PWD Approval Notification Step-by-Step

1. Copy your Recon SR number down (either copy via your computer or write it down)
2. Go to the Case
3. Select the Service Requests sub-tab and click New
4. Input the following fields
    a. Type = File Review
    b. Contact Method = Worker Initiated
    c. Priority = Urgent
    d. Dude Date = (as you see fit)
5. "Drill down" into the SR (click on the SR # blue link)
6. Type "RB comment" into the Memo Field
7. Make your notes (the same thing you would write for the notification) beginning with "RB Comment:" and Lock
8. Select Related SRs sub-tab and click Add
9. Paste in or type in your Recon SR number and click Go and OK
10. Change the Service Office to reflect the Local Office (or to the PLMS office)
11. Change SR to Ready
12. Remove your name from Owner field

PWD FLOW CHART

Houskeeping

- Assume File
- Basic Eligibility
- Open file - IA
- Check GA#
- Review HAB Decision to determine what was denied
- Review Client's Self-Report

Medical Diagnoses

- Diagnoses of medical disorders related to the impairment
- Pay attention to the physician's narrative for "hidden" diagnoses.
- Two year duration

Physical Impairment

- Basic physical functioning skills
- Application: pp. 10 & 15
- Assistive device: pp. 9 & 20
- Can mention pp. 11 – mobility inside & outside the home.
- Include any references to these basic skills in the physician's or assessor's narratives if pertinent and not just a repeat.
- Address attachments to application
- Address info in R4R

Mental Impairment

- Basic mental functioning skills
- Application: pp.10, 16 & 19 (Social Functioning)
- Include any reference to these basic skills in the physician's or assessor's narratives and not just a repeat.
- Address attachments to application.
- Address info in R4R

Daily Living Activities

How are impairments to physical skills restricting DLA's?

- Application: pp. 11, 17 & 18
- Include any references to DLA restrictions in physician's or assessor's narratives if pertinent and not just a repeat.
- Address attachments to application.
- Address info in R4R if pertinent.

Daily Living Activities

How are impairments to mental skills restricting DLA's?

- Application: pp. 11 & 17-19
- Include any reference to DLA restrictions in physician's or assessor's narratives if pertinent and not just a repeat.
- Address attachments to application.
- Address info in R4R if pertinent.

Help Criterion

Does the information provided establish that the applicant requires significant assistance from another person in order to perform DLA's? Does the applicant require assistive devices? Does the applicant require support/supervision to maintain him/herself in the community?

ASwift

PWD TRAINING MODULE 1

OVERVIEW AND ORIENTATION TO PWD

Objectives of the module:

- **To provide a basic understanding of how Disability Assistance has evolved over time.**
- **To provide a context for understanding the *Employment and Assistance for Persons with Disabilities Act* and Regulation.**

HISTORICAL REVIEW OF DISABILITY PROGRAMS:

Historically, social assistance has been delivered to British Columbians by various ministries or agencies under changing legislative authorities and names since 1920, beginning with the *Mother's Pension Act* of British Columbia.

Gain For Handicapped (GFH) – 1976-1996

- Established in 1976 under the Guaranteed Available Income for Need Act and Regulations.
- Was a higher rate of income support in recognition of unique needs of handicapped persons.

To be considered a "handicapped person" and receive the higher rate certain criteria had to be met:

> "Handicapped person" meant an individual 18 years of age or older who, at the discretion of the Director (of GAIN), had been designated as handicapped due to the individual being:
>
> - Mentally ill or mentally retarded as defined in section 2 of the *Provincial Mental Health Act*, 1964, or
> - Due to the individual having a physical injury, amputation, or physical malfunction of the body.

Such designation was made only after a qualified medical practitioner confirmed that the disability was apparently permanent, there was no remedial therapy available for the individual that would significantly lessen the disability, and provided that the disability was sufficiently severe that

a) the individual required extensive assistance or supervision to manage normal daily functioning, or
b) as a direct result of the disability the individual required unusual and continuous monthly expenditures for transportation, special diets or for other unusual but essential and continuous needs.

For the purposes of the regulations, the definition excluded individuals who, regardless of any physical or mental disability, had not tried or completed all possible training or retraining for employment and had not tried or completed all possible remedial treatment to overcome their disability.

The designation, by policy, was for the lifetime of the individual.

Disability Benefits Program 1996-2002

The BC Benefits Disability Program was introduced with the implementation of the *BC Benefits Disability Benefits Program Act* and Regulation in 1996.

The intent of the program was to assist persons with disabilities who were in financial need and who required additional support for their disability related needs, and to provide access to medical goods and supplies and other benefits not available through other government programs.

A person with disabilities was defined as either an individual who was designated a handicapped person under the GAIN Act or was a person

a) who was 18 years of age or older
b) who, as a direct result of a severe mental or physical impairment
   - required extensive assistance or supervision in order to perform daily living tasks within a reasonable time, or
   - required unusual and continuous monthly expenditures for transportation, or for special diets, or for other unusual but essential and continuous needs, and
c) who had confirmation from a medical practitioner that the impairment existed and
   - was likely to continue for at least 2 years, or
   - was likely to continue for at least one year and would likely recur.

This new definition removed the restrictive elements related to employability (training or re-training) and remedial treatments. The new approach provided separate statutory and regulatory authority for income assistance to persons with disabilities.

A new application was designed and was open to significantly broad interpretations not only on the part of those who completed the form but adjudicators as well. The application form provided for the collection of information from the applicant, the medical practitioner, and an assessor. Assessors could be qualified health professionals or anyone who the applicant felt could provide support information (e.g. a neighbour or teacher).

The designation, by policy, was for the lifetime of the individual.

PWD – Persons with Disabilities October 2002

The philosophical shift to a culture of self-sufficiency and financial independence brought the introduction of the *Employment and Assistance for Persons with Disabilities Act*. A new definition of persons with disabilities was introduced in the act and a more comprehensive application form was designed to allow the gathering of more detailed information for better evidence based decision making by adjudicators.

The *Employment and Assistance for Persons with Disabilities Act* recognizes that persons with disabilities face unique challenges in daily living and may require supports to employment and/or continuous assistance.

The Act restricts the types of assessors, to qualified health professionals or registered social workers, and the new definition focuses on the functional impact of mental or physical impairments on daily living activities and whether the individual requires help to perform those activities.

The designation, can be reviewed as there is legislative authority to rescind the designation.

Refer to following page: Legislation

LEGISLATION

The following excerpts from the *Employment and Assistance for Persons with Disabilities Act* and Employment and Assistance for Persons with Disabilities Regulation defines persons with disabilities by setting out specific criteria against which the evidence in the application is evaluated.

EMPLOYMENT AND ASSISTANCE FOR PERSONS WITH DISABILITIES ACT

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;

"prescribed professional" has the prescribed meaning.

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

(a) in the opinion of a medical practitioner is likely to continue for at least 2 years, and

(b) in the opinion of a prescribed professional

(i) directly and significantly restricts the person's ability to perform daily living activities either

(A) continuously, or

(B) periodically for extended periods, and

(ii) as a result of those restrictions, the person requires help to perform those activities.

(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.

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

EMPLOYMENT AND ASSISTANCE FOR PERSONS WITH DISABILITIES REGULATION

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 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.

(2) For the purposes of the Act, **"prescribed professional"** means a person who is authorized under an enactment to practice the profession of

(a) medical practitioner,

(b) registered psychologist,

(c) registered nurse or registered psychiatric nurse,

(d) occupational therapist,

(e) physical therapist,

(f) social worker,

(g) chiropractor, or

(h) nurse practitioner.

PWD TRAINING MODULE 2

LEGISLATION AND CRITERIA

Objective of the module:

- **To review the provisions of the *Employment and Assistance for Persons with Disabilities Act* and the Employment and Assistance for Persons with Disabilities Regulation.**
- **To review the 5 key criteria in the legislative test.**
- **To examine the criteria to clarify the intent of legislation with respect to the PWD Designation.**

PERSONS WITH DISABILITIES - INTRODUCTION

The *Employment and Assistance for Persons with Disabilities Act* recognizes that persons with disabilities face unique challenges in daily living and may require supports to employment and/or continuous assistance.

Under the legislation a person with disabilities is a person with a severe physical or mental impairment who is directly and significantly restricted in his or her ability to perform daily living activities either "continuously or periodically for extended periods" and, as a result of these restrictions, requires assistance with daily living activities. That assistance could come from another person, an assistance animal or an assistive device.

The legislation focuses on functional limitations, which makes the definition of disability consistent with human rights case law.

The legislation provides that a disability "designation" may be rescinded. Once granted, a designation is maintained until a review indicates that it should be rescinded. A review shows that a person's eligibility for the designation has changed. Periodically files may be reviewed.

LEGISLATION

The following excerpts from the *Employment and Assistance for Persons with Disabilities Act* (the Act) and Employment and Assistance for Persons with Disabilities Regulation (the Regulation) define persons with disabilities by setting out specific eligibility criteria against which the evidence in the application is evaluated.

EMPLOYMENT AND ASSISTANCE FOR PERSONS WITH DISABILITIES ACT

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;

"prescribed professional" has the prescribed meaning.

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

(a) in the opinion of a medical practitioner is likely to continue for at least 2 years, and

(b) in the opinion of a prescribed professional

(i) directly and significantly restricts the person's ability to perform daily living activities either

(A) continuously, or

(B) periodically for extended periods, and

(ii) as a result of those restrictions, the person requires help to perform those activities.

(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.

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

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 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.

(2) For the purposes of the Act, **"prescribed professional"** means a person who is authorized under an enactment to practice the profession of

(a) medical practitioner,

(b) registered psychologist,

(c) registered nurse or registered psychiatric nurse,

(d) occupational therapist,

(e) physical therapist,

(f) social worker,

(g) chiropractor, or

(h) nurse practitioner.

WORKBOOK EXERCISE

Looking at the legislation excerpt from the *Employment and Assistance for Persons with Disabilities Act* and Regulation identify the essential elements. (i.e. what criteria must be met to approve PWD designation?)

FIVE KEY CRITERIA

CRITERION #1: 18 YEARS OF AGE

Persons age 18 and over can be considered for the *Person with Disabilities* designation. An application can be submitted if the applicant is less than 6 months from his/her 18th birthday to facilitate a smooth transition when the applicant reaches the age of 18.

CRITERION #2: DURATION OF AT LEAST 2 YEARS

The physician completing Section 2 of the application will indicate if the duration of the impairment is expected to be at least 2 years. If the physician indicates the duration is less than 2 years because the case is terminal or palliative, this satisfies the intent of the duration criteria.

CRITERION #3: SEVERE PHYSICAL OR MENTAL IMPAIRMENT MUST BE PRESENT

A physician provides the diagnoses. These are essential but only assist the adjudicator to understand the impairment. The impairment may be physical or mental, and mental impairment includes a mental disorder. The physician and the assessor provide information about the impairment. **The adjudicator determines if the impairment is severe.** This relates to section 2(2) of the Act that states "the Minister is satisfied that the person has a severe mental or physical impairment". An adjudicator makes this determination as the Minister's delegate.

CRITERION #4: SEVERE IMPAIRMENT DIRECTLY AND SIGNIFICANTLY RESTRICTS ABILITIES TO PERFORM DAILY LIVING ACTIVITIES

Prescribed professionals completing the application describe how the impairment directly and significantly restricts the person's ability to perform daily living activities. The adjudicator decides if the information provided by the physician and/or the assessor supports determinations that

- the applicant's ability to perform daily living activities is significantly restricted
- the impairment directly causes the significant restriction of the applicant's ability to perform daily living activities; and
- the applicant's ability to perform daily living activites is restricted either (A) continuously, or (B) peridocially for extended periods.

This relates to section 2(2)(b)(i) of the Act that states "in the opinion of a prescribed professional directly and significantly restricts the person's ability to perform daily living activities either (A) continuously, or (B) periodically for extended periods...".

CRITERION #5: REQUIRE HELP TO PERFORM DAILY LIVING ACTIVITIES DUE TO RESTRICTIONS

Prescribed professionals provide information regarding the help the person requires with daily living activities. The adjudicator determines if information provided by either the physician or the assessor support a determination that as a result of the significant restrictions on the applicant's ability to perform daily living activities, he or she requires help, in the form of an assistive device, help or supervision of another person, or the services of an assistance animal to perform daily living activities. If the applicant requires the help of another person the adjudicator must determine whether the amount or degree of help required is significant. This relates to section 2(2)(b)(ii) of the Act "in the opinion of a prescribed professional...as a result of those restrictions, the person requires help to perform those activities.

All five criteria must be satisfied for the application to be approved.

WORKBOOK EXERCISE

CASE HISTORY # 1

The applicant is a 38 year old female with a diagnosis of Multiple Sclerosis (MS).

Health History: The applicant was diagnosed with MS two years ago after she complained of episodes of arm weakness and clumsiness of the left leg. She also has occasional bouts of double vision. As the disease progresses she will have increased difficulty walking and will most likely need a cane. Presently she manages mobility independently except during recurrences where she may take longer as she stops and rests more often. She complains that during exacerbations she cannot walk to the store or her kids to school the same as she did before and must stop and rest on the way even though the school is only 6 blocks away. She manages lifting, carrying and holding presently but will require increasing assistance in the future. Fatigue occasionally makes it more difficult to do heavy housework and yardwork and she receives periodic assistance in these areas. Presently her spouse is very supportive and assists her when needed. Over the past year she has experienced 3 recurrences that have lasted from 3 days to 2 weeks. As the disease progresses the episodes will become more frequent and the symptoms will become more limiting in that she will require some assistance with daily living activities.

CASE HISTORY # 2

The applicant is a 42 year old male with a diagnosis of Hepatitis C (Hep C) and substance addiction issues.

Health History: The applicant has faced a number of substance related problems over the years and is now Hep C positive with a positive RNA. He is suffering some depressive symptoms (with decreased motivation and attention/concentration), probably related to his Hep C diagnosis which compounds his fatigue. He experiences chronic fatigue and some days doesn't get out of bed. He takes significantly longer walking outdoors, climbing stairs and requires periodic assistance with carrying. He lives alone but gets assistance from his landlord or a friend with daily shopping and cooking and generally doesn't keep very good personal hygiene. He takes significantly longer with basic housekeeping and often lets this go. When depressed he self isolates and has marginal functioning with social networks. He has not undergone treatment yet but ribavirin with interferon will be considered shortly.

PWD TRAINING MODULE 3

THE APPLICATION FORM

Objective of the module:

- **To provide an overview of the application form.**
- **To understand how the questions in the form relate to the requirements contained in the *Employment and Assistance for Persons with Disabilities Act* and Employment and Assistance for Persons with Disabilities Regulation.**
- **To understand the intent of the questions contained in the application.**
- **To understand the definition of Prescribed Professional (as it pertains to the Assessor) under the Regulation.**

THE PWD DESIGNATION APPLICATION FORM

The PWD application form was designed following consultation with stakeholders (e.g. Occupational Therapists, Social Workers, Physicians, Psychologists, Canadian Mental Health Association, among others) to allow for comprehensive information to be gathered to support evidence-based decision making by adjudicators.

The application consists of three sections:

- Section 1: Applicant Information
- Section 2: Physician Report
  Must be completed by a "medical practitioner" as defined in the *Interpretation Act*.
- Section 3: Assessor Report
  Must be completed by a prescribed professional as defined in the Employment and Assistance for Persons with Disabilities Regulation (the Regulation).

NOTE: The information provided in the narrative sections of the application should not be considered in isolation. This is particularly true if the information provided supports a denial.

SECTION 1: APPLICANT INFORMATION

A. <u>Personal Information</u> (pg 3) – This information is required to properly identify the applicant in order to ensure that the correct person receives the designation and any related benefits (the SIN number is the best means of identifying the correct client). This section also includes the applicant's birthdate. This allows for verification that the applicant meets the age criterion (at least 18 years old).

B. **Disabling Condition** (pg 3-5) – The information provided by the applicant is useful to provide insight into the applicant's perspective on their disability and also serves to provide a context for the other parties who are completing the form. The applicant provides a self-report indicating their diagnosis, level of impairment and resulting restrictions to function from their point of view. The adjudicator must read and consider this information. If there is inconsistency between the information provided by the applicant and either of the prescribed professionals, the adjudicator must decide how to weigh this evidence. This determination must be described clearly in the decision summary. The applicant has the choice not to complete this section and the application is to be considered whether information is provided or not.

