.				
2. Height an	d Weight (if relevant to the	impairmer	nt):		
Height	- ,	Weight	•		
J		_	-		

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## 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 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 syndrome14.4 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

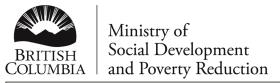
16.3 Environmental sensitivities

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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 you what is the entisinated duration of the modications and/or treatments.
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:
D – 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:

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E – Functional Skills	
Note: For the purposes of questions #1 and #2, 'person, assistive device or assistance animal.	"unaided" means without the assistance of another
<ul> <li>1. How far can this person walk unaided on a f</li> <li>□ 4+ blocks</li> <li>□ 1 to 2 blocks</li> <li>□ 2 to 4 blocks</li> <li>□ Less than 1 block</li> </ul>	□ Unknown
2. How many <b>stairs</b> can this person <b>climb una</b> i	ided?
☐ 5+ steps ☐ 2 to 5 steps [	☐ None ☐ Unknown
3. What are the person's limitations in <b>lifting</b> ?	
☐ No limitations ☐ 2 to 7 kg (5	to 15 lbs)
☐ 7 to 16 kg (15 to 35 lbs) ☐ Under 2 kg	(Under 5 lbs) ☐ Unknown
4. How long can this person remain <b>seated</b> ?	
☐ No limitation ☐ 1 to 2 hours	☐ Unknown
☐ 2 to 3 hours ☐ Less than 1 hour	
•	ther than a lack of fluency in English?) ☐ Yes ☐ No
If yes, what is the cause: $\square$ Cognitive $\square$ M	<del>-</del>
<ul> <li>Are there any significant deficits with cognitive. Yes</li></ul>	re evident and provide details below:  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

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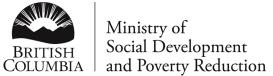
F - Daily Living Activities
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Does the impairment directly restr	ict the persoi Jnknown		-	iving Activities e following tabl		
Daily Living Activities	Is activity restricted? (check one) If yes, describe extent of (check one) restriction in "comments" below					
	Yes	No	Unknown	Continuous <sub>1</sub>	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 commer	ts regarding	the degree of	restriction:			
What assistance does your patien another person, equipment and as extent of assistance required.						

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<sup>1</sup> Continuous assistance - refers to needing significant help most or all of the time for an activity.

<sup>2</sup> **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 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 their daily functioning (e.g. hospitalization related to the impairment).						
the impact these have on their da	iny furictioning (e	.g. 1103pitalization	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 Applicant in the past 12 months?						
□ 0 □ Once □ 2-10 times □ 11 or more times						
Comments:						
I – Certification						
I						
am a <b>Physician</b> registered with the	e College of	am a <b>Nurse Pra</b> c	ctitioner and am registered to			
Physicians and Surgeons of British Columbia and		practice with the BC College of Nurses and Midwives.				
licensed to practice clinical medicine in BC.  Mi  I am a General Practitioner		iviidwives.				
☐ I am a specialist in						
Medical Practitioner Number Registration Nur		mber				
Tregistration realition re						
This report (and attached documents) contains my findings and considered opinion at this time.						
Signature Date Signed (YYYY MMM DD)						
Telephone Number	Fax Number		Email Address (Optional)			
Print/Stamp Address						

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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.

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

Please keep a copy of the completed Section 3 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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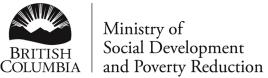
#### **PROGRAM DEFINITIONS**

- 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).

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<u> </u>	<u></u>						
A – Applicant Informati	on						
Last Name	First Na	me		Dat	e of Birth (Y	YYY MMM DD)	Personal Health Number
B – Living Environment							
1. Does the Applicant liv	e 🗌 Alo	ne? [	☐ With fa	amily,	friends or c	aregiver?	☐ In a care facility?
Comments:							
C - Mental or Physical	mpairm	ent					
"Impairment" is a loss or abno restriction in the ability to func							
What are the Application     manage Daily Living	Activiti			_		hat impad	ct their ability to
2. Ability to Communic	ate	1 -	1				
Please indicate the level of ability in the following areas:		Satisfactory	Poor	Unable	Explain /	Describe	
Speaking							
Reading							
Writing							
Hearing							
3. Mobility and Physica	al Ability	,		<u>'</u>			
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 device(s	and specify assistive
Walking indoors							
Walking outdoors							
Climbing stairs							
Standing							
Lifting							
Carrying and holding							

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<sup>1</sup> **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.

<sup>2</sup> Continuous assistance - refers to needing significant help most or all of the time for an activity.

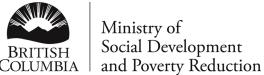
## C – Mental or Physical Impairment (continued)

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	Ir	npact on Dai	ly Functionin	ıg
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)				
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						
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			<u>'</u>			
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 (inclu	ding a	descri	otion of t	he type	e and amo	unt of assistance required and

identification of any **safety issues**):

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<sup>3</sup> **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.

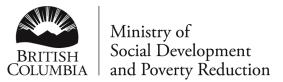
<sup>4</sup> Continuous assistance - refers to needing significant help most or all of the time for an activity.

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

s (cont	tinued)				
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
•	•	'			
b					
		Independent Periodic Assistance 3 from another person	Independent Periodic Assistance 3 from another person or unable unable	Independent Periodic Assistance 3 from another person Continuous assistance 4 from another person or unable Uses Assistive device (Explain)	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)

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

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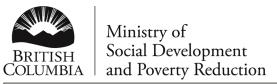


## D – Daily Living Activities (continued)

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

Coolai i arrottorinig only complete	, 11115 11 11	ic / tppii	· · · · · · · · · · · · · · · · · · ·	arradiant in pairment, 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 i	mpacts	the Ap	plicant's	relationship with their:
immediate social network (par	tner, fa	mily, fri	ends)	
good functioning - positive relationshi	ips: asse	ertively o	contribute	es to these relationships
marginal functioning - little significant	particip	ation/co	mmunica	ation: relationships often minimal and fluctuate in quality
□ very disrupted functioning - aggression	on or abi	use: maj	jor withd	rawn: often rejected by others
Comments				
extended social networks (nei	ghbourl	hood co	ontacts,	acquaintances, storekeepers, public officials, etc.)
good functioning - positively interacts	with the	commu	unity; ofte	en participates in activities with others
marginal functioning - little more than	minima	I acts to	fulfill ba	sic needs
very disrupted functioning - overly dis	ruptive !	behavio	ur; majoı	social isolation
Comments				
If the Applicant requires help, as indic help to maintain them in the communi		ove, ple	ease des	scribe the support/supervision required which would
Additional Comments (including identif	ication o	of any <b>s</b> a	ifety iss	ues):

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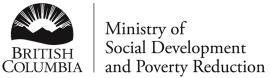


E – Assistance Pro	ovided for Appli	cant	
Assistance provid	ed by other peo	ple	
The help required for	or daily living acti	vities is provided by:	
Family	Health Auth	ority Professionals (e.g. Nurs	se) Community Service Agencies
Friends	Volunteers		Other
Comments:			
If help is required be	ut there is none a	available, please describ	e what assistance would be necessary.
•	•	use of Assistive Devic	
What equipment or impairment? <b>Check</b>			to help compensate for their
☐ Cane	Lifting device	☐ Feeding device	☐ Communicative devices
☐ Crutches	☐ Hospital bed	☐ Breathing device	☐ Interpretive services
☐ Walker	☐ Prosthesis	☐ Commode	
☐ Manual wheelchair	Splints	Urological appliance	Bathing aids
Power wheelchair	Braces	☐ Ostomy appliance	Other
☐ Scooter			Specially designed adaptive housing
Please provide deta	ills on any equipr	ment or devices used by	the Applicant:
If equipment is requis needed:	iired but is not cu	irrently being used, plea	se describe the equipment or device that
Assistance provid	ed by Assistand	ce Animals	
Does the Applicant	have an Assistar	nce Animal?	s 🗌 No
If yes, please specif	y either the natur	e of the assistance provi	ded 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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H – Frequency of Contact		
1. Is this your first contact with th	e Applicant? Yes No	
2. How long have you known this	Applicant?	
3. Prior to today, how often have	you seen the Applicant in the pas	t 12 months?
□ None   □ Once	☐ 2-10 times ☐	11 or more times
<ol> <li>Briefly describe the type and d providing or have provided to t</li> </ol>		you or your organization are
l - Certification		
l,	am a	(enter professional discipline)
practicing in British Columbia.		
I am registered with a professiona	l regulatory body: U Yes I N	No
Name of regulatory body:		
My registration number is:		
I am employed by:		
☐ Self-employed; private practice	☐ A Health Authority	
☐ Other employer (please specify)	y):	
This report (and attached docume	nts) contains my findings and con	· · · · · · · · · · · · · · · · · · ·
Signature		Date Signed (YYYY MMM DD)
Telephone Number	Fax Number	Email Address (Optional)
Print/Stamp Address		

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Important: To avoid de	elay in	i payment please co	mpiete e	very field of the in	IVOICE
Invoice #1					
	Invoi	ce No.	Invoice D	Date	Date of Service
Select who is billing Prescribed Profession	ional	Nurse Practit	ioner		
Your Employer (Self/Health Authority/Other)				Registration Numbe	r
Your Name				Your Profession	
Applicant/Client Name		Applicant Date of Birth		Personal Hea	th Number
				, 5,55,14,1,154	
Description of Service			<b>#</b> 400.00	(O   6 N	5 \
Completion of Medical Report Section 2					·
Completion of both Sections 2 and 3			\$205.00	(Only for Nurse F	Practitioner)
Completion of Assessors Report Section	3		.\$75.00		
Make cheque payable to:					
Payee Name					
Address				Postal Code	Telephone
Signature					
Important: To avoid do	elay in	ı payment please co	mplete e	very field of the in	nvoice
·		ı payment please co	mplete e		nvoice  Date of Service
·	Invoi		Invoice D		
Invoice #2	Invoi	ce No.	Invoice D		
Invoice #2  Select who is billing Prescribed Profession	Invoi	ce No.	Invoice D		Date of Service
Invoice #2  Select who is billing Prescribed Profession	Invoi	ce No.	Invoice D	) Date	Date of Service
Invoice #2	Invoi	ce No.	Invoice D	) Date	Date of Service
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Invoice #2  Select who is billing Prescribed Profession  Your Employer (Self/Health Authority/Other)  Your Name	Invoi	ce No.	Invoice D	Pate Registration Numbe	Date of Service
Invoice #2  Select who is billing Prescribed Profession  Your Employer (Self/Health Authority/Other)  Your Name  Applicant/Client Name	Invoi	ce No.	Invoice D	Registration Numbe	Date of Service
Invoice #2  Select who is billing Prescribed Profession  Your Employer (Self/Health Authority/Other)  Your Name  Applicant/Client Name  Description of Service	Invoid	ce No.  Nurse Practit  Applicant Date of Birth	Invoice E	Registration Number Your Profession Personal Hea	Date of Service
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Invoice #2  Select who is billing  Prescribed Professi  Your Employer (Self/Health Authority/Other)  Your Name  Applicant/Client Name  Description of Service  Completion of Medical Report Section 2  Completion of both Sections 2 and 3	Invoid	ce No.  Nurse Practit  Applicant Date of Birth	Invoice E ioner \$130.00 \$205.00	Registration Number Your Profession Personal Hear	Date of Service  th Number  Practitioner)
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Select who is billing Prescribed Professi  Your Employer (Self/Health Authority/Other)  Your Name  Applicant/Client Name  Description of Service  Completion of Medical Report Section 2  Completion of both Sections 2 and 3  Completion of Assessors Report Section  Make cheque payable to:	Invoid	ce No.  Nurse Practit  Applicant Date of Birth	Invoice E ioner \$130.00 \$205.00	Registration Number Your Profession Personal Hear	Date of Service  th Number  Practitioner)
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Ministry of Social Development and Poverty Reduction Accounts Payable PO Box 5051 Stn Terminal Vancouver BC V6B 4A9

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