DISABILITY LEVEL II (DBLII) APPLICATION

INTRODUCTION

The purpose of this form is to collect information necessary to determine eligibility for Social Assistance for individuals with disabilities in accordance with the *Nisga'a Social Development Program Policy and Procedures Manual*.

The terms and definitions that are applicable to this Application are contained in pages 2, 3 and 4.

This Application has three sections (refer to page 5 for detailed instructions for completion):

Section 1: **Applicant Information** (for completion by the Applicant).
Section 2: **Physician Report** (for completion by the Applicant's Physician as defined on page 2).
Section 3: **Assessor Report** (for completion by the Applicant's Physician or a Health Professional, who is not employed by an Administering Authority, as defined on page 2).

The Administering Authority will pay the Physician and Assessor upon receipt of the completed sections and required invoices.

Administering Authority Office Use Only

The following must be signed in order for the Application to be processed.

The Applicant is in receipt of Social Assistance or would qualify for Social Assistance for individuals with Disability Level II in accordance with *Nisga'a Social Development Policy and Procedures Manual,* if found eligible for Disability Level II designation.

Administering Authority #	Nisga'a Social Development Worker (Print Name)	Signature

Print / Stamp Address	Date Signed (Year Month Day)

If you have questions regarding this Application, please contact NLG at 250-633-3078 or 1-866-633-3018.

Nisga'a TERMS AND DEFINITIONS

The following Terms and Definitions apply to this Application:

"Administering Authority" means the Nisga'a village that is authorized by a funding agreement with NLG to administer the Nisga'a Social Development Program in the community where the Application is made.

"Applicant" means a person who is applying for Social Assistance for Persons with Disabilities and who:

(a) is 18 years of age at the time of applying for Social Assistance for Persons with Disabilities, and meets the financial eligibility requirements for Social Assistance for Persons with Disabilities in accordance with the Nisga'a Manual; or

(b) is a person under 18 years of age who completes an Application for Social Assistance for Persons with Disabilities up to four months before his or her 18th birthday, and who is likely to be eligible for Social Assistance for Persons with Disabilities in accordance with the NLG's Manual at the time of completing the Application and on his or her 18th birthday.

"Application" means this application form which consists of three sections:

Section 1 - Applicant Information;
Section 2 - Physician Report completed by the Applicant's Physician; and,
Section 3 - Assessor Report completed by a Health Professional.

"Assessor" means a "Health Professional" as that term is defined in the *BC Act* and who is not employed by an Administering Authority for the purpose of administering NLG's Social Development Program.

"*BC Act*" means the *British Columbia Employment and Assistance for Persons with Disabilities Act.*

"Daily Living Activities" has the same meaning as provided in the *BC Act* and Regulation.

"NLG" means the Nisga'a Lisims Government.

"NLG Manual" means the *Nisga'a Social Development Program Policy and Procedures Manual.*

"Health Professional" means a person who is a "Health Professional" as that term is defined in the *BC Act* and who is not employed by an Administering Authority for the purpose of administering INAC's Social Development Program.

"Physician" means a "Medical Practitioner" as that term is defined in the *BC Act*.

"Persons with Disabilities" or "PWD" means a person or persons designated as a person with disabilities as provided in section 2 of the *BC Act*.

"Social Development Program" means Nisga'a Social Development Program for which the Administering Authority receives contribution funding from NLG.

"Social Assistance for Persons with Disabilities" means social assistance that an Applicant may receive under NLG's Social Development Program if the Applicant is designated as Disability Level II.

PROVINCIAL DEFINITIONS (*BC Act* and Regulation)

The following section is taken from the BC *Employment and Assistance for Persons with Disabilities Act* that sets out the criteria for designation as a person with disabilities.

Persons with Disabilities

2(1) In this section:

"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;

"daily living activity" has the prescribed meaning;

"health professional" means a person who is authorized under an enactment to practice the profession of

(a) a medical practitioner,
(b) a registered psychologist,
(c) a registered nurse or registered psychiatric nurse,
(d) an occupational therapist,
(e) a physical therapist, or
(f) a social worker.

2(2) The Director may designate a person who has reached 18 years of age as a person with disabilities for the purposes of this ACT if the Director is satisfied that the person has a severe mental or physical IMPAIRMENT that

(a) in the opinion of a medical practitioner is likely to continue for at least 2 years, and
(b) in the opinion of a health 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 Director may rescind a designation under subsection (2).

PROVINCIAL DEFINITIONS (continued)

The following section is taken from the BC Employment and Assistance for Persons with Disabilities Regulation that sets out the definition of **"daily living activities."**

2 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 who 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.

INSTRUCTIONS FOR COMPLETION

PLEASE DO NOT TAKE THIS BOOKLET FORM APART - KEEP TOGETHER

ONLY THE ORIGINAL APPLICATION FORM WILL BE ACCEPTED FOR ADJUDICATION

1. The Nisga'a social development worker must complete and sign the "Administering Authority Office Use Only" section on page 1.

2. Sections 1, 2 and 3 of the Application must be completed in the following order:
   Section 1 - APPLICANT INFORMATION - Completed by the Applicant
   Section 2 - PHYSICIAN REPORT - Completed by the Physician
   Section 3 - ASSESSOR REPORT - Completed by the Assessor

3. The Applicant must first:
   a. complete Section 1 (Applicant Information);
   b. sign the Declaration and Consent; and
   c. take the Application to his/her Physician to complete Section 2 (Physician Report).

4. Then the Applicant's Physician:
   a. must complete Section 2 (Physician Report);
   b. may complete Section 3 (Assessor Report);
   c. must complete the invoice on page 27; and
   d. return the Application to the Applicant.

- **If the Physician completes Section 2 and Section 3, go to step 6.**
- **If the Physician completes Section 2 only, go to step 5.**

5. Then the Applicant takes the Application to a Health Professional (as defined in section 2 of the *BC Act*) who is not employed by the Administering Authority to administer NLG's Social Development Program. The Health Professional:
   a. must complete Section 3 (Assessor Report);
   b. must complete the invoice on page 27; and
   c. return the Application to the Applicant.

6. Then the Applicant:
   a. reviews the checklist at the end of the Application booklet (on page 26) to ensure the Application is fully completed; and
   b. returns the Application form to the Administering Authority.

7. The Administering Authority will pay the Physician's and Assessor's invoices.

8. Lastly, the Administering Authority mails the application to NLG.

The personal information requested on this form is collected and will be used for the purpose of determining the Applicant's eligibility for Social Assistance for Persons with Disabilities in accordance with the *NLG Social Development Program Policy and Procedures Manual*. The collection, use and disclosure of personal information is subject to the provisions of the *Nisga'a Privacy Act and the Personal Information Protection and Electronic Documents Act*. If you have any questions about the collection, use or disclosure of this information, please contact your local Administering Authority office.

You may have someone help you complete this Section of the Application.
Important Note: *You MUST sign the "Declaration and Consent" on page 9 of this form in order for your Application to be processed.*

A - PERSONAL INFORMATION

Last Name	First Name	Middle Name	Date of Birth (Year Month Day)

Personal Health Number	Social Insurance Number (optional)	Telephone Number

Street Address	City	Postal Code

Do you need help completing this Application?

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

B - DISABLING CONDITION

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

☐ **I choose not to complete this self-report.** (Please proceed to Declaration and Consent on page 9).

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

1. Please describe your disability.

8- DISABLING CONDITION (cont'd)

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

B - DISABLING CONDITION (cont'd)

C - DECLARATION AND CONSENT

I, _________________________________, am applying for Disability Level II designation with the Nisga'a Social Development department and in accordance with the Nisga'a *Social Development Policy and Procedures Manual.*

I declare that the information provided in Section 1A and 1B is true and complete. I understand that I will have the opportunity to review completed Section 2, (Physician Report) and Section 3, (Assessor Report), before submitting the completed designation application form to NLG.

I consent to NLG taking whatever action may be necessary to verify the information in the Application for the purpose of determining or confirming my eligibility for Disability Level II designation. Where person(s) have information or documents relevant to my Application, **I further consent** to their releasing them to NLG or the relevant Administering Authority.

* Applicant Signature

Witness Signature

Date Signed (Year Month Day)

Witness Name (Please Print)

Witness Address & Telephone

* If the Applicant is incapable of signing this Application, it may be signed by a person who has legal authority to act on behalf of the Applicant. If you are signing on behalf of the Applicant, you must state your legal authority to act on behalf of the Applicant and you must attach proof of that legal authority (for example, a copy of the court order naming you as Committee) to this Application.

My legal authority to act for the Applicant is ____.

NOTE: Proof of Committee, Power of Attorney and/or Parent/Guardian status must

accompany this Application if it is signed by a person other than the Applicant.

The personal information requested on this form is collected and will be used for the purpose of determining the Applicant's eligibility for Social Assistance for Persons with Disabilities in accordance with the *Nisga'a Social Development Program Policy and Procedures Manual*. The collection, use and disclosure of personal information is subject to the provisions of the *federal Privacy Act and the Personal Information Protection and Electronic Documents Act*. If you have any questions about the collection, use or disclosure of this information, please contact your local Administering Authority office.

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

The purpose of the Physician Report is to provide information to NLG about the Applicant's physical or mental impairments associated with diagnosed medical conditions relevant to this Application for **Disability Level II *(DBLII)*** designation. The emphasis is on how the medical conditions and impairments affect the Applicant's ability to perform Daily Living Activities as this term is defined in the *British Columbia Employment and Assistance for Persons with Disabilities Act* and Regulation. This Application is **not** intended to assess employability or vocational abilities.

Please answer all questions completely as this will assist NLG to determine whether the Applicant meets the criteria for Social Assistance Disability Level II (DBLII).

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 Health Professional completing Section 3 of this Application;
- the report may be shared with and reviewed by an individual or an employee of an agency contracted by NLG to adjudicate this Application.
- the report may be reviewed by a Health Professional consulting with NLG;
- the report will be shared with an appeal committee if an appeal is initiated regarding eligibility for a Disability Level II (DBLII) designation.

Fee

Payment will be made by the Administering Authority and in accordance with the established rate, provided that:

1. The Application process has been initiated by the band social development worker for the Administering Authority office as indicated by the address and signature on page 1 of this Application; and
2. The Physician has fully completed Section 2 of the Application.

Fees for Physicians completing this section are paid by the Administering Authority. Please fill out the invoice on page 27. Do not bill the provincial Medical Services Plan (MSP).

Please keep a copy of Page 1, the completed Section 2 of the Application and your invoice until such time as you receive payment for your fee.

Physicians having questions regarding this Section may contact NLG at 250-633-3078 or 1-866-633-3018.

TO BE COMPLETED BY THE APPLICANT'S PHYSICIAN ONLY

A - DIAGNOSES

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

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

Comments:

DIAGNOSTIC CODES

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

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

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

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

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

Diseases of the nervous system & sense organs - Neurological
6.0 Neurological disorders - other
6.1 Epilepsy
6.3 Brain tumors
6.4 Parkinson's disease
6.5 Cerebral palsy
6.6 Paraplegia
6.7 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 Chronic fatigue syndrome
16.2 Sleep apnea
16.3 Environmental sensitivities

B - HEALTH HISTORY

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

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

Height: ____________________ Weight: ____________________

3. Has the Applicant been prescribed any medication and/or treatments that interfere with his/her ability to perform **Daily Living Activities**? ☐ Yes ☐ No

If yes, please explain:

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

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

If yes, please explain:

C - DEGREE AND COURSE OF IMPAIRMENT

1. Is the impairment likely to continue for two years or more from today? ☐ Yes ☐ No

What is the estimated duration of the impairment and are there remedial treatments that may resolve or minimize the impairment?

Please explain:

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D - FUNCTIONAL SKILLS

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

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

☐ 4+ blocks ☐ 1 to 2 blocks ☐ Unknown

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

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

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

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

☐ No limitations ☐ 2 to 7 kg (5 to 15 lbs) ☐ No lifting

☐ 7 to 16 kg (15 to 35 lbs) ☐ Under 2 kg (Under 5 lbs) ☐ Unknown

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

☐ No limitation ☐ 1 to 2 hours ☐ Unknown

☐ 2 to 3 hours ☐ Less than 1 hour

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

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

Comments:______________________________

____

6. Are there any significant deficits with **cognitive and emotional function?** ☐ Yes ☐ No ☐ Unknown

If yes, check those areas where the deficits are evident and provide details below:

☐ Consciousness *(orientation, confusion)*

☐ Executive *(planning, organizing, sequencing, calculations, judgement)*

☐ Language *(oral, auditory, written comprehension or expression)*

☐ Memory *(ability to learn and recall information)*

☐ Perceptual psychomotor *(visual, spatial)*

☐ Psychotic symptoms *(delusions, hallucinations, thought disorders)*

☐ Emotional disturbance *(e.g. depression, anxiety)*

☐ Motivation *(loss of initiative or interest)*

☐ Impulse control

☐ Motor activity *(goal oriented activity, agitation, repetitive behaviour)*

☐ Attention or sustained concentration

☐ Other *(specify)* ______________________________

____

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Comments: ______________________________

E - DAILY LIVING ACTIVITIES

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

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

☐ Yes ☐ No ☐ Unknown

If yes, please complete the following table:

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

* If "Periodic", please explain:

____

____

** If Social Functioning is impacted, please explain:

____

____

Please provide additional comments regarding the degree of restriction:

____

____

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

____

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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.

F - ADDITIONAL COMMENTS

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

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G - FREQUENCY OF CONTACT

How long has the Applicant been your patient? ______________________________

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

☐ 0 ☐ Once ☐ 2 - 10 ☐ 11 or more

Comments:

____

H - CERTIFICATION

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

☐ I am a General Practitioner

☐ I am a specialist in ______________________________

Medical Practitioner Number: ______________________________

This report and attached documents, if any, contain my findings and considered opinion at this time.

Signature	Date (Year Month Day)	Telephone

Fax	E-mail Address (optional)

Print / Stamp Address

The personal information requested on this form is collected and will be used for the purpose of determining the Applicant's eligibility for Social Assistance for Persons with Disabilities in accordance with the *NLG Social Development Program Policy and Procedures Manual.* The collection, use and disclosure of personal information is subject to the provisions of the *Nisga'a Privacy Act and the Personal Information Protection and Electronic Documents Act.* If you have any questions about the collection, use or disclosure of this information, please contact your local Administering Authority office.

This Assessor Report is to be completed by a Health Professional (Medical Practitioner, Registered Psychologist, Registered Nurse or Registered Psychiatric Nurse, Occupational Therapist, Physical Therapist or Social Worker who is **not** employed by an Administering Authority to administer Nisga'a Social Development Program).

The purpose of the Assessor Report is to document the Applicant's impairments and their impact on performance of Daily Living Activities. The Application is **not** intended to assess employability or vocational abilities.

This section should be completed by a Health 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 NLG in determining whether the Applicant meets the criteria for Social Assistance Disability Level II (DBLII).

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

- the report will be shared with the Applicant;
- the report will be shared with the Physician completing Section 2 of this Application;
- the report may be shared with and reviewed by an individual or an employee of an agency contracted by NLG to adjudicate this Application;
- the report may be reviewed by a Health Professional consulting with NLG;
- the report will be shared with an appeal committee if an appeal is initiated regarding eligibility for Disability Level II (DBLII) designation.

Fee :

Payment will be made by the Administering Authority and in accordance with the established rate provided that:

1. The Application process has been initiated by the Nisga'a social development worker for the Administering Authority office as indicated by the address and signature on page 1 of this Application; and
2. The Physician or Health Professional has fully completed Section 3 of the Application.

Fees for Physicians and other Health Professionals completing this section are paid by the Administering Authority. Please fill out the invoice on page 27. Do not bill the provincial Medical Services Plan (MSP).

Please keep a copy of Page 1, the completed Section 3 of the Application and your invoice until such time as you receive payment for your fee.

Assessors having questions regarding this Section may contact NLG at 250-633-3078 or 1-866-633-3018.

A - LIVING ENVIRONMENT

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

Comment:

B - MENTAL OR PHYSICAL IMPAIRMENT

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

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

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

Comments:

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

Comments:

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

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

[3] **Assistive Device** – see page 21 for examples.

B - MENTAL OR PHYSICAL IMPAIRMENT (cont'd)

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

4. Cognitive and Emotional Functioning

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

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

Comments:

C - DAILY LIVING ACTIVITIES

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

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

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

C - DAILY LIVING ACTIVITIES (cont'd)

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

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

C - DAILY LIVING ACTIVITIES (cont'd)

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

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

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

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

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

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

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

Comments:

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

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

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

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

Comments:

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

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

D - ASSISTANCE PROVIDED FOR APPLICANT

Assistance provided by other people

The help required for daily living activities is provided by:

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

Comments: ____

____

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

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Assistance provided through the use of Assistive Devices

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

Check (√) appropriate item(s):

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

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

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

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Assistance provided by Assistance Animals

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

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

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E - ADDITIONAL INFORMATION

Please provide any additional information that may be relevant to understanding the nature and extent of the Applicant's impairment and its effect on **Daily Living Activities.** Please note if you are attaching additional reports.

F - APPROACHES AND INFORMATION SOURCES

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

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

G - FREQUENCY OF CONTACT

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

2. How long have you known this Applicant? ____________________

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

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

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

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H - CERTIFICATION

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

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

Name of regulatory body: ____________________

My registration number is: ____________________

I am employed by:

☐ Self-employed; private practice ☐ A Health Authority

☐ Other employer (please specify) ____________________

I am not employed by an Administering Authority to administer the Nisga'a Social Development Program.

This report and attached documents, if any, contain my findings and considered opinion at this time.

Signature	Date (Year Month Day)	Telephone

Fax	E-mail Address (optional)

Print / Stamp Address

APPLICANT CHECKLIST

CHECKLIST

- ☐ I have completed Section 1, Applicant Information.
- ☐ I have read and signed the Declaration and Consent, Section 1C.
- ☐ The Physician has completed and signed the Physician Report, Section 2.
- ☐ The Physician or the Health Professional has completed and signed the Assessor Report, Section 3.
- ☐ I have included all additional information I want considered.
- ☐ If required, proof of the legal authority to act on behalf of the Applicant is attached.
- ☐ I have kept a copy of all of the above information for my records.
- ☐ I have filled in my name and address in the Acknowledgement of Application below.

Submit the completed Application to the local Administering Authority office.

ACKNOWLEDGEMENT OF APPLICATION RECEIVED BY NLG

Your Application was received on:	

_______________________ Name

_______________________ Address

_______________________ City/Town

_______________________ Postal Code

NLG WILL MAIL A COPY OF THIS ACKNOWLEDGEMENT TO THE ADMINISTRATING AUTHORITY

The Nisga'a Social Development Worker to Mail Completed Application Form to:

PROTECTED B
PWD – Nisga'a Social Development Program
Nisga'a Lisims Government
P O Box 229
New Aiyansh, BC
V0J 3T0

NISGA'A LISIMS GOVERNMENT

PHYSICIAN'S INVOICE

Invoice Date

Application #

Applicant's Name

Applicant's Date of Birth

Personal Health Number

Completion of DBLII Physician Report – Section 2………………….. $ 130.00

Date of Service

Description of Service

Make cheque payable to:

Supplier's Name

Physician's Signature

Address

City

Postal Code

Telephone

ASSESSOR'S INVOICE

Invoice Date

Application #

Applicant's Name

Applicant's Date of Birth

Personal Health Number

Completion of DBLII Assessor Report – Section 3…………………….. $ 75.00

Date of Service

Description of Service

Make cheque payable to:

Supplier's Name

Assessor's (Physician's) Signature

Address

City

Postal Code

Telephone