C. **Declaration** (pg 5) – The applicant declares that the information provided in Section 1 is true and agrees that the Ministry may verify the information provided in all sections of the Application. The Declaration must be signed below the declaration statement in order for the application to be adjudicated. If an application is submitted unsigned, attempts should be made to obtain the signature where this is possible. Except in extraordinary circumstances, the Declaration must be signed below the declaration statement in order for the application to be adjudicated. If you have any questions check with a senior adjudicator prior to adjudication (also see Module 5).

SECTION 2: PHYSICIAN REPORT

A. **Diagnoses** (pg 8) – Diagnoses related to the person's impairment are required to establish a foundation to understand the physical or mental impairment. Note: although the question does ask for the "diagnoses relating to the Applicant's impairment", many physicians include a complete list of medical conditions and it may be helpful to the adjudicator to determine which conditions contribute to the severe impairment.

B. **Health History** (pg 9) – This section elicits information regarding the severity of the relevant medical conditions. A diagnosis alone does not provide this information, as many conditions have a wide range of impact on impairment. The physician is asked for test results or reports that may be appropriate.

Height and weight (if relevant) – this information is valuable where gross obesity or underweight conditions are a significant factor relating to the Applicant's impairment.

Medications/treatments that interfere with Daily Living Activities (DLAs) and the anticipated duration of the medications/treatments – this information helps the adjudicator to understand the impairment and is valuable in the determination of an appropriate review date. Sometimes the physician will list medications but be unclear regarding the side effects or how they interfere with DLA's. It is helpful to have an understanding of the side effects of certain medications (e.g. Compendium of Pharmaceuticals and Specialties). However,

unless it is indicated in the application that the applicant experiences these the adjudicator cannot assume whether or not the applicant experiences them.

Prostheses or Aids (pg 9) – This is the physician's opinion as to whether the applicant is reliant on any assistive devices or prostheses in order to manage with their impairment. This is one indicator of the applicant's level of disability and mobility.

C. **Degree and Course of Impairment** (pg 10) – This section provides information to address the following requirements of the Act section 2(2) "...the minister is satisfied that the person has a severe mental or physical impairment that..." and section 2(2)(a) "in the opinion of a medical practitioner is likely to continue for at least 2 years...". The PWD designation cannot be determined if the impairment is not indicated to continue for two or more years (from the date of the application).

The question regarding remedial treatment provides information to assist in the determination of an appropriate review level (full, partial, minimal). It may also clarify which condition establishes duration.

D. **Functional Skills** (pg 10) – This section relates to the degree of impairment. The Act, section 2(2)(b)(i) states "in the opinion of a prescribed professional directly and significantly restricts the person's ability to perform daily living activities...". Information is requested regarding the following functional skills:

- Mobility - walking, stair climbing
- Endurance - walking, stair climbing, lifting, sitting
- Communication
- Cognitive and emotional functioning (note: always relevant in mental impairment cases and sometimes relevant in physical impairment cases).

All of these are relevant to the severity of the physical and mental impairment and will provide evidence as to the effects of the impairment on the defined daily living activities.

E. **Daily Living Activities** (pg 11) – The Act, section 2(2)(b), requires the opinion of a "prescribed professional" regarding: (a) restrictions to the person's ability to perform daily living activities, and (b) the help the person requires with these activities. The physician completing this section provides an opinion on which DLA's are restricted and the degree of restriction. The information captured in this section is augmented by the Assessor Report, Section 3 which provides further details of the degree of restriction and whether all or part of each DLA is affected.

F. **Additional Comments** (pg 12) – This section provides the physician with the opportunity to include useful additional information on the applicant's condition. We also specifically ask about an applicant's hospitalizations.

G. **Frequency of Contact** (pg 12) – This provides the adjudicator with insight into the physician's familiarity with the applicant's medical condition and history. This is important as it helps the adjudicator assess the weight to be given to the information provided.

H. **Certification** (pg 12) – The physician indicates that they are registered to practice medicine in BC, whether they are a General Practitioner (GP) or a Specialist, their registration number and by providing their signature certify that the information they provide is their opinion at that time. They are asked for contact information and an office stamp. This provides the adjudicator with a method of contacting the physician should this be required and provides context as to the physician's role in the applicant's medical care (i.e. specialist vs. GP).

SECTION 3, ASSESSOR REPORT

A. **Living Environment** (pg 15) – This section provides information about assistance or help required.

B. **Mental and Physical Impairment** (pg 15-16) - The PWD definition requires that the impairment directly and significantly restrict the applicant's ability to perform daily living activities, so the relationship between the impairment and the restriction must be established (the Act section 2(2)(b)(i)). Diagnoses that are included from an assessor, other than a medical practitioner, are not provided for under the legislation. **Where the additional diagnoses provided by the assessor are instrumental in either the approval or denial of the application, the adjudicator must confirm the diagnosis with a physician.**

1. What impairments impact the applicant's ability to perform DLA's (pg 15): The assessor is asked about impairments to determine the prescribed professional's focus and understanding of the applicant's situation. Where this is not consistent with the physician's report, the adjudicator will determine which report writer is likely to have the more relevant expertise regarding the impairment and give more weight to that information or determine if further clarification is required to reach a decision. (Refer to the Guidelines for Requesting Clarification).

2. Ability to Communicate (pg 15): This is part of the determination of the nature and extent of impairment. English as a Second Language issues are not indicative of an impairment, unless it is indicated that the applicant is unable to learn English due to a medical condition.

3. Mobility and Physical Ability (pg 15): This relates to the determination of the nature and extent of impairment. This section is used in both the determination of the presence of a severe mental or physical impairment (criterion 3) and whether that impairment directly and significantly restricts applicant's ability to perform daily living activities (criterion 4). It should be used in conjunction with the physician's information provided on page 10.

If the assessor indicates periodic or continuous assistance is needed then the requirement for 'significant help' is established as a result of the footnotes. Periodic assistance means "the need for significant help for an activity some of the time..." and continuous assistance means "needing significant help most or all of the time...".

The application does not ask that the assessor to identify the frequency or duration of assistance that is required. This information is needed to determine 'extended periods of time' when determining periodic assistance. If no information is available to the adjudicator in the narrative then the adjudicator must seek clarification.

The application form asks the assessor to indicate whether or not an assistive device is used and to specify assistive device(s) needed. It also asks the assessor to indicate if the task takes 'significantly longer' to perform and to describe how much longer.

4. Cognitive and Emotional Functioning (pg 16): This section is only to be completed for an applicant with an identified mental impairment including a brain injury. Some applications have this question completed when there is no mental impairment identified. In these circumstances, the adjudicator should consider this information as augmenting information regarding daily functioning.

When a mental impairment is identified the adjudicator uses the information in this section with the physician's information from page 10 to understand the impact of the impairment on daily functioning, including social functioning (see Section 3C). The assessor is asked to indicate the level of impact the applicant experiences in 14 areas. The adjudicator is to determine whether the impairment is severe (is there 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),

C. The assessor can provide additional comments which can be very helpful to provide a 'picture' of the significant restrictions faced by the applicant. **Daily Living Activities** (pg 16-19) – The activities that are DLAs are listed in the Regulation section 2(1)(a) and (b). Questions asked here capture information on the impact of the applicant's impairment on each daily living activity listed in regulation. In relation to a person who has a severe physical impairment or a severe mental impairment DLAs are:

- prepare own meals;
- manage personal finances;
- shop for personal needs;
- use public or personal transportation facilities;
- perform housework to maintain the person's place of residence in acceptable sanitary condition;
- move about indoors and outdoors;

- perform personal hygiene and self care; and
- manage personal medication.

In relation to a person who has a severe mental impairment, there are two additional DLAs:

- make decisions about personal activities, care or finances; and
- relate to, communicate or interact with others effectively.

NOTE: the determination of whether the restriction is "direct and significant" must be made after considering the person's overall or 'global' ability to perform daily living activities.

Information is also collected regarding the assistance that the applicant requires with DLAs. This meets the requirement in the Act, section 2(2)(b)(ii), that the applicant must need help to perform the DLA's where he or she experiences significant restrictions due to the severe physical or mental impairment. The application does not ask that the assessor identify the frequency or duration of assistance required. If the assessor has not provided information regarding the frequency and duration such that 'extended periods of time' can be determined the adjudicator must seek clarification.

It is recognized that there are situations where an applicant may "require help" with DLAs, but maintains independence by persisting in taking whatever time is required to perform the tasks or enduring the resulting pain or other difficulty. So as to not exclude these individuals from consideration for the PWD designation, for each daily living activity, the assessor is asked if it takes the applicant 'significantly longer than typical' to perform the activity. The assessor is asked to "describe how much longer" when indicating this box.

Separate questions are asked with regard to "Social Functioning" (pg 19) for those applicants who have an identified mental impairment. Social functioning relates to the definition of DLAs in the Regulation as it is understood to mean "daily decision making, interacting, relating and communicating with others."

Additional Comment: at the bottom of each page the assessor is able to provide additional comments. They are specifically asked to identify any safety issues as well as describe the type and amount of assistance. The information provided in the narrative should not be considered in isolation, rather it should be considered along with the rest of the information provided in the application.

D. **Assistance Provided For Applicant** - this section relates to the Act, section 2(2)(b)(ii) which states "as a result of the restrictions [with DLAs], the person requires help to perform those activities." Section 2(3)(b) defines assistance as being significant help or supervision from a person, an assistive device or an assistance animal.

The **adjudicator determines,** based on the information provided, if the assistive device is required to enable the applicant to perform the daily living activity that, because of a severe impairment the person is otherwise unable to perform.

E. **Additional Information** – This section may provide useful additional information on the applicant's functioning.

F. **Approaches and Information Sources** - In general this contributes to a fulsome understanding of the information reported.

G. **Frequency of Contact** – This section provides the adjudicator with information about how well the prescribed professional knows the applicant and in what professional capacity.

H. **Certification** – This section elicits information to establish whether the assessor is "qualified" under the Act to complete Section 3 of the application. The Regulation, section 2(2) defines "prescribed professional" as a person who is authorized under an enactment to practice the profession of:

- medical practitioner
- registered psychologist
- registered nurse or registered psychiatric nurse
- occupational therapist
- physical therapist,
- social worker(g) chiropractor, or
- nurse practitioner.

This is not discretionary; therefore, it is important that the adjudicator establishes that the assessor meets this definition. For the Social Worker category the individual must be entitled to use the title "Social Worker" under the *Social Workers Act*:

8 (1) A person must not represent himself or herself as a social worker unless the person

(a) is registered in accordance with rules made under section 4,
(b) is employed as a social worker by
(i) Canada or the government or an agent of either,
(ii) a board, commission or other body any member of which is appointed by Canada or the government,
(iii) a municipality, regional district, hospital district board or board of school trustees,
(iv) an Indian band, a tribal council, the Nisga'a Nation or a Nisga'a Village, or
(v) a society incorporated under the *Society Act* and approved by the director designated under the *Child, Family and Community Service Act* for the purpose of section 2(1)(a) of the *Society Act*, or
(c) teaches or is engaged in research as a social worker under an academic appointment or program in a university, college or institute.

To meet criteria 8(1)(a) the social worker must be registered with the British Columbia College of Social Workers (BCCSW) (not the Association of Social Workers) and should provide their registration number. If the number is not provided, contact the assessor to obtain it.

PWD TRAINING MODULE 4

PWD ADJUDICATION FUNDAMENTALS – GUIDELINES AND APPLICATION OF CRITICAL DEFINITIONS

Objective of the module:

- **To review the guiding principles of the adjudication guidelines.**
- **To understand the principles of Administrative Fairness.**
- **To understand the relationship of the guidelines to the adjudication process and how to use them.**
- **To understand the intent of the legislation and the definitions of critical terms.**
- **To understand the Guidelines for Requesting Clarification.**

INTRODUCTION

The PWD application elicits information from the applicant, medical practitioner and other prescribed professionals, relative to the five key criteria for PWD designation, all of which are fundamental to an evidence-based decision making process. Personal knowledge of or biases about specific diagnoses should not be used to make assumptions in order to arrive at a decision.

Acquired expertise will effectively assist adjudicators in determining the need for further clarification. Adjudicators are not to "read between the lines" to arrive at their decision. Adjudicators must consider all the information provided in the application as a whole. The information provided in the narrative should not be considered in isolation, rather it should be considered along with the rest of the information provided in the application. This is particularly true if the information provided supports a denial.

Examining the information to make fair, consistent and reliable decisions requires an organized and structured approach. Adjudication guidelines provide the structure and support for an objective assessment of the information submitted.

Therefore the purposes of the adjudication guidelines are to:

- assist adjudicators in determining eligibility for the *Persons With Disabilities* (PWD) designation outlined in the *Employment and Assistance for Persons with Disabilities Act* (the *Act*) and Employment and Assistance for Persons with Disabilities Regulation (the Regulation).

- ensure consistency in the interpretation of the evidence-based information provided in the PWD Designation Application.

- ensure the decision making process is reliable, transparent, effective and administratively fair.

ADJUDICATION PRINCIPLES

These guidelines are based on the following principles:

- Decisions are based on the information provided in the application as it relates to the criteria outlined in legislation and by following the principles of administrative fairness.
- Criteria are met when, on a balance of probabilities, the information indicates that the legislation has been satisfied.
- Knowledge and acquired expertise about the medical condition is applied only to determine when clarification of information is required of the referring professionals.
- Guidelines support objectivity by providing a cumulative basis for evidence-based decisions.
- Results of the adjudication process must be clear, have integrity, and display full and substantive reasons for the decision.

ADMINISTRATIVE FAIRNESS

Adjudicators make important decisions that affect the lives of applicants. Given this, it is critical that the process and procedures used to make this determination follow a consistently fair procedure. The principles of administrative fairness are:

THE CLIENT HAS A RIGHT TO UNDERSTAND THE DECISION AND HAVE THE OPPORTUNITY TO RESPOND.

This principle requires that the applicant is given adequate notice of a decision and is provided with all of the information that was considered in the decision making process. This is achieved through providing substantive reasons to the applicant. The Reconsideration and Appeal process provides the client with the opportunity to respond to the decision. For this reason, it is critical that the applicant be provided the Reconsideration and Appeal pamphlet with the written decision.

In cases where the physician and/or assessors sends a completed application directly to the ministry, the applicant will most likely not have a copy of the completed form. As a result, the complete information relied upon by the adjudicator and information potentially needed to draft a Request for Reconsideration is not available to the applicant. If the applicant advises that she or he would like to request a reconsideration of a PWD denial decision, the applicant must be provided a copy of "all documents and information" that were relied upon in determining the applicant did not meet the eligibility

criteria. Unless the applicant has confirmed that they have a copy of the completed PWD application form which was submitted to the ministry, a copy is to be provided to the applicant, along with the Request for Reconsideration form.

A copy of all information obtained through clarification with physicians and/or assessors must also be included. Adjudicators are reminded not to use any information that is pre-existing in the applicant's file. Only information in the application and obtained through clarification should be taken into consideration.

THE DECISION MAKER MUST GIVE REASONS FOR THE DECISION.

The adjudicator must provide reasons for the decision. The applicant must be provided with clear and substantive reasons for the decision. This includes referring to the information submitted by the applicant in addition to the applicable legislation, regulations and policy. It must also document the reasoning the adjudicator relied on when making the decision. This includes all information obtained through clarification with physicians and assessors. This ensures that the applicant is aware that the ministry considered all of the information presented and how that information was assessed against the eligibility criteria. The decision should clearly explain how the decision was arrived at. The adjudicator should not use any information that is pre-existing in the applicant's file, only the information in the application and obtained through clarification should be taken into consideration. (For the nine steps in communicating decisions see Module 5)

THE DECISION MAKER IS IMPARTIAL AND UNBIASED.

An unbiased decision maker means the adjudicator making the decision and relies only on the arguments and evidence that are presented by the applicant and related parties (i.e. prescribed professionals). The adjudicator cannot have, or appear to have, a personal connection with the applicant or a personal interest in the outcome of the decision. Additionally, the adjudicator must avoid showing bias in their attitudes or assumptions towards particular types of people or their situations.

THE PERSON WHO HEARS THE CASE MUST MAKE THE DECISION.

The adjudicator who reviews the information is obligated to make the decision. While they may seek advice from others, they cannot delegate making the decision or allow the advice they have received to replace their own reasoning.

LEGISLATION

The following excerpts from the *Employment and Assistance for Persons with Disabilities Act* and Employment and Assistance for Persons with Disabilities Regulation define persons with disabilities by setting out specific eligibility criteria against which the evidence in the application is evaluated.

EAPWD Act

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;

"prescribed professional" has the prescribed meaning;

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

(a) in the opinion of a medical practitioner is likely to continue for at least 2 years, and

(b) in the opinion of a prescribed professional

(i) directly and significantly restricts the person's ability to perform daily living activities either

(A) continuously, or

(B) periodically for extended periods, and

(ii) as a result of those restrictions, the person requires help to perform those activities.

(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.

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

EAPWD REGULATION

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 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.

(2) For the purposes of the Act, **"prescribed professional"** means a person who is authorized under an enactment to practice the profession of

(a) medical practitioner,

(b) registered psychologist,

(c) registered nurse or registered psychiatric nurse,

(d) occupational therapist,

(e) physical therapist,

(f) social worker,

(g) chiropractor, or

(h) nurse practitioner.

FIVE KEY CRITERIA

The five key criteria are:

1. 18 Years of Age
2. Duration of at Least Two Years
3. Severe Physical or Mental Impairment Must be Present
4. Severe Impairment Directly and Significantly Restricts Ability to Perform Daily Living Activities
5. Requires Help to Perform Daily Living Activities Due to Restrictions

All five criteria must be satisfied for the application to be approved.

CRITERION ONE: 18 YEARS OF AGE

OVERVIEW

The age of the applicant is only required to determine that the applicant meets the legislated criterion for a minimum age of 18 years. Persons age 18 and over can be considered for the *Person with Disabilities* designation.

An application can be adjudicated if the applicant is less than 6 months from his or her 18th birthday to facilitate a smooth transition when the applicant reaches the age of 18. Applications from MCFD's At Home Program are handled according to the At Home transition process.

CONSIDERATIONS IN ADJUDICATION

RELEVANCE

In most cases age should not influence the decision making process. Just because a person is past a certain age, his or her case should not be adjudicated in a different manner than a younger person with the same circumstances. However, the severity of some medical conditions, though not severe in themselves, could be exacerbated by advancing age to the point of causing a severe impairment which significantly restricts DLAs.

AGE OF ONSET OR IMPACT ON RECOVERY

The age of onset may impact some conditions. Likewise, recovery could be compromised in older applicants with certain conditions. Where there is an impact of age on the severity of impairment, the evidence must be documented in the Physician and/or Assessor Reports. The adjudicator cannot make assumptions regarding the impact of age on impairment and restrictions with DLAs when the prescribed professionals have not indicated this to be the case.

Where the impact of age is on duration of the condition/illness, the adjudicator should consider the extra time needed for recovery and set the review period accordingly. Similar to above, the extra time must be noted by a prescribed professional.

CRITERION TWO: DURATION OF AT LEAST TWO YEARS

OVERVIEW

The physician completing Section 2 of the application will indicate if the duration of the impairment is expected to be at least two years. In general, it is assumed that the duration is from the date of the physician's signature. The PWD designation cannot be granted if the duration of the impairment is indicated to be less than two years. However, if the case is palliative or terminal, as indicated by the physician, then the application can be approved regardless of the duration specified.

CONSIDERATIONS IN ADJUDICATION

PHYSICIANS ONLY

The duration criterion can **only** be satisfied by the physician. In Section 2 of the application the physician may indicate duration by checking the appropriate box, through providing an explicit narrative or with supplemental information elsewhere in the application.

It is important for the adjudicator to consider the question of duration with respect to the severe impairment and not any medical condition or underlying issue causing the severe impairment. The medical condition may last more or less (although probably not likely) than two years; however, it is the severe impairment that must last at least two years.

SEVERE ILLNESS VS IMPAIRMENT

The physician sometimes mistakes the duration criterion and refers to the illness rather than the impairment. This is often seen with applicants who have severe illness. The physician will indicate that the duration will not last two years because they are unsure of the impact of the treatment (e.g. chemotherapy). However, the requirement is that in the opinion of the physician, the impairment is 'likely' to continue for at least two years. In complex cases such as these, check with the senior adjudicator to determine if additional clarification should be sought.

It is important for the adjudicator to assess Criterion 2 with respect to the duration of the impairment and not the duration of the medical condition.

CRITERION THREE: SEVERE PHYSICAL OR MENTAL IMPAIRMENT MUST BE PRESENT

OVERVIEW

The adjudicator must determine if a severe physical or severe mental impairment exists after reviewing the information provided by the applicant (Section 1), the physician (Section 2) and the assessor (Section 3). Section 2(2) of the Act states "if the minister is satisfied that the person has a severe mental or physical impairment...". The adjudicator represents the Minister in making this determination; therefore **the adjudicator determines if the impairment is severe.**

The applicant, physician and assessor provide information about the impairment. A physician provides the diagnoses. These are essential but only assist the adjudicator to understand the impairment. Sometimes an assessor will provide additional diagnoses; if the assessor is not a physician, and the additional diagnoses is instrumental in either the approval or the denial of the application, the additional diagnoses must be confirmed by a physician.

To determine severity, the adjudicator must decide if the information provided in the application demonstrates that the applicant's physical or mental function is severely restricted and results in an impairment. The ministry has adopted the World Health Organization's (1980) definition of impairment. This definition states that an 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"*. Evidence of severity of the impairment may be found anywhere in the application form.

CONSIDERATIONS IN ADJUDICATION

APPLICANT SELF REPORT (SECTION 1)

The applicant provides a self-report indicating their diagnoses, level of impairment and resulting restrictions to function from their point of view. The adjudicator must read and consider this information. If there is inconsistency between the information provided by the applicant and either of the prescribed professionals, the adjudicator must decide how to weigh this evidence. This determination must be described clearly in the decision summary.

DISTANCE FROM THE NORM

In determining severity, the adjudicator must consider the degree of functional loss that impacts independence and effectiveness in overall day-to-day functioning.

To simplify, impairment means loss of structure or function, either mental or physical that affects a person's ability to function at a normal level. The degree of impairment is determined by establishing the distance from the functional norm.

IMPACT NOT DIAGNOSIS

The physician often uses the terms mild, moderate and severe to describe a medical condition or a symptom. The adjudicator must focus on the impairment resulting from the diagnosis and not the diagnosis itself. The severity would be determined by the impacts on the applicant's ability to function.

ASSESSING THE DEGREE OF PHYSICAL IMPAIRMENT

Both the physician (Section 2(D), page 9 &10) and the assessor (Section 3(B), page 15) are asked to provide information related to the applicant's physical impairment. It is important to note that either prescribed professional may address the physical impairment in their narrative. The physician is asked to identify how far the applicant can walk unaided, how many stairs they can climb unaided, how long they can remain seated, how much they can lift and what type of prostheses or aids they need. The assessor is asked to identify what type of help, from another person or an assistive device, the applicant requires in order to walk, stand, climb stairs, lift, carry or hold. They are also asked to specify how much extra time, if any, is required with these tasks.

The adjudicator should pay attention to the link between the diagnosis, the physician's assessment and the assessor's information as these three sets of information should logically align. When the assessor's information and the physician's diagnosis and assessment differ, determining the actual level of impairment can be difficult and the adjudicator should seek clarification to resolve the differences.

EXPLANATION OF MENTAL IMPAIRMENT

A mental impairment can be caused by many categories of diagnoses including, but not limited to: developmental delays, neuroses, psychoses, schizophrenia, bipolar mood disorders, severe depression, drug or alcohol misuse, autism, chromosomal disorders, dementia, or personality disorders, in addition to a brain injury. A brain injury can result from a number of factors including, but not limited to: birth trauma, congenital conditions, addictions, cardio-vascular accidents, and traumatic injuries.

Personality traits, disagreeable dispositions and impulsive tendencies are not mental impairments. Similarly, lifestyle choices or low levels of education are also not considered mental impairments. Some of these may result from a mental impairment, but they are not in and of themselves a mental impairment.

ASSESSING MENTAL IMPAIRMENT: COGNITIVE AND EMOTIONAL FUNCTIONING

There are two sections in the application where specific information regarding cognitive and emotional functioning is gathered in order to assess the mental impairment or brain

injury. The physician completes Section 2(D)(6), (page 10) and the assessor completes Section 3(B)(4), (page16).

The section on page 10 is used to determine if there is **an identified mental impairment.** The physician is asked if there are any **significant** deficits with **cognitive and emotional function.** There is a yes/no/unknown response. If the physician indicates "yes" the direction is to check the appropriate boxes that describe 12 possible areas where deficits are evident. Through the check boxes the physician indicates that the significant deficit exists. The physician may use the narrative (comments) to describe the degree of the deficits.

The section on page 16 is used to determine the **degree** of the mental impairment. The assessor is instructed to complete the item only if there is an identified mental impairment or brain injury. This may be identified on the basis of the diagnosis or on the information provided by the physician. The assessor is asked to determine the degree of impact that cognitive and emotional deficits have on 14 daily functions. They may indicate "no" "minimal" "moderate" or "major" impact. There is sufficient room on the application for an assessor to provide explanation as to how the impacts affect functioning. However, a narrative is not required unless the assessor has indicated that the impact is episodic or varies over time.

At times an assessor will identify some of the 14 factors impacted when there is no indication of a mental impairment. The adjudicator should consider this information as augmenting the information provided regarding the applicant's daily functioning as long as it is directly related to their impairment. **The adjudicator must focus on factors that suggest severe impacts on independent, effective and appropriate functioning in determining the degree of mental impairment.**

ASSESSING IMPACT OF ADDICTIONS

Addictions are classed by the medical community as a mental health condition and therefore are to be considered by the adjudicator as a medical condition that could cause impairment depending on the client's specific circumstances. Information provided by the prescribed professionals regarding drug and alcohol diagnoses should be adjudicated as any other medical condition.

There are several factors that need to be considered when determining the severity of any resulting impairment. The addiction may complicate other medical conditions or compromise mental health treatment and contribute to general ill health. Because there is no guarantee that if the addictions were treated that the applicant would return to full functioning, the adjudicator must make their determination of impairment on the current situation. The adjudicator may choose to issue a 'full' review in cases where addictions play a part in the applicant's impairment due to the possibility of rehabilitation.

Assessing Multiple Diagnoses

Most cases will include information or evidence of more than one diagnosis.. Generally, only one or two medical conditions contribute in a significant way to the impairment, and the physicians often list the rest as extra information.

The diagnoses can be related to each other or can be separate and affect different organs or systems. The symptoms related to the diagnosis may be all physical, all mental, or a combination of both. They may be chronic, or acute; recently acquired or of long standing. They can be progressive, improving, or static. The complex interactions of the treatments and prognoses often make it difficult for the adjudicator to make a decision. It is important to weigh all the information regarding the diagnoses. The adjudicator must explain how the information provided contributed to the decision.

Causal relationship to impairment and severity:

The adjudicator is to determine which diagnoses are most relevant in causing impairment that will last for a period longer than two years and the subsequent restrictions on DLAs.

Cumulative impact of conditions:

A common difficulty occurs when there is both a physical impairment that on its own is not severe, and a mental impairment that is also not severe. Each case must be assessed individually to determine if there is an interaction between the two that results in a severe impairment that significantly restricts the person's ability to perform DLAs.

Adjudicators are not to draw conclusions about the cumulative impact of multiple diagnoses in the absence of evidence. If the adjudicator feels the evidence provided may result in an impairment, but that is not explicitly stated they should follow up with the physician to clarify.

Medications and Treatments

Impact

The effects of medications and treatments need to be assessed in determining both severity of the impairment and the degree of restriction to DLAs. There are situations where medications or treatments can reduce the severity of the impairment to the extent that the person is no longer significantly restricted in performing DLAs. On the other hand, there are other situations where the improvement is minimal or transitory.

Note: The length of time a person has been taking the medications or receiving a treatment is relevant in determining whether its effectiveness in reducing the severity of the impairment and/or the restrictions in DLAs is enduring or transitory.

Current situation

Each case is adjudicated according to the degree of impairment and restriction to DLAs that typifies the applicant's **present situation**, not how they **would** function if they did not have the medication or treatment they have now, or how they would function with different or new medication or treatment.

Side effects

It is important to note that the side effects of treatment or medications may be causing impairment, and an explanation of the impact on functioning is required in the application. Length of the medication/treatment protocol will assist in determining if the severity and duration criteria are met and/or in setting an appropriate review period.

Difficulties in adjudication arise when:

(a) the explanation of the side effects of the treatment is not given,
(b) it is unclear for how long the treatment is required, or
(c) it appears the side effects are overstated.

ASSESSING DETERIORATING CONDITIONS

Most chronic medical conditions deteriorate over time to a greater or lesser degree depending on the following factors:

- overall health of the applicant
- aggressiveness of the disease
- interactions with other medical conditions
- treatments

The long-term consequences of some conditions are catastrophic and it is often the end result that can influence the adjudicator's decision. While this is understandable, **the adjudicator must assess the application on the basis of the situation presented at the time of the application and not what may occur in the long run.** A person can re-apply for PWD when the situation has deteriorated and affects DLAs.

Special consideration needs to be applied for applicants with terminal illness or catastrophic conditions (e.g. cancer). It is reasonable to expect that applicants may require assistance and experience physical impairments as a result of the treatment that they must undergo (e.g. chemotherapy) despite the fact that their current level of functioning is normal. The physician may write something such as "may require some help in the future" or "terminal illness". The adjudicator must determine if the application contains sufficient information to indicate an impairment and a restriction to the ability to perform DLAs is imminent and can be demonstrated. If the information suggests that this may be the case, but is not clear, seek clarification from the physician.

CRITERION FOUR: SEVERE IMPAIRMENT DIRECTLY AND SIGNIFICANTLY RESTRICTS ABILITIES TO PERFORM DAILY LIVING ACTIVITIES (DLAS)

OVERVIEW

Questions regarding DLAs capture information on the impact of the applicant's impairment on each daily living activity defined in regulations. DLAs are those activities people normally tend to everyday without needing assistance. Once it has been established that the person has a severe impairment, **the adjudicator must determine if the applicant's ability to perform DLAs is directly and significantly restricted by the impairment either continuously or periodically for extended periods and if, as a result of those restrictions, the person requires help to perform those activities.**

The information related to DLAs is provided by the physician (Section 2(E) page 11 and 12) and the assessor (Section 3(C) page 17 – 19). The Regulation section 2(1)(a) and (b) defines daily living activities as the following:

(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 effective.

CONSIDERATIONS IN ADJUDICATION

DAILY LIVING ACTIVITIES (DLAS)

In assessing DLAs, the adjudicator should refer to the following guidelines:

- Restricts
- Significantly Restricts
- Periodically for Extended Periods
- Takes Significantly Longer

The adjudicator must assess the information provided regarding DLAs in the context of the intent of the legislation.

DIRECTLY RESTRICTS

Directly means that the impairment is the immediate cause of the restrictions and not extraneous or intervening factors.

Examples of extraneous factors include:

1. Social situation - having to provide care for others (e.g. childcare, caring for disabled spouse)
2. Geographical location - distance from stores
3. Lack of financial resources - lack of affordable housing (cooking, lack of facilities or safe storage) or a lack of transportation (no car, or can't afford to take public transit)
4. Lack of sufficient education - poor reading or writing skills
5. Lack of knowledge rather than an inability - "never learned to cook" or "has never had to do own laundry"

The adjudicator has to ensure that the restrictions identified in the report directly cause the impairment.

SIGNIFICANTLY RESTRICTS

Significantly means that the restrictions caused by the impairment prohibit or substantially limit an individual's ability to perform DLAs as compared to the ability of the average person, of a similar age in the general population, performing the same activity. **The adjudicator must consider the age appropriate norms for stamina, agility, strength, sensory perception, and mental alertness when assessing these abilities.**

It is important to note that the physician is only asked to provide additional information regarding restrictions if the restriction is "periodic" and in relation to impacts to "social functioning". Physicians are asked to provide comments regarding the degree of restriction and what assistance is required (section 2(E), page 11). The assessor is asked to provide information regarding the type of assistance required and how much longer it takes the applicant to perform DLAs. They are also asked to explain or describe the degree and duration of the support or supervision required in relation to social functioning (Section 3(C), page 17-19). If the information provided is not sufficient for the adjudicator to determine whether a significant restriction exists, they must contact the physician or assessor to clarify. See **Guidelines for Requesting Clarification** for more information.

In order for an applicant to be 'directly and significantly restricted' in their ability to perform DLAs the adjudicator must consider the applicant's **overall or global** ability to perform DLAs. The inability to perform fractions or segments of the defined activities

does not meet the test of significant restriction although if the person is unable to perform a major portion of that activity, they may meet the test.

In cases where the impairment may be episodic in nature and the restrictions may be periodic at varying duration, **the adjudicator must assess the frequency and duration of the restrictions in order to determine if the person is significantly restricted.**

PERIODICALLY FOR EXTENDED PERIODS

In the Act, the phrase "periodically for extended periods" is used in relation to defining both the frequency of the restriction (i.e. how often) and the duration over which it occurs (i.e. over what period of time). The term periodic is used in the application in two areas. The first describes the nature or duration of a restriction on DLAs (page 11). The other describes the amount or frequency of help that is provided by another person (page 17 – 19).

ASSESSING FREQUENCY AND DURATION

The adjudicator, having established that there are significant restrictions, must now determine if the restrictions occur continuously or periodically for extended periods. The adjudicator does this by determining the frequency and duration of the restrictions. The physician or assessor may provide information related to the frequency and duration of the restriction anywhere in their narrative. It is important to note that, with the exception of the physician's requirement to comment on the periodic duration of restrictions, neither the physician nor the assessor are specifically required to provide information related to the frequency or duration of the restriction. If the physician does not answer the "if periodic please explain" question on page 11, and there is not information provided elsewhere in the application, the adjudicator must seek clarification.

Once the frequency and duration are clear, the adjudicator needs to determine if this meets the criteria of 'extended periods" or "continuously". Assessing if the restriction is for an extended period requires careful analysis on a case-by-case basis. The adjudicator is encouraged to take into consideration the "normal" frequency of the performance of the DLA affected as some activities are daily, weekly or monthly events.

See the **Guidelines for Requesting Clarification** for more information.

TAKES SIGNIFICANTLY LONGER

The phrase "takes significantly longer than typical" is used in the application to describe the extra time a person with a severe impairment may require in performing a defined DLA. This information is provided by the assessor (pages 17 – 19). **The adjudicator must assess the indication of "takes significantly longer"** in determining if the person is significantly restricted in their ability to perform DLA's. The assessor is asked

to provide information regarding how much longer and this information is required to determine the level of restriction.

The adjudicator assesses this information on the basis of the following factors:

1. The overall time a task typically takes.
   - How long does it typically take to do laundry, housework, cook a meal, walk to the store, etc?
2. The age appropriate range for completing a given activity.
   - The amount of time taken for an activity often increases with age. Therefore it is important to assess the situation in the context of the age-related norms.
3. The impact of the relationship between the DLA and the restriction on a person's life.
   - mobility versus managing finances.
   - medication management may be far more important in some situations such as diabetes than others such as high cholesterol.
4. The direct relationship of the restriction to the impairment.
   - Reading takes longer to do, but the impairment is related to back pain.
5. The description and information provided by the assessor or physician.
   - an activity takes 10 minutes to complete
   - an activity takes 50% longer to do
   - an activity takes 3 times as long

A description of the actual time required is most useful. However, some assessors will use 20 to 50% as a description of how much longer an activity may take. (a 10-minute activity now takes 12 to 15 minutes to perform). Other assessors describe the situation in terms of multiples of time taken to complete an activity (2X as long or 5X longer). Still others use blanket statements (all moving about takes 2-3 times longer). The adjudicator must consider all descriptions of time relative to the impairment and reasonableness. If a wide range of activities were described as taking twice as long, this could be significant. Whereas if only one activity or a few subsets of activities took twice as long this would not likely be considered a significant restriction nor would the requirement of help necessarily be implied.

CRITERION FIVE: REQUIRE HELP TO PERFORM DAILY LIVING ACTIVITIES DUE TO RESTRICTIONS

OVERVIEW

Prescribed professionals provide information regarding the help required to perform daily living activities. It is the adjudicator who makes the decision as to whether the degree of help required meets the intent of the Act.

Once it has been established that the person has a severe impairment that restricts the applicant's ability to perform DLAs continuously or periodically for extended periods, **the adjudicator must determine if the person requires help to perform those activities.**

The information related to DLAs requiring help is provided by the physician (Section 2(E) page 11) and the assessor (Section 3(C) page 17 – 20). The assessor is asked to comment on the nature of help required and whether it is periodic or continuous. Information regarding assistive devices is provided by the physician (Section 2(B) page 9) and assessor (Section 3(D) page 20). There may be additional information in the narrative.

The Act (section 2(3)(b)) states that a person requires help in relation to a DLA 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.

The adjudicator is tasked with determining whether or not the physician and/or assessor have provided opinions on whether help is required. The adjudicator is not tasked with determining if help is actually required. Significant is generally understood in legislation as "considerable or substantial".

The information provided by the physician as to what type of assistance is required must be considered in conjunction with the information provided by the assessor.

CONSIDERATIONS IN ADJUDICATION

DLAs MUST BE SIGNIFICANTLY RESTRICTED

The person may require significant help for a particular activity, but overall their DLAs are not significantly restricted, and/or they do not have a severe impairment, and therefore the application does not meet all the criteria. There should be a reasonable link between the impairment, restriction indicated by the physician and need for assistance.

Help that is provided, based on societal or cultural norms, rather than need, will not meet the test of 'help required'. The person must be significantly **restricted** in an activity in order for the help to be **required.**

The adjudicator must determine that the reason for the help from another person is linked to the restrictions caused by a severe impairment.

SIGNIFICANT HELP FROM A PERSON

The application form does not elicit specific information about the degree of help received from other people. Therefore, if the physician or assessor does not provide information indicating the level, type or frequency of help that is required the adjudicator must seek clarification. If the physician or assessor indicates in their narrative details about the help that is required and the narrative indicates that the required help is not significant the adjudicator must take this information into consideration when

determining whether the help is significant and required to perform the activity in question.

SUPERVISION

Supervision of an activity is most relevant where there is a mental impairment and may be the primary type of help required. This can include prompts or reminders to do specific activities as well as safety concerns that involve the actual supervision of an activity. The level, type or frequency of help needed must be explained by the physician or assessor as indicated by the application form. If this information is not provided clarification must be sought. The adjudicator must determine if the narrative provided indicates that the supervision required is significant and required to perform the activity in question.

ASSISTIVE DEVICE

Means a device designed to enable a person to perform a DLA that, because of a severe mental or physical impairment, the person is otherwise unable to perform. The application asks the physician and/or assessor to explain how the need for an assistive device relates to the applicant's ability or inability to perform the DLAs. Many physicians and assessors will indicate that the applicant uses countertops, walls, and furniture as assistive devices. These are not assistive devices as defined in the legislation.

It is important that the assistive device is directly linked to restrictions from a severe impairment. If the assistive device is not directly enabling the applicant to perform DLA's restricted by the severe impairment the device does not satisfy the intent of help.

Medications/treatments do not meet the definition of a device.

In relation to assistive devices or assistance animals, the adjudicator must determine that the information provided supports an opinion that the applicant's ability to perform DLAs is directly and significantly restricted. To make this determination, the adjudicator should use all information provided in the application that relates to the amount of help needed from an assistive device or animal.

ASSISTANCE ANIMAL

The ministry considers only animals specifically trained to assist persons with DLA's to be 'assistance animals' and does not include those animals acting as companions etc. (the comfort cat does not satisfy the intent of the legislation).

In order for the adjudicator to determine whether or not the assistance animal is required for assistance with DLA restrictions, there must be additional information provided by the physician or assessor. See **Guidelines for Requesting Clarifying** for additional information.

KEY DEFINITIONS IN APPLICATION

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 otherwise unable to perform

Directly Restricts: The restriction is as a direct result of the impairment, not extraneous or intervening factors. Direct in this context means without anyone or anything else being involved.

Impairment: 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.

Mental Impairment: includes developmental delays, brain injury, cognitive impairment, mental illness, and motor neurological impairment.

Physical Impairment: includes illnesses, physiological impairment, and physical abnormalities.

Restricts: the impairment confines or limits the person's ability to perform DLAs

Severe: very bad in degree or extent; grave or grievous; to be determined by the adjudicator on a case by case basis.

Significant help or supervision of another person: another person is required to do the activity, remind the person to do the activity, supervise the activity for safety reasons or ensure the activity is done correctly and appropriately assists the applicant to do the task.

Significantly longer than typical: this will vary, activity to activity. This is a measure of the severity of the impairment, as well as a description of the extent of the assistance required.

Significantly restricts: the restriction is substantial, either because it prevents activities from being performed at all, because it impacts activities by causing the person to take much longer to do them, or it decreases the extent to which the activity can be performed.

FACTORS INFLUENCING DECISION MAKING

INFORMATION SUBMITTED

The adjudicator must determine if the information submitted provides an opinion that is reasonable, supported and reliable. An adjudicator cannot take portions of each assessment to determine eligibility. There must be 'an opinion' from a prescribed professional that a direct and significant restriction exists.

When resolving inconsistent or conflicting information, consider the following:

- Which source of information is more reliable?
- How long has the physician known the applicant?
- How long has the other prescribed professional known the applicant?
- What is the type or depth of treatment, number of visits, etc. provided by each professional?
- What type of test results, if any, were provided?
- Is one of the professionals a specialist in their field or more experienced in the subject matter provided?
- What type of information was available (i.e. past history, chart, assessments, test results, or other supplemental information) to the professional when the application was completed?

The adjudicator may need to contact the physician to verify whether or not the restriction and amount of assistance described by the assessor would be consistent with the physician's knowledge of the applicant's condition. Please see **Guidelines for Clarifying Information.**

EVIDENCE BASED DECISION MAKING

In order to stay focused on achieving an 'evidence-based' decision, the following questions should be considered:

- Is the impairment severe? What evidence supports that?
- Does the impairment significantly restrict daily living? What evidence supports that?
- Does the person require significant help or supervision? What evidence supports that?
- Does the relationship between the medical condition and the severity of the impairment make sense?

DECISION SUMMARY

To be administratively fair, the decision summaries must be properly articulated with substantive reasons. The applicant must be told what and how the information submitted was used, what conclusions were reached with respect to each eligibility criterion, and the reason why those conclusions were reached. The applicant must be

able to understand the basis on which the decision was made which allows them to make a reasoned determination whether or not to request a reconsideration or appeal. It also provides the Tribunal with the ministry's reasoning.

In the decision summary the adjudicator must fully explain how any inconsistencies were resolved. If evidence is submitted it must be clear how the adjudicator used that evidence to support or deny the relevant eligibility criteria. If evidence was insufficient the adjudicator should explain the reasons as to why the evidence was considered insufficient to make a decision. If the adjudicator has determined that there is a basis to weigh one professional's information over the other's the reasons for this determination must be fully explained (i.e. source of information, length of time the professional has known or observed the applicant, etc.).

DISCREPANCIES BETWEEN PHYSICIAN AND ASSESSOR REPORTS

VARYING BUT NOT CONFLICTING:

There are times when the physician and the assessor reports provide similar information but there is a variance in the indications relating to the degree of functionality. Similarly one report may focus on the physical impairment and the other on the mental impairment. In these circumstances the application needs to be looked at as a whole and the decision based on the cumulative evidence gathered in both reports.

CONFLICTING

There may be situations where the information in Sections 2 and 3 is conflicting and would lead the adjudicator to different conclusions.

This may occur for any of the following reasons:

- One party may know the applicant in a different context than the other.
- One party might be drawing conclusions based on objective evidence, the other on more subjective information, such as the applicant's self-report.
- One party might know the applicant better than the other.
- The two prescribed professionals may have different medical opinions about what is a severe impairment, what is a restriction to daily living, what restrictions require assistance, etc.

In assessing these different opinions, it is important for the adjudicator to consider which prescribed professional is likely to be most reliable regarding the criteria and give greater weight to that information in the decision making process. If there is no basis for weighing one professional's information over the other's then no finding can be made on the issue or application and clarification must be sought.

PHYSICIAN OR ASSESSOR PROVIDES INSUFFICIENT INFORMATION

The adjudicator needs to consider all of the information that **Is** presented in the application and make the decision accordingly.

Indications may be made by the prescribed professionals (I.e. ticked boxes) without sufficient explanation to assist the adjudicator in determining if the criteria have been satisfied. Carefully assess whether or not to seek clarification from one or both of the prescribed professionals. Insufficient information regarding the frequency and duration of the restriction to DLAs must be clarified. More information on when to request clarifying information can be found in the **Guidelines for Requesting Clarification.**

The decision summary on a denial that is based on insufficient information must clearly demonstrate where and why the criteria was not met.

MULTIPLE HANDWRITING STYLES IN THE PHYSICIAN OR ASSESSOR REPORTS.

There are situations where it appears that a variety of writers have completed portions of either Sections 2 or 3. These situations must be assessed on a case-by-case basis.

Where the source of authenticity of the information provided is not clear, the physician or assessor should be contacted to verify the information.

The legislation requires that a perscribed professional and medical practitioner must confirm the existence of specific criteria required for designation as a person with disabilities. Generally, information completed by someone other than the physician or assessor is not considered, and reference to this is to be made in the decision summary.

Refer to Guidelines for Requesting Clarification

PERSONAL BIASES

Decisions are to be based on the information provided in the application and other documents that are submitted with the application. Care must be taken to ensure personal knowledge and biases do not influence the decisions made in the adjudication process. The adjudicator must not bring personal experiences into the decision making process. Providing thorough written reasons and addressing all information provided will help the adjudicator rely only on the information in the application.

To meet the requirements of administrative fairness, the adjudicator should have no ties, perceived or real, with the applicant. For example, if the applicant is a neighbour; related to a friend; or attends the same club, group or church as you; you should pass the application on to a colleague to adjudicate without further discussion regarding any background information. To avoid the perception of bias, any connection that can be seen to exist that COULD result in personal bias must be avoided.

MEDICAL DIAGNOSES

Applications may be received where the information on the impairment, impact on daily living activities and assistance required, does not appear consistent with what would normally be expected, based on the diagnostic information provided by the physician. In these situations clarification may be required. (See Guidelines for Requesting Clarification)

GUIDELINES FOR REQUESTING CLARIFICATION

(Note: these guidelines are intended to assist the adjudicator to decide when it is appropriate to request clarification from a physician and/or assessor. It is understood that circumstances do exist where clarification may be requested for other reasons upon the approval of the PWD supervisor.)

As a general overall principle, the decision to approve or deny PWD rests on the evidence presented in the application. The onus is on the applicant and the physician and/or assessor to present clear and complete information.

In some instances, after reviewing the entire application, it may be appropriate for adjudicators to gather additional information from physicians or assessors, for the purposes of clarification. Such special circumstances are outlined below.

Administrative fairness dictates that any information that contributes to a decision must be provided to the applicant through the written decision. This is particularly true for information that is received through clarification. If the decision is a denial, the applicant will have the opportunity to respond to all information, including any new information through the reconsideration process.

Where there has been clarification, it is useful to describe, in the decision summary, why clarification was necessary (e.g. inconsistencies, missing information, overall picture of applicant's condition is very different from physician and assessor, etc.). In the decision summary all information provided, whether through the application form or clarification must be addressed.

Note: A record of all calls/faxes must be kept and scanned into CTS along with the application, decision summary and approval/denial letter. If the phone call or fax requesting information is not returned, the blank phone log indicating each attempt should be attached to the decision, as should the copy of the fax request and the fax confirmation

1. Key information is not legible or the source is in question.

- If the handwriting is not legible a call to the appropriate party may be made to determine what is being reported.
- It is unclear whowriting what in the report (e.g. applicants sometimes make additions to reports, assessors change reports later, physician has an office assistant hand write information). If the decision could be affected, a call may be appropriate to clarify the source and authenticity,

The remaining Guidelines generally require discussion with a supervisor before contact is initiated.

2. Incomplete applications where a severe impairment is clearly indicated.

- At times, entire sections are not completed and there is an obvious severe impairment.
- At other times, there is no need to acquire that information because other sections of the application provide sufficient information to make a decision. When the adjudicator is unclear how to proceed, the senior adjudicator will provide direction.

3. Discrepancies between a physician report and an assessor report.

- There are times when the information in the physician's report is not reflected in the assessor's report or vice-versa. One set of information may support a denial, the other an approval. The adjudicator must decide if one party appears to have more experience or expertise with the medical condition or may know the applicant in this context better and may decide to weigh the evidence accordingly.
- If there is information provided in the physician's report or in the information provided through clarification that is seriously inconsistent with the assessor report the assessor should be contacted for further clarification. If the clarification reveals that the assessor did not have sufficient information to make a determination for the application, the adjudicator must indicate in the decision summary that the assessor had limited opportunity to observe the applicant and relied on the applicant's self-report. As a result the adjudicator has relied more on the physician's report when discrepancies exist. The decision summary should indicate the areas of discrepancy and why the physician's report was preferred.
- Where there is no direct conflict between the two reports, but the physician's report would not appear to support the assessor's description of the severity of restriction and/or amount of assistance needed clarification should be sought. Clarification with the assessor may include their personal knowledge of the client and opportunity to observe or clarify the reason for the reported debilitating effects of a condition that is not ordinarily so disabling. Clarification with the physician may include confirming that the assessor's description is consistent with the physician's knowledge of the condition.

4. Degree of impairment described is not consistent with the reported medical condition(s)

- The apparent severity of the medical condition as described would suggest the likelihood of significant impacts on a person's daily living, yet the physician or assessor report does not indicate this (for extreme cases).
- The degree of impairments or impacts indicated by the physician or assessor is much greater than one might expect given the described medical condition.

5. Acute or recently acquired medical conditions still under investigation

- Some applications are received soon after a significant medial problem has occurred. The duration of the condition may last the required 2 years, but the degree of impairment may be transitory. Heart attacks, strokes, and injuries from accidents are common examples. There is often a 2 to 4 month gap between when the application was completed and when it is adjudicated. Clarification of the current situation (at the time of adjudication) may be appropriate in these cases.
- In addition, the applicant may be scheduled for treatment of the impairing condition during the time between the writing of the application and adjudication, so again clarification of the current situation may be appropriate.

6. Concerns regarding the duration of the impairment

- An applicant may have several medical conditions, but the one causing the impairment may be acute or is being treated, and may be resolved in fewer than two years. Clarification may be required to address this duration issue.
- There are also situations where the 2 year duration has not been confirmed, or it doesn't appear consistent with the nature of the medical condition. These circumstances may need to be clarified.

7. Clarifying if the DLA restrictions are relevant to the impairment, as opposed to external factors.

- There are situations where lack of experience, cultural norms or poverty issues can impact an applicant's ability or opportunity to perform some DLA's. It may be necessary to clarify this in order to assess eligibility.
- Frequency and duration of 'periodic' restrictions to DLAs.
- The physician indicates 'periodic' restrictions to DLAs but does not provide the frequency and duration. The adjudicator is then prevented from determining whether this results in a restriction that occurs continuously or periodically 'for extended periods'. It may be necessary to clarify frequency and duration with the physician or assessor.

WORKBOOK EXERCISE

1. What is the purpose of following adjudication guidelines?

2. List the five key criteria that must be met to receive PWD designation.

3. Who must specify duration?

4. What are some of the points to keep in mind when considering severity?

5. What are some of the extraneous factors often reported in the application but do not constitute direct restrictions from the severe impairment?

6. Why is it important to note the frequency of contact of the physician/assessor with the applicant? What circumstances may this become important?

PWD TRAINING MODULE 5

ADJUDICATING THE APPLICATION START TO FINISH

Objective of the module:

- **To provide an understanding of how to assess information presented in an application and how to use it to make decisions.**
- **To demonstrate the importance of a structured and organized approach to the decision making process.**
- **To demonstrate the purpose, use and importance of the decision summary in writing justifiable decisions.**
- **To provide a basis for setting appropriate review dates/types.**
- **To understand how to assign appropriate denial codes and why this is critical**
- **To learn how the client is informed of the decision – (i.e. loading).**

STEPS INVOLVED IN PWD ADJUDICATION

CHECKING FOR ELIGIBILILITY TO APPLY:

In order to be eligible to apply for PWD designation, an applicant must intend to apply for disability assistance and must meet the financial eligibility requirements for disability assistance. The adjudicator must check the Ministry Information System (MIS) to determine this. The file status can be found through the FPI screen and to see if the client is receiving cheques look at the ALL screen.

It is vital at this step to verify that the data sheet and information on it is for the correct applicant and that it is profiled in ICM under the correct client and number. Verify the birthdate/SIN/name/GA# match that on the FPI screen. Check to see if the applicant has applied previously. If the applicant applied previously and you adjudicated a prior application, according to administrative fairness principles you should not adjudicate this request to avoid the perception of bias.

VERIFICATION OF SIGNATURES:

The Adjudicator must verify that all required signatures are in place before proceeding with the adjudication process. The following signatures are required:

1. **Office Authority:** There should be a signature from the Ministry Signing Authority accompanied by the Employment and Assistance Centre Stamp. This is found on page 1 of the application form. If there is no signature but:
   - The application is properly completed;
   - You can verify that the applicant is in receipt of assistance; and

- The applicant does not have an application pending with the Reconsideration Branch or the Employment and Assistance Appeals Tribunal (check with ICM and MIS)

Then proceed to adjudicate the application. Check with the senior adjudicator to confirm.

2. **Applicant's Signature:** The applicant or their legal authority must sign the declaration on page 5 (Section 1 C) and this signature must appear under the written declaration to verify that they are agreeing with the conditions outlined in this statement. If an individual other than the applicant has signed the declaration, documentation must be provided to prove that they have the legal authority to sign on the applicant's behalf. In the instance where the applicant is unable to sign and there is no legal signing authority in place, bring to the senior adjudicator to follow up, as there is some discretion to adjudicate without the signature if all attempts to obtain it fail. However, if the applicant has refused to sign this consent, the application cannot proceed.

3. **Witness's Signature:** There should be a signature from a witness in the declaration page 5 (Section 1 C). If this signature is missing and all other information appears to be in order, continue with adjudication. If there are concerns consult with the senior adjudicator.

4. **Physician's Signature:** The physician who completed Section 2 of the application must sign page 12 (Section 2 H). This physician must be licensed to practice in BC as defined under the *Medical Practitioners Act*. There are rare circumstances where an out of province physician can complete Section 2). Please check with a senior adjudicator to discuss. Similarly, licensed out of country practitioners may be accepted where the applicant has a serious or urgent condition and does not yet have a physician in Canada and the out of country physician agrees to complete the application. Check with the senior adjudicator prior to adjudicating these applications.

   Please ensure that the physician has provided an office stamp. *If there is no office stamp* and you cannot determine a physician actually completed the form, contact the physician's office to confirm.

5. **Assessor's Signature:** The assessor who completed Section 3 of the application must sign page 22 of the form (Section 3 H). The adjudicator must ensure that the assessor meets the qualifications specified in the Act as:

   a) A medical practitioner,
   b) A registered psychologist,
   c) A registered nurse, or registered psychiatric nurse,
   d) An occupational therapist,
   e) A physical therapist,
   f) A social worker (as defined under the *Social Workers Act*),
   g) A chiropractor, or
   h) A nurse practitioner.

Various types of handwriting may appear on the application that you cannot confirm is the physician's or assessor's writing. In such cases, although the physician's or assessor's signature may be on the form it is difficult to determine if the additional comments were added before or after the application was signed. You may wish to contact the prescribed professional for clarification (see Guidelines for Clarifying Information Module 4).

If any of the required signatures are missing, the adjudicator must determine if the application needs to be sent back for completion. If the assessor signature is missing or the assessor is not qualified under the Act to complete Section 3, a determination needs to be made as to whether a decision (approval) can be made based on the physician's report alone (a "No Assessor Report"). If insufficient information is provided in the physician section to make an approval decision, or if the physician info would result in a denial, the application will be returned to the client. (Note: this should be identified when the application initially arrives at HAB).

The adjudicator cannot deny an application based on the physician's section alone. Even if the duration is missing or it is clear from reviewing the information in the physician's section that a denial is likely, in keeping with administrative fairness the entire application be reviewed before this is determined.

When too much information is missing to make a decision, the Health Assistance Branch will seek completion of the application (e.g. contacting the originating Employment and Assistance Office, etc.) in the most appropriate manner based on the amount and type of information missing.

While missing information is being acquired the file stays open in the deferred folder to wait. Form letters (for cases where the applicant needs to be notified in writing) exist and the full instructions for each situation are listed in our "matrix" and can be found in either of the following locations:

K:\Branch Getdoc\FIELD SERVICES AREA\Team2 Folder\PWD procedures
https://hsd.wss.gov.bc.ca/PSPP/HAB%20Procedures/Forms/AllItems.aspx

Many times the physician will "sign off" the application although he or she did not complete it. The ministry's view is that by signing the application, the physician is taking responsibility for the information in the form and the information submitted is that of the physician. If the information provided is inconsistent with the assessor's information you must seek clarification (refer to Module 4 for more information).

REVIEW APPLICATION TO ASSESS CRITERIA:

CRITERION ONE: AGE

This is confirmed by checking the FPI screen when checking for the GA file and confirming that the correct applicant has been loaded in the Care Analysis Tracking system (CAT) (data sheet). To be potentially eligible for the PWD designation the

applicant must be at least 18 years of age. We will accept applications up to 6 months prior to their 18th birthday. If approved disability assistance would commence on the applicant's 18th birthday. (In these cases there are special procedures followed to ensure a smooth transition. Designated adjudicators take care of all underage applications). At times the applicant will be over age 65. These applicants may not have enough residency in Canada to collect a pension and may be eligible for Disability Assistance benefits. Check with the senior adjudicator if you are unsure whether or not to adjudicate the file.

CRITERION TWO: DURATION

Legislation states that "in the opinion of the medical practitioner [the impairment] is likely to continue for at least 2 years". Therefore, this criterion cannot be satisfied by information submitted by anyone other than a physician.

We ask this question directly of the physician on pg. 10 of the application. Note that there are boxes to indicate "yes" or "no" in response to this question. The lines provided for explanation are in response to the follow-up question around remedial treatments. If the answer is not "yes" the duration criterion has not been met. If the question is not answered but the information is clearly stated by the physician elsewhere, the adjudicator may determine whether there is sufficient information to establish duration. Pay attention to narrative in these cases as the physician may indicate that one condition is life-long but that the condition related to the impairment may not meet the two year criterion. This should be clearly explained in the decision summary.

CRITERION THREE: SEVERE IMPAIRMENT

The adjudicator determines whether the evidence demonstrates that the applicant has a severe mental or physical impairment. This is achieved by looking at the cumulative evidence presented by the physician and the assessor. Determine that the degree of impairment is reasonably consistent with the diagnosis. Refer to the Adjudication Guidelines in Module 4.

Physical Impairment

The assessment of the applicant's level of physical functioning includes:

PHYSICIAN	ASSESSOR
Section 2 D (page 10) • how far they can walk, • how many stairs they can climb unaided, • how much they can lift, • how long they can remain seated	Section 3 B (page 15) • brief description of how impairments restrict functioning • speaking, hearing, reading, writing • walking, climbing stairs, standing, lifting, carrying/holding
Section 2 C (page 9) • prostheses or aids required	Section 3 B, C (page 15, 17-19) • assistive devices needed
Section 2 F (page 12) • additional information	Section 3 E (page 21) • additional information

The adjudicator is to consider the opinions and evidence on these pages and any other relevant narrative throughout the application in order to determine if a severe physical impairment exists. The applicant's information from Section 1 should also be considered when assessing the physical impairment.

Mental Impairment

The assessment of the applicant's level of mental functioning includes:

PHYSICIAN	ASSESSOR
Section 2 D (page 10) • cognitive and emotional functioning Section 2 E (page 11) • social functioning	Section 3 B (page 15, 16) • brief description of how impairments restrict functioning • degree of cognitive and emotional function impairments
Section 2 C (page 9) • prostheses or aids required	Section 3 C (page 19) • assistive devices needed • support/supervision required
Section 2 F (page 12) • additional information	Section 3 E (page 21) • additional information

The assessor is asked to indicate whether the cognitive and emotional functioning is impacted episodically or if the impact varies over time. They also indicate whether there is no impact, minimal, moderate or major impact. The assessor is asked to comment on the impact of the restrictions but this is not a specific requirement of the legislation. Therefore, if not enough information is provided, the adjudicator must seek clarification prior to making a denial.

The adjudicator is to consider the opinions and evidence on these pages and any other relevant narrative throughout the application in order to determine if a severe mental impairment exists. The applicant's information from Section 1 should also be considered when assessing the mental impairment.

CRITERION FOUR: DIRECT & SIGNIFICANT RESTRICTIONS TO ABILITIES TO PERFORM DAILY LIVING ACTIVITIES (DLAS)

The **adjudicator determines** whether a severe impairment results in direct and significant restriction on an applicant's ability to perform DLAs. DLAs are defined in regulations.

Steps in assessment:

1) Determine whether the restrictions to DLAs are directly caused by the impairment. The evidence must demonstrate that the restrictions make sense with respect to the identified impairment. It is important to ensure there is a linkage between the restricted DLA and the impairment.

2) Determine whether the DLAs are significantly restricted and whether the number and/or type of DLAs restricted are sufficient to allow approval of the PWD designation.

   The adjudicator determines if the cumulative evidence provided demonstrates a level of overall significant restriction in the applicant's ability to perform DLAs. Refer to the Adjudication Guidelines in Module 4.

3) Determine if the restrictions are **continuous**. Is this reasonable based on the severity of the impairment described? Ensure that the restrictions match the impairment described. Is it reasonable that most or all aspects of an activity are restricted for the applicant based on their impairment?

   If the restrictions are periodic, assess if they are for **extended periods of time.** Determine if the extended period of time indicated is reasonable, based on the severity of the impairment described. If frequency and duration of the restrictions are not indicated, and the adjudicator is unable to determine they occur for extended periods, clarification should be sought.

When considering 'direct and significant', consider the overall impact on daily function. The physician and assessor provide information in the following sections:

PHYSICIAN	ASSESSOR
Section 2 E (page 11) • DLAs affected by Impairment • Is the activity restricted • is restriction periodic or continuous	Section 3 C(page 17-19) • assistance needed with DLAs restricted (independent, periodic, continuous) • how much longer it takes to perform DLAs
Section 2 E (page 11) • assistance needed • type of assistance needed	Section 3 C (page 17-19) • assistive devices used • support/supervision required
Section 2 F (page 12) • additional information	Section 3 E (page 21) • additional information

The adjudicator is to consider the opinions and evidence on these pages and any other relevant narrative throughout the application in order to determine if a direct and significant restriction on the applicant's ability to perform to DLAs exists. The applicant's information from Section 1 should also be considered.

CRITERION FIVE: ASSISTANCE

Section 2(3)(b) of the Act specifically links the assistance required to the significantly restricted DLAs. Therefore, the adjudicator must determine whether the assistance/assistive device indicated by the physician or assessor is required for those activities established as significantly restricted in Criteria 4. Assess which activities are restricted and how much help or extra time is required to perform them. Determine if the

cumulative restrictions result in the applicant **requiring** help. The assistance may be in the form of an assistive device, an assistance animal or the significant help or supervision from another person.

The frequency and duration or extent of assistance from another person is important to determine whether the help or supervision required is significant. However, the application form does not specifically require this information; if it is not included in the narrative the adjudicator must seek clarification. In the case of assistive devices and assistance animals "significant help" is not required, therefore lack of comment on frequency or duration is less important. Regardless, the adjudicator must confirm that assistance is in relation to the DLAs that are directly and significantly restricted as a result of the impairment.

When considering 'assistance required', the physician and assessor provide information in the following sections:

PHYSICIAN	ASSESSOR
Section 2 E (page 11) • assistance required with DLA Section 2 B (page 9) • prostheses or aids required	Section 3 C(page 17-19) • assistive devices used • support/supervision required
Section 2 F (page 12) • additional information	Section 3 E (page 21) • additional information

The adjudicator is to consider the opinions and evidence on these pages and any other relevant narrative throughout the application in order to determine if an applicant requires assistance in relation to a DLA. The applicant's information from Section 1 should also be considered.

MAKING THE DECISION:

MINIMUM INFORMATION REQUIRED FOR DECISION MAKING

A fully competed application will provide a great deal of information to assist adjudicators in the decision making process.

Physician – At the least, the physician will be expected to provide a diagnosis, duration of the impairment, and some information about the degree of impairment. If this is all that is provided, a complete assessor report might provide the balance of the information necessary to adjudicate the application.

Assessor – At the least, the assessor will be expected to provide information about the restrictions on DLAs due to the impairment, what help is required and in what form.

If both parties provide minimal information, an informed decision may not be possible. It will be difficult for adjudicators to determine the degree of impairment. Much will depend on the severity of the underlying medical condition and the level of help required.

The onus is on the applicant and the physician and assessor to present clear and complete information However, the adjudicator may need to contact the physician and/or assessor for clarification in certain situations. For more information on when to seek clarification, consult the Guidelines for Requesting Clarification, Module 4.

POSSIBLE DECISIONS

APPROVE

All five criteria are satisfied. The adjudicator can confirm that the applicant meets designation criteria of a person with disabilities.

DENY IMPAIRMENT AND DAILY LIVING ACTIVITIES

The information provided does not support all the criteria. The applicant does not have a severe impairment; it cannot be determined that their ability to perform activities of daily living would be restricted. The reasons for denial must clearly articulate what legislated criteria are not met and why (full and substantive reasoning).

APPROVE IMPAIRMENT BUT DENY DAILY LIVING ACTIVITIES

The evidence supports a severe physical or mental impairment but there is not sufficient evidence to establish that the identified impairment results in direct and significant restriction to DLAs resulting in the need for help either periodically for extended periods or continuously. The reasons for denial must clearly articulate what legislated criteria are not met and why (full and substantive reasoning).

APPROVE IMPAIRMENT AND DAILY LIVING ACTIVITIES BUT DENY DURATION

The application establishes both the impairment and a direct and significant restriction to DLAs resulting in a need for assistance; however the physician does not confirm that the condition will last for two or more years. The reasons for denial must clearly articulate what legislated criteria are not met and why (full and substantive reasoning).

APPROVE DURATION, IMPAIRMENT AND DAILY LIVING ACTIVITIES BUT DENY REQUIRES HELP

If the application supports an impairment that restricts DLAs but the evidence clearly indicates that despite restrictions to DLAs, the applicant manages without help then the applicant has not met all legislated criteria. The reasons for denial must clearly articulate what legislated criteria are not met and why (full and substantive reasoning).

THE DECISION SUMMARY

FULL AND SUBSTANTIVE REASONING

Clearly, there is a significant amount of information to consider in a 22 page application. In order to make a decision that is based on the information collected in the application, a structured and organized approach is required. The structure of the decision summary sheet reflects the five criteria in a visual manner which directs the adjudicator to the appropriate parts of the application form to gather the information required to make a decision.

Each decision should be clear, concise and contain all the reasons why the evidence was accepted or rejected. Clear and substantive reasoning is important so that the applicant understands the logic and reasons behind the adjudicator's decision. Should the applicant decide to request a reconsideration or appeal the decision, the Reconsideration Officer and Tribunal panel will also need to fully understand the logic and reasoning behind the decision. It is also important for the applicant to be able to address any concerns or deficiencies in their application in the reconsideration and appeals process. Therefore, language such as "the evidence does not support a finding..." must be followed with a full explanation of what the evidence was and why it did not support a finding.

Unless the applicant has confirmed that they have a copy of the completed PWD application form which was submitted to the ministry, a copy is to be provided to the applicant, along with the Request for Reconsideration form. A copy of all information obtained through clarification with physicians and/or assessors must also be included. Adjudicators are reminded not to use any information that is pre-existing in the applicant's file. Only information in the application and obtained through clarification should be taken into consideration.

It is up to each adjudicator to find a decision summary style that best suits them. Decision summaries can be written from a second person perspective (e.g. "your physician indicates", "you are diagnosed with") or a third person perspective (e.g. "the physician indicates", "the diagnosis is"). Whatever style the adjudicator chooses it is important to consider the reader (i.e. the applicant, possibly their physician, assessor or advocate, a Reconsideration Officer, or a Tribunal panel member).

Grammar, phrasing and tone are important to consider when writing decision summaries. Please review the MHSD style guide and ensure that ministry standards are adhered to. These include:

- Write out numbers under 10 and use digits for numbers 10 and over.
- Use one space after a period at the end of a sentence.
- The full name of a specific legislative *Act* is italicized but regulations of that *Act* are not.
- Capitalize all proper names, departments, and agencies of provincial and federal governments, political parties, names of associations, companies, clubs,

religions, languages, bands, trade names, races, places, and addresses (e.g. Ministry of Housing and Social Development, Family Maintenance Program).
- Use lower case 'm' when the word "ministry" is not used with the full ministry name. (e.g. I have been advised by ministry staff that...).
- Specific geographic regions are capitalized (e.g. Lower Mainland, Downtown Eastside).
- Use May 15 and January 21; not May 15th and January 21st.
- Express percentages in numbers and spell out the word per cent. The symbol (%) may be used in tables, Do not mix the word and the symbol in one body of text.

View the MHSD communications guide at
http://icw.hsd.gov.bc.ca/commun/index.htm?rnav=commtools

SETTING A REVIEW PERIOD:

Once the adjudicator has determined an applicant meets all the criteria for PWD designation a review date must be set. The adjudicator will select a review type (full, partial, or minimal) see Module 2.

UNDER SECTION 2(4) OF THE ACT, THE MINISTER MAY RESCIND THE PWD DESIGNATION. THIS PROVISION IN THE ACT IS THE BASIS FOR CONDUCTING REVIEWS THAT PROVIDE THE MINISTER WITH THE INFORMATION REQUIRED TO DETERMINE CONTINUED ELIGIBILITY. TYPES OF REVIEW

Full Review (F) = There is a likelihood of improvement e.g. due to recent onset of condition, treatment available, indication of improvement by physician/assessor or typical course of condition/disease process.

Partial Review (P) = The applicant may see improvement but not as likely as with the Full review set.

Minimal Review (M) = Permanent conditions as identified below. Some examples include: quadriplegia, Alzheimer's, double amputation, Cerebral Palsy, total blindness, profoundly deaf, paraplegia, ALS and similar conditions, and Muscular Dystrophy. There are various other neuromuscular and neurological syndromes (too numerous to list) that are not likely to improve. These have to be evaluated through research and consultation.

Conditions that could improve or have lengthy remissions may cause severe impairments but require periodic review. The information in the application regarding treatments will assist in making these types of decisions.

SELECTING DENIAL CODES:

In the case of a denial, the adjudicator must select the appropriate denial codes and indicate these on the decision summary. These reflect pre-scripted statements that relate to the criteria and reflect the reason the applicant was not found eligible for PWD designation based on the information provided. It is critical that these are assigned correctly.

DENIAL CODES

10 You are not 18 years of age.

20 The medical practitioner has not confirmed that your impairment is likely to continue for at least 2 years.

30 You do not have a severe mental or physical impairment.

40 Your impairment does not directly restrict your ability to perform DLAs.

41 Your impairment does not directly and significantly restrict your ability to perform DLAs.

42 Your impairment does not significantly restrict your ability to perform DLAs.

43 Restrictions on your DLAs are neither continuous nor periodic for extended periods.

50 You do not require help to perform the DLAs restricted by the impairment, in the form of either an assistive device, the significant help or supervision of another person, or the services of an assistance animal.

52 You do not require significant help or supervision of another person to perform DLAs restricted by your impairment.

54 The assistive device identified in your Form does not enable you to perform the DLAs that are restricted by your impairment.

55 The assistance animal identified in your Form does not enable you to perform DLAs restricted by your impairment.

DENIAL CODING GUIDELINES TO GO WITH FLOW CHART

Denial codes should reflect the decisions made in the case profile adjudication summary (i.e. should accord with the explanation provided for each criterion).

CODE 41 VERSUS CODE 42

Code 41 = no restrictions

Code 42 = direct but not significant restrictions

1. Look at all tick boxes, comments, telephone logs in both physician and assessor sections and see if any activities are restricted, take significantly longer or require assistance as these all count as restrictions.

2. Note:. any information in functional skills, mobility and physical ability, and communication sections, should be added into DLA sections of the decision.

3. Marginal social functioning is a restriction.

4. Note: telephone logs may provide information that supports an increase or decrease restrictions and this should be incorporated in the summary info/decision and of course the denial codes.

CODE 43 = 'FLARE UP' CODE

1. This code is issued in cases where the person is bedridden 1 day a month i.e. significantly restricted but not for extended periods..

2. You can always add code 42 as well if there are two conditions causing different restrictions.

CODE 50 = NO HELP

Use this if no help indicated

- In physician and assessor help sections
- Anywhere in form as a comment
- No periodic or continuous assistance/support indicated on pages 17 to 19
- No periodic or continuous restrictions on page 11

CODE 52 = NOT SIGNIFICANT HELP

This code is used most often. Use this if help is mentioned in a comment or tick box

- In physician and assessor help sections
- Anywhere in the form as a comment
- As periodic or continuous assistance/support indicated on pages 17-19
- As periodic or continuous restrictions on page 11

If you find family helps and cane is checked – use code 52 (i.e. default to this code over 54 or 55).

CODE 54 = ASSISTIVE DEVICE DOES NOT HELP DLAS

Use this if no help from persons is indicated on the form.

However, do not use this code i.e. just do not enter a code for this section if, for example, the assistive device is helping them in their day to day affairs.

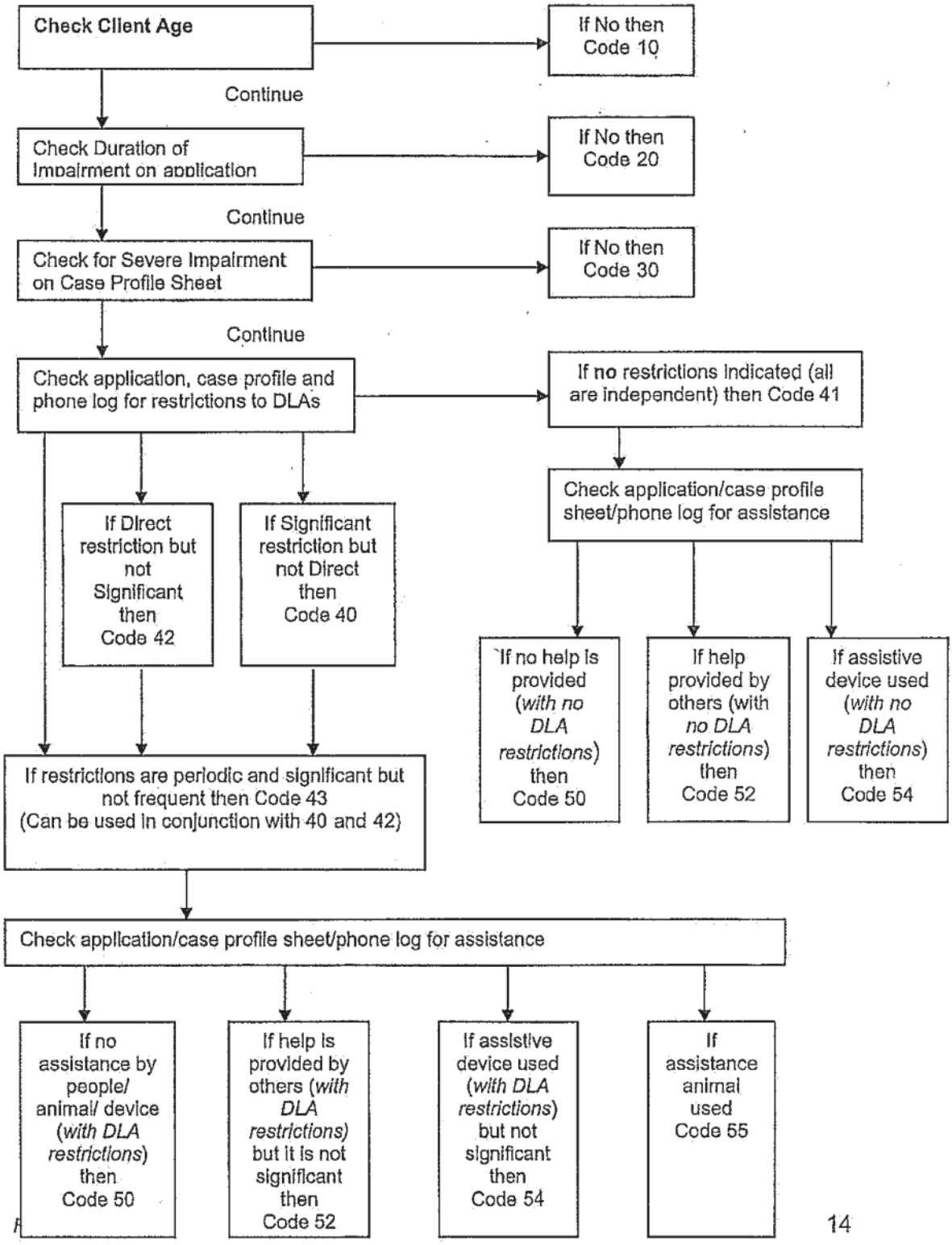
For example do not code the following:

- The person who needs the hearing aid to hear conversations
- The person who has some balance issues and the cane is a good idea
- The person who wears a back brace, which needs to be worn for DLA's but applicant is fine with it on.

CODE 55

Use this code when the assistance animal is not enabling the person to perform DLAs.

PWD Denial Reason Flow Chart



INFORMING THE CLIENT

LOADING PROCESS

There are four steps to loading; checking that the CAT address is current (i.e. matches MIS address), entering the information relating to the decision on MIS, generating a letter to the applicant on CAT and updating ICM. Please refer to attached tables for procedures.

HAB DOCUMENT POLICIES

Your completed decision summary should be saved in your folder on the K drive in case access to this document is required in the future. Do not save any decisions on your local C drive, as this is not in line with HAB's document storage policies. Do not, under any circumstances, keep printed hard copies of your decisions, This is inappropriate and is not in line with HAB's document handling policies.

Double check the address, GA, name and Personal ID (PID) before mailing to avoid a breach of information by accidentally sending you letter to the wrong person. If you are working on a letter or file and have this information at your desk, it must be LOCKED out of sight when you are away from your desk. All of the PWD information is locked out of sight at the end of each day. Check with your senior adjudicator if you have any questions.

Once the loading process is complete the letters are signed in blue ink and placed in the ICM Packaging Team 2 basket.

(See following cheat sheets for loading procedures.)

UPDATING MIS

Before loading any decision please check G HST Q GA___ to ensure client has not deceased.

APPROVALS	DENIALS
Creating an HS File: • G FPI L GA_____ • Check client address on CAT correct (see top of CAT page) • "q" client name • "r" client's GA number • tab to "Caseload Number" and enter 070000 • date registered should be **today's date** • tab to "File Type" and enter "hs" • Press Ctrl **Updating the PE1 Screen:** • G PER U GA_____ • Left click on client's name and press F5 key – PE1 screen will appear • Change R to E • Enter **today's date** next to "PWD Adjudication Date" • Enter the **review date** next to "PWD Next Action Date" • Tab to "PWD Review Type" and enter appropriate letter (M, P or F) • Press Ctrl	**Check file still open and correct address:** • G FPI L GA_____ • Check client address on CAT is same as MIS (see top of CAT pg) **Updating the PE1 Screen:** • G PER U GA _____ • Left click on client's name and press F5 key – PE1 screen will appear • Change R to I • Enter **today's date** next to "PWD Adjudication Date" • Press Ctrl

ICM

Approvals	Denials
Adjudicator: • Change status to "**ready**" and destination to "**packaging**". • Comment in big box "PWD status approved for (client name) on (date). Letter mailed to client. • "**Save**" **Admin:** • Packaging admin will scan letter/additional documents into ICM and attach to document set. • Change destination to "blank" and transfer to D.O.	**Adjudicator:** • Change status to "**ready**" and destination to "**packaging**". • Comment in big box "PWD status denied for (client name) on (date). Letter and decision summary mailed to client. All documents are available on ICM client summary." • "**Save**" **Admin:** • Packaging admin will scan letter and decision summary/additional documents in to ICM and attach to document set. • Change destination to "denial" and "**complete**".

GENERATING A LETTER ON CAT

First check to ensure the address on CAT is the same as that on MIS FPI. If not correct the address needs to be re-scraped. While in the PFI screen, 'q' the correct ga for client. Go to CAT Applicant info screen and select "refresh MIS data" and if correct displayed select "import". This should bring the correct address from MIS to CAT.

- Once address correct, click on "requests made" and then click on "zoom" next to the PWD application. This will bring up the PWD application page.

Approvals	Denials
• Go to the application screen • Change "**Under Review/New Info Received**" to "**Approved**" (today's date will automatically come up) • Enter appropriate date under "**Review Date**" • Document the review type in the comment section. If "**Full Review**" given – enter rationale for full review into comment box i.e. what type of info would we be looking for in the future. • Hit "**Save**" button. • Select "**Generate Letter**" • Select "**New Application Approved**" letter – MHR T01 • Ensure effective date is correct (blue box) • Select "**Generate Letter**" • Select "**Letters**" on top tab bar • Print Letter • Sign Letter with blue ink	• Go to the application screen • Change "**Under Review/New Info Received**" to "**Denied**" (today's date will automatically come up) • Select "**Generate Letter**" • Select "**New Application Denied**" letter – MHR T02 • Enter denial reasons by clicking on the **code number** and then "**Add Reason**" (will see the wording appear in the box below) - Repeat for all appropriate codes. • Select "**Generate Letter**" • Select "**Letters**" on top tab bar • Print Letter **Very Important: check each printed letter to ensure all applicable denial codes are present.** • Sign letter with blue ink

PWD QUICK CHECKLIST

- Pick app from ICM and move to your own destination.
- Note GA# and see if app is for main player or spouse
- Check MIS to ensure person is eligible to apply for PWD (GA file open, chqs in pay, or clearly would be eligible for PWD if approved – e.g. CPP $700) [If file closed or otherwise not eligible to apply, check with senior adjudicator. Do not proceed with adjudication.]
- Check CAT to ensure the app is loaded, and to see if there are recent apps. Ensure you did not adjudicate a previous app for this applicant. Have the application assigned to someone else if you have.
- Check to ensure address in CAT matches MIS.
- Open up application and check that client, doctor, and assessor sections are completed and signed, and that Doctor and assessor are "qualified" under the Act. Ensure the application is loaded under correct client.
- Check that diagnoses are correctly entered in CAT, update if not.
- Open a new blank approval or denial template and add GA and PID. Save as GA###### Lastname in the appropriate folder. Ensure you wrote the correct GA number. If you accidentally copied and pasted the wrong one, it could result in your updating the wrong file and a subsequent breach of information. **ALWAYS DOUBLE CHECK THIS**
- Adjudicate application – review the information and make a decision.
    - Use notes if they work for you
    - Pull app off shelf if hard to read, or if you have concerns re: authorship or alterations.
    - Consider the information in both sections – does it make sense? Are there inconsistencies?
    - Use the information to evaluate if all eligibility criteria as set out in legislation have been met.
- Once your decision has been made (these can be done in any order as long as all steps are done):

Approvals	Denials
Make appropriate comments on ICM (applicant name approved PWD on date, letter to client this date. Initials, adjud HAB) and save the document set to "packaging"	Make appropriate comments on ICM (applicant name denied PWD designation on date. Letter and decision summary to client. Initials, adjud. HAB) and save the document set to "packaging"
If there are documents to add to ICM paperclip them to letters.	If there are documents to add to ICM paperclip them to letters.
Update CAT: change application to "approved" and put review type in comment box but only if a "F" full or "M" Minimal review, provide rationale in the comment box to explain (i.e. "cancer, may recover"). SAVE	Update CAT: change application to denied. SAVE
Generate letter: select "new application approved" letter and print it.	Generate letter: select "new application denied" letter and enter appropriate denial reasons. Print it. Check that the denial reasons printed accurately.
	Complete the decision summary and print it. Save it in the K drive. Initial the last page.
Sign letter and place in packaging.	Sign the letter. Paperclip it to the decision summary and place in packaging.
Update MIS: make an HS file and update the pe1 screen (access via per U, f5) to "E" for eligible and enter the decision and review dates and type.	Update MIS: access the pe1 screen and enter "I" for ineligible and today's date.
Finished	

PROCEDURE FOR DENTAL DECISIONS

In order to conduct reconsiderations of dental decisions, it is necessary to have the applicable legislation and Schedules of Fee Allowances-Dentist, Denturist, and Dental Hygienist on hand. Copies of the legislation are attached. The Schedules of Fee Allowances are available in the Policy and Procedure Manual– click on Health Supplements/Dental and Orthodontia in the Index. The Fee Schedules under Resources.

Dental decisions are challenging for a few reasons:

1. The complexity of the legislation
2. Lack of information to indicate what has been requested
3. Lack of information to indicate what has been denied
4. Eligibility issues [particularly if the applicant is MSO]

Step 1 – Gather All the Information Necessary to Make a Decision

Dental files are assumed as soon as they arrive at RB. Because administration of the dental plan is contracted out to PBC, it is sometimes necessary for the RO to search for the answers to such basic questions as:

What was requested?

What was denied?

What were the reasons for the denial?

It may be necessary to review the applicant's history in ICM for evidence of a denial [when and by whom]. The EAW may have contacted HAB for an opinion. Usually this is recorded in the Notes.

It may be necessary to call the dental office and ask if PBC was contacted for eligibility.

Note: At times the dental practitioner's name is not provided, and it is necessary to contact the client for this information.

If there is **no denial**, the matter may not be open to reconsideration. In this case, discuss the file with the Trainer/Supervisor before proceeding with a non-reconsideration. The matter may have to be referred to LLB. We do have a template for this situation.

Out of time: Often the client is not informed of a denial until months after the fact, particularly when pre-authorization is required. PBC communicates directly with the dental office. The dental office doesn't always contact the client. Check for the date the client was informed of the decision on the EIA100. If the R4R has been submitted well beyond the 20-day time limit [a month or more], check the client's history on ICM for extenuating circumstances. If the delay is due to an administrative error on the part of the ministry; reconsideration should proceed. If reasons for the delay are not provided, it may be necessary to proceed with a non-reconsideration. Check with the Trainer/Supervisor if this is the case.

The R4R should arrive with documents from the dental practitioner setting out the names and numbers of the procedures requested; the numbers of the teeth involved, and the proposed fees. It is often necessary to contact the dental practitioner's office for these details. With Crown and Bridgework, it is possible to obtain all documents exchanged between PBC and the dentist's office. Email the contact group at PBC and they will send them as an email attachment.

Step 2 – Determine Basic Eligibility

BASIC ELIGIBILITY

- **Basic eligibility** criteria for **general health supplements** are set out in **section 67 of the EA Regulation** and **section 62 of the EAPWD Regulations**. Refer to the **Table: Eligibility for Health Supplements** for eligibility of various client categories.
- To receive ***basic dental services*** under the **EA Regulation**, it is necessary to meet one of the basic eligibility criteria set out in **section 68** of the EA Regulation. This section refers back to section 67.
- **Who is** eligible**?**
    - See the current Health Supplement Eligibility Summary in the Policy and Procedure Manual.
- To receive ***basic dental services*** under **section 63** the **EAPWD Regulation**, it is necessary to meet one of the criteria set out in Section 62 of the EAPWD Regulation.
- **Who is** eligible**?**
    - See the current Health Supplement Eligibility Summary in the Policy and Procedure Manual.

Dependent Children
Dependent children (persons under 19 years of age) of recipients of income assistance and disability assistance are eligible for $2000 for basic dental services every two years.

Healthy Kids
Dependent children of families in receipt of Premium Assistance through MOH are eligible for $2000 for basic dental services every two years under section 72 and Schedule C, section 7 of the EA Regulation.

Children in the Home of a Relative
Children in the Home of a Relative are eligible for $2000 for basic dental services every two years. (If they were CIHR prior to March 31, 2010 or had applied for CIHR prior to that date and were found eligible.)

Steps to Determine Basic Eligibility

- Confirm that the applicant has an open file. Make a note of the length of time the applicant has been on IA.
- Determine whether applicant has PWD or PPMB designation (Check SD More Info).
- Remember that the applicant may be the spouse or dependant of a person with PWD or PPMB designation, in which case he/she is considered a "recipient" of disability or (PPMB) income assistance.
- If the applicant is designated **PWD** or is the spouse or dependant of a recipient of disability assistance, the request will be adjudicated under the ***Employment and Assistance for Persons with Disabilities*** **[EAPWD]** ***Act*** **and Regulation**.
- If the applicant is qualified for the PPMB category, is the spouse or dependant of a recipient of income assistance who is designated as **PPMB**, or is simply on income assistance, the request will be adjudicated under the ***Employment and Assistance*** **[EA]** ***Act*** **and Regulation**.
- Obtain the applicant's PHN number from ICM and record it. To obtain the PHN number – go into the case, then contact. Highlight the client's name then click SIN/PHN. Record the PHN.
- Log on to CaresNet to obtain claims history. PBC will also have an accurate description of the applicant's status (i.e., PWD or PPMB designated, dependent child, spouse, CIHR, Emergency Only, etc.).

REMEMBER: IN MOST CASES, DETERMINATION OF BASIC ELIGIBILITY IS FAIRLY STRAIGHTFORWARD, AS THE APPLICANT IS EITHER DESIGNATED PWD OR PPMB, OR IS ON INCOME ASSISTANCE. IN THE CASE OF MSO, IT WILL BE NECESSARY TO DETERMINE WHAT THE CLIENT'S STATUS WAS BEFORE TRANSITIONING TO MSO.

Step 3 – Determine Eligibility for Dental Services Requested

BASIC DENTAL SERVICES

Recipients of Income Assistance and Adult Dependants

Recipients of income and hardship assistance are **not eligible for *basic dental services***. They are **only eligible for *emergency dental services,*** under the **EA Regulation, section 70 and Schedule C, section 6**, provided the legislative requirements are met.

Designated PWD and PPMB Recipients

The "nuts and bolts" for the provision of ***basic dental services*** are set out in **Schedule C, section 4** of both Regulations. Essentially, those having PWD or PPMB designations are **covered by the ministry for basic dental services to a maximum of $1000 for every "period"**. A "period" means a 2 year period beginning on January 1, 2003 and on each subsequent January 1 in an odd numbered year. The current "period" started on January 1, 2013.

It will be necessary to review the client's dental history with PBC to determine how much of the $1000 has been used. This information may be obtained from the PBC CaresNet site. The report will have a record of procedures performed, the teeth involved, the total amount paid on behalf of the client, the amount remaining to the client for basic dental services, and denial information, if any. **Note**: If there has been a recent transition in the applicant's status from Emergency Only to PPMB or PWD, be certain to check out the claims history under the former designation as well.

Basic dental services are set out in Part B of the Schedule of Fee Allowances – Dentist and Schedule of Fee Allowances – Denturist (the "Schedules"). These Schedules provide a description of the service, the fee number, and the amount the ministry is authorized to pay for the service.

Note: Be certain to read the Note at the beginning of each service section. That is where frequency and financial restrictions are described. Some services, such as restorations on a particular tooth and x-rays, have financial restrictions. Others, such as exams, have frequency restrictions. In these cases, it is necessary to access the client's claims history. The CaresNet site will provide information about the client's next eligibility date for certain services.

Check the Schedules of Fee Allowances to determine if there are any frequency and financial restrictions on the services requested and the rates the ministry is authorized to pay. You will be able to determine if the client has had previous restorations on a particular tooth. You may find that certain procedures are requested are not listed in the Schedules of Fee Allowances.

You will often find that the dental practitioner's fees are in excess of those set out in the Schedules. The ministry is not authorized to pay for procedures not listed in the Schedules or to pay for services at rates above those set out in the Schedules. The rationale for that is:

- **Section 63 of the EAPWD Regulation** and **section 68 of the EA Regulation** state that the minister may provide any health supplement set out in **section 4 of Schedule C**.
- **Section 4(1.1) of Schedule C** states that **the health supplements that may be paid under section 63 or section 68 are *"basic dental services"*.**
- ***"Basic dental services"*** are **defined in section 1** as those:
- that are **set out in the Schedules of Fees Allowances** for the current period, and
- **provided at the rates set out in the Schedules** of Fee Allowances.
- If the dental practitioner requests procedures that are not included in the Schedules of Fee Allowances and/or are not provided at the rates set out in the Schedules, they are not "basic dental services" that can be paid under section 63 or section 68 of the Regulations.
- Therefore, the ministry is not authorized to pay for procedures that are not set out in the Schedules of Fee Allowances or pay amounts for dental services at rates in excess of those set out in the Schedules.

For an example, see the "Fees in Excess" section of the decisions attached. In a number of cases, the applicant will be eligible for the procedures requested, but not at the rates specified.

DENTURES

Recipients of Income Assistance and Adult Dependants
Recipients of income assistance are **not eligible for dentures under section 68**. They are **eligible under the EA Regulation, section 69 and Schedule C, section 5,** provided the legislative requirements are met.

Under **section 69** of the EA Regulation, dentures are available to persons on income assistance and their dependants who are not eligible for dentures under section **68 *"if the recipient or dependant has had tooth extractions performed in the last six months because of pain and those extractions resulted in the recipient or dependant requiring a full upper denture, a full lower denture or both."***

The EA Regulation, Schedule C, section 5 stipulates that the health supplements that may be provided under section 69 are ***"denture services"***. *"Denture services"* are **defined in section 1 of the EA Regulation** as **procedures set out under certain fee numbers in the Schedules** and **provided at the rates set out for those procedures or items**. If provided by a **dentist**, the **fee numbers are 51101 to 51302** in the **Schedule of Fee Allowances-Dentist**. If provided by a **denturist**, the **fee numbers are 31310 to 31331** in the **Schedule of Fee Allowances-Denturist**. It the procedures or rates requested are not those listed in section 1 or in excess of the rates set out, this will have to be addressed as part of the reconsideration decision.

Designated PWD and PPMB Recipients
PWD and PPMB designates are eligible for **dentures** as ***basic dental services*** under **section 68 and Schedule C, section 4 of the EA Regulation** and **section 63 and Schedule C, section 4 of the EAPWD Regulation**.

Schedule C, section 4(2) of the Regulations sets out that **dentures may be provided to persons who have never worn dentures or whose dentures are more than 5 years old**. It is necessary to know whether the dentures requested are initial or replacement dentures. You will find this information in the applicant's claims history on CaresNet.

Under **Schedule C, section 4(3)** the ministry will pay the **amount necessary to provide dentures in excess of the $1000 limit providing certain conditions are met**. These conditions are set out in **subsections 4(3)(a), (b), and (c)**. It is necessary to have the applicant's dental history to determine whether the criteria are met.

NB:
- Check how long the applicant has been on IA to determine eligibility for replacement dentures. They must have been in receipt of disability assistance or income assistance for at least 2 years or a dependant of that person to qualify.
- Make certain the procedures requested are one of those listed in **subsections 4(5) and 4(6)**.

If the applicant is eligible for dentures but not at the rates submitted by the dental practitioner, you must address the rate issue in your decision.

Exception – Replacement Dentures
There is an exception in policy for the provision of replacement dentures before the five-year limit has expired if there is information to establish that the recipient's health may be compromised if replacement dentures are not provided

EMERGENCY DENTAL AND DENTURE SUPPLEMENTS

Recipients of Income Assistance and Adult Dependants
As stated, recipients of income and hardship assistance who do not qualify for the PPMB category are only eligible for ***emergency dental services***, which the ministry is authorized to provide under **section 70 and Schedule C, section 6 of the EA Regulation.**

An **"emergency dental service"** is **defined** in **section 1 of Schedule C** as
- a dental service necessary for the *immediate relief of pain*
- is set out in the Schedules of Fee Allowances-Emergency Dental-Denturist, and
- provided at a rate set out in those Schedules.

Emergency dental procedures are set out in Part D of the Schedules of Fee Allowances. If the procedures requested are not listed in Part D, they are not "emergency services" as defined by the legislation. If they are listed, but the rates proposed are in excess of those set out in the Schedules, that issue needs to be addressed as part of the reconsideration decision.

Designated PWD and PPMB Recipients
If applicants in these categories have utilized their $1000 maximum for basic dental service, the ministry may provide coverage for emergency dental supplements under **section 70 and Schedule C, section 6 of the EA Regulation** and section **64 and Schedule C, section 5 of the EAPWD Regulation**.

Note: The **basic requirements** that apply are: **the services requested are in the Schedule of Fee Allowances-Emergency Dental and Denturist, and they are provided at the rates set out in those Schedules**.

CROWN AND BRIDGEWORK SUPPLEMENT

Coverage for crown and bridgework is **only available to PWD and PPMB designates.**

Crown and Bridgework services are not "basic dental services". Requests must always be pre-authorized. Therefore, the information necessary to make a decision is more likely to be included with the R4R. If the information is not included, contact April Anderson at PBC and request the documents exchanged between the dentist and PBC to be sent. They will be sent as a PDF attachment to an e-mail.

Basic eligibility criteria to be considered for this supplement are set out in **Section 68.1 of the EA Regulation** and **Section 63.1 of the EAPWD Regulation**. **Further criteria are stipulated in Schedule C, Section 4.1 of both Regulations**. The applicant's limit of $1000 per "period" is not considered when making a determination about eligibility.

"Crown and Bridgework" is **defined in section 4.1** as **a service set out in the Schedule of Fee Allowances-Dentist-Crown and Bridgework and provided at a rate set out for that service**. It is necessary to refer to the Schedule of Fee Allowances-Dentist – Part F to

determine whether the services requested are listed there and at what rates. Crowns and bridges are **limited to one per tooth in a five-year period**. Therefore, it is necessary to obtain a record of the applicant's dental history with PBC for the past five years. This should be available on CaresNet. If not, contact April Anderson. In most cases, we are not dealing with replacement crowns.

If the applicant is eligible for Crown and Bridgework but the rates proposed exceed those set out in the Schedule of Fee Allowances that issue must be addressed as part of the reconsideration decision.

If the applicant has been provided with Crown and Bridgework and then applied to the ministry for reimbursement, the request is denied because pre-authorization is required.

LIFE-THREATENING HEALTH NEED

The ministry may provide health supplements set out in Schedule C to a person who is not otherwise eligible for the health supplement under **section 69 of the EAPWD Regulation and section 76 of the EA Regulation**.

Compelling information from a medical or dental practitioner may be submitted to establish a life-threatening health need for the items requested. However, **sections 69 and 76 only apply to supplements provided under Schedule C, section 2(1)(a) (medical supplies) and 2(1)(f) medical transportation and section 3 (medical equipment). Dental supplements are not provided under these sections. Therefore, sections 69 and 76 do not apply.**

For wording please refer to the template attached.

Step 4 – Enter outcome in ICM

Step 5 – Prepare Decision Package

Remember to include a copy of those portions of the Schedules of Fee Allowances – Dentist and/or Denturist used in making the decision.

Step 6 – Prepare Approval Letters for the Client, Dentist and PBC

- Prepare a standard form approval letter for the client, to be included with the decision package.
- Prepare an approval letter for the dentist, setting out the procedures and rates approved. Templates for dental form letters are provided in the RO Resource folder under "Approval Letter Templates". The original is to be sent to the dental office by mail or by fax.
- Save a copy of the Dentist Approval Letter in PDF format. Attach it to an email to April Anderson (AAnderson@pac.bluecross.ca).
- The letter is to be scanned into ICM so the EAW's and HAB have access to the decision should there be any questions.

- Complete the activity plan. If you have approved the services requested but not the fees charged, it will be a dual decision – approved/denied. It will be necessary to prepare an NOA for the client in that case.
- Send blind copy to the client and make a Note on ICM. "RB comment: SR1-XXXXX completed. Client (client's name) approved/denied for coverage for dental services requested (see dentist approval letter). Ministry not authorized to provide coverage for fees in excess of rates set out in the Schedule of Fee Allowances-Dentist (or Denturist, Crown & Bridgework).

INFANT FORMULA

1. What categories of clients are eligible for infant formula? Where can you find this information? Please cite legislation for each category.

- Dependent Child of Recipient of Income Assistance
- Dependent child of recipient of income assistance with PPMB classification
- Dependent child of person residing in Special Care
- Dependent child of recipient of disability assistance
- Dependent child of person receiving MSO
- Dependent child of recipient of Transitional Health Servcies

Eligible Categories	Legislation (to be updated)
A dependent child of a recipient of income assistance under section 4 of the *Act*	EA Regulation, subsection 74.1(a)
A dependent child of a recipient of hardship assistance under section 5 of the *Act*	EA Regulation, subsection 74.1(b)
A dependent child of a person referred to in section 67(1)(f) of the Regulation (on the day the person turned 65 they were a recipient of income assistance under section 2, 4, 6, 8 or 9 and were eligible for health supplements under section 2 or 3 of Schedule C.)	EA Regulation, subsection 74.1(c), and subsection 67(1)(f)
Note: A person eligible to receive a health supplement under subsection (1)(c) may receive the supplement for a maximum of one year from the date on which the person referred to in section 67(1)(f) ceased to be eligible for income assistance.	EA Regulation, subsection 74.1(2)
A dependent child of a person referred to in section 67(1)(g) of the Regulation (a person who has not reached 65 years of age; is a part of a family unit that ceased to be eligible for income assistance as a result of a payment made to the person or another member of the person's family unit under the settlement agreement approved by the Supreme Court in Action No. S50808, Kelowna Registry; was eligible for health supplements under section 2 or 3 of Schedule C on the day the person's family unit ceased to be eligible for income assistance).	EA Regulation, subsection 74.1(c.1), and subsection 67(1)(g)
A dependent child of a person referred to in section 67(1)(h) of the	EA Regulation, subsection 74.1(c.2), and

Regulation (a person who is part of a family unit that ceased to be eligible for income assistance as a result of an award of compensation under the *Criminal Injury Compensation Act* or an award of benefits under the *Crime Victim Assistance Act* made to the person or another member of the person's family unit; was eligible for health supplements under section 2 or 3 of Schedule C on the day the person's family unit ceased to be eligible for income assistance; is part of a family unit that is receiving premium assistance under the *Medicare Protection Act*.)	subsection 67(1)(h)
Note: A person eligible to receive a health supplement under subsection (1)(c) may receive the supplement for a maximum of one year from the date on which the person referred to in subsection 67(1)(f) ceased to be eligible for income assistance.	
A dependent child of a recipient of disability assistance under Schedule A	EAPWD Regulation, subsection 67.1(1)(a)
A dependent child of a recipient of hardship assistance under Schedule D	EAPWD Regulation, subsection 67.1(1)(b)
A dependent child of a person referred to in (i) section 1(b)(i) or (f) if the family unit is receiving premium assistance under the *Medicare Protection Act* (a person with disabilities who has not reached 65 years of age and who has ceased to be eligible for disability assistance because of employment income earned by the person or the person's spouse, if either the person or the person's spouse is under age 65 and the family unit is receiving premium assistance under the *Medicare Protection Act*, or is aged 65 or more and the person in the family unit is receiving the federal spouse's allowance or the federal guaranteed income supplement) (a person with disabilities who has ceased to be eligible for disability assistance because of an award of compensation under the *Criminal Injury Compensation Act* or an award of benefits under the *Crime Victim Assistance Act* made to the person or the person's spouse if the person is under age 65 and the family unit is receiving premium assistance under the *Medicare Protection Act*, or the person is aged 65 or more and any person in the family unit is receiving the federal spouse's allowance or the federal guaranteed income supplement,)	EAPWD Regulation, subsection 67.1(1)(c)(i) and subsections 62(1)(b)(i) or (f)
A dependent child of a person referred to in subsection 62(1)(b)(ii)	EAPWD Regulation, subsection 67.1(1)(c)(ii) and

(A person with disabilities who has not reached 65 years of age and who has ceased to be eligible for a disability assistance because of a pension or other payment under the Canada Pension Plan)	subsection 62(1)(b)(ii)
A dependent child of a person referred to in subsection 62(1)(b)(iii) (A person with disabilities who has not reached 65 years of age and who has ceased to be eligible for a disability assistance because of money received by the person or the person's spouse under the settlement agreement approved by the Supreme Court in Acton No. S50808, Kelowna Registry.	EAPWD Regulation, subsection 67.1(1)(c)(iii) and subsection 62(1)(b)(iii)
A dependent child of a person who was a recipient of disability assistance on the day he or she became 65 years of age.	EAPWD Regulation, subsection 67.1(1)(d)
A dependent child of a person whose family unit ceases to be eligible for disability assistance because of financial assistance provided through an agreement under section 12.3 of the *Child, Family and Community Service Act*, during the term of the agreement	EAPWD Regulation, subsection 67.1(1)(e) and subsection 62(1)(g)
Note: A person eligible to receive a health supplement under subsection (1)(c)(ii) or (d) may receive the supplement for a maximum of one year from the date on which the person referred to in section 62(1)(b)(ii) ceased to eligible for income assistance.	

2. What is the definition of "dependent child"? Where do you find it?

"dependent child", with respect to a parent, means a child, other than a child who is 18 years of age and is a person with disabilities, who resides in the parent's place of residence for more than 50% of each month and relies on that parent for the necessities of life, and includes a child in circumstances prescribed under subsection (2);
EA & EAPWD Act, Section 1 (definitions)

3. What is the definition of "infant formula"? Where do you find it?

There is no definition of infant formula

4. There are two situations where infant formula may be necessary. What are they?

(i) The dependent child needs a *specialized infant formula* to treat a *medical condition*.

(ii) The dependent child needs infant formula because the child is at *risk of contracting a disease that is transmissible through the mother's milk.*

5. How long can a dependent child described in paragraph (ii) receive infant formula? What kind of infant formula can they receive?

A dependent child described paragraph (ii) can receive the infant formula until the end of the month in which they turn a year old. They can receive normal infant formula – it does not need to be specialized to treat a medical condition, unless they happen to have a medical condition as well.

6. How long can a dependent child described in paragraph (i) receive infant formula? What kind of infant formula can they receive?

A dependent child described in paragraph (i) can receive infant formula for as long as it is prescribed by a medical or nurse practitioner. They may receive it as a standing order for two years if required (two years from the end of the month it was approved) if necessary. It must be a specialized infant formula to treat a specific *medical condition*. For example, a baby may be premature and classified as "failure to thrive". Therefore, they require Nestlé's Good Start for the first few months. Or, a child may have autism and an aversion to the consistency of most foods. Therefore, Pediasure is prescribed to maintain nutrition.

7. What are the ministry's basic requirements for infant formula?

A medical practitioner or nurse practitioner *confirms in writing* that either of the situations described above exists and the ministry is satisfied that the infant formula is medically required to treat the medical condition or respond to the risk identified.

MEDICAL EQUIPMENT AND DEVICES

1. **What categories of clients are eligible for medical equipment and devices? Where can you find this information? Please cite legislation for each category.**

- Dependent child of recipient of income assistance
- Dependent child and recipient of income assistance with PPMB designation
- Persons residing in Special Care
- Dependent child of recipient of hardship assistance
- Dependent child and recipients receiving Medical Services Only
- Dependent child of IA recipient eligible for Transitional Health Services
- Dependent child and PPMB recipient eligible for Transitional Health Services
- Life-Threatening Health Need

Eligible Categories	**Legislation (to be updated)**
All adults in family unit have PPMB status.	EA Regulation, section 67(1)(a)(i)(ii)
One adult in family with PPMB designation and one adult is employable and under 65.	EA Regulation, section 67(1)(a)(i)(ii)
One adult with PWD designation and one adult is employable and under 65.	EAPWD Regulation, section 62(1)(a)and(d)
All adults in family unit with PWD designation.	EAPWD Regulation, section 62(1)(a)
Adults in a *Special Care Facility* and their adult dependants.	EA Regulation, section 67(1)(b)and(c)
Medical Services Only (MSO)	EA Regulation, section 66.1(b)(i)(ii) EA Regulation, section 67(1)(f) EAPWD Regulation, section 61.1
Persons eligible for health supplements for persons with a life-threatening health need.	EA Regulation, section 76 EAPWD Regulation, section 69
Dependent children of recipients of income assistance, hardship assistance, or disability assistance.	EA Regulation section 67(1)(e) EAPWD Regulation, section 62(1)(d)and (e)
Children in the home of a relative if coverage is not available through the child's parents.	Was repealed but transitional legislation is in place **Child in home of relative transition** 1. The provisions referring to a child in the home of a relative, or otherwise applying in relation to such a child or the relative with whom such a child resides, of the

	Employment and Assistance Regulation, B.C. Reg. 263/2002, and of the Employment and Assistance for Persons with Disabilities Regulation, B.C. Reg. 265/2002, as those regulations read on March 31, 2010, continue to apply in relation to 1. (a) a child in the home of a relative who was eligible to receive income assistance under section 6 of the Employment and Assistance Regulation, on March 31, 2010, 2. (b) a child whose application under section 6 of the Employment and Assistance Regulation was received on or before March 31, 2010 and approved on or after that date, and 3. (c) the family unit of a relative with whom a child referred to in paragraph (a) or (b) was residing on March 31, 2010, until the date the child ceases to be eligible for income assistance under section 6 of the Employment and Assistance Regulation as it read on March 31, 2010. (B.C. Reg. 48/2010)

This information can be found in the OnLine Resource – Health Supplement Survey/Resources for Staff

Categories not eligible for medical equipment and devices include:

- All adults in family unit are under 65 and employable.
- Adult recipients of hardship assistance.

2. What types of medical equipment and devices does the ministry provide? Where can you find this information?

Types of Medical Equipment: April 1, 2010

April 1, 2010
Medical equipment and devices include **only** the following types of items:

- canes
- crutches
- walkers
- manual and power wheelchairs
- wheelchair seating systems
- scooters
- bathing and toileting aids
- hospital beds
- pressure relief mattresses
- floor or ceiling lift devices
- positive airway pressure devices
- apnea monitors
- suction machines and related supplies
- percussors
- nebulizers
- medical humidifiers
- inhaler accessory devices
- hearing instruments
- non-conventional glucose monitors

You can find this information on the Policy and Procedure Manual – Medical Equipment and Devices – Policy

Medical Equipment and devices provided by the ministry are also set out in the EA and EAPWD Regulation, Schedule C, sections 3.1 to 3.12.

3. **Where should you check for items that may be provided by the ministry that are not set out in the legislation or listed in the POLICY AND PROCEDURE MANUAL?**

This is a trick question. If the item is not listed in the legislation or the Policy and Procedure Manual), then it is most likely an "ineligible" item.

4. **What are the general requirements for *all* types of medical equipment and devices? Where can you find this information?.**

FROM THE Policy and Procedure Manual

Eligibility Criteria: December 6, 2010

December 6, 2010
Medical equipment and devices for medically essential needs are available to clients who are eligible for general health supplements. [For information on eligibility for general health supplements, see Related Links - Health Supplement Summary.]
Clients who are eligible for general health supplements may request medical equipment and devices. A requested item must meet the following:

- General Requirements for **All** Medical Equipment and Devices;
  and
- Specific Requirements for each **Individual Type** of Medical Equipment and Device.

General Requirements for <u>All</u> Medical Equipment and Devices

A client requesting medical equipment or devices must meet general requirements that apply to all medical equipment and devices:

- there are no resources available to the *family unit* to pay the cost of or obtain the medical equipment or device;
- the item is the least expensive, appropriate medical equipment or device;
- the item must be prescribed by a *medical practitioner* or *nurse practitioner*; **and/or** the medical need must be confirmed by the assessment of a relevant therapist (occupational, physical, or respiratory therapist)

  Note: a medical need for a positive airway pressure device must be prescribed by a medical practitioner or nurse practitioner **and** the medical need must be confirmed by a respiratory therapist
- the request must be pre-approved by the ministry prior to purchase;

  Note: the ministry will **not** accept payment responsibility, **except in cases of a life-threatening emergency**, for medical equipment purchased without prior approval.

LEGISLATION

General Requirements for all Medical equipment and devices (EA and EAPWD Regulations, Schedule C, section 3)

3 (1) Subject to subsections (2) to (5) of this section, the medical equipment and devices described in sections 3.1 to 3.12 of this Schedule are the health supplements that may be provided by the minister if
(a) the supplements are provided to a family unit that is eligible under section 67 (or section 62 for EAPWD) *[general health supplements]* of this regulation, and
(b) all of the following requirements are met:
(i) the family unit has received the pre-authorization of the minister for the medical equipment or device requested;
(ii) there are no resources available to the family unit to pay the cost of or obtain the medical equipment or device;
(iii) the medical equipment or device is the least expensive appropriate medical equipment or device.

5. What are the specific requirements for each type of medical equipment and device? Where can you find this information?

FROM THE POLICY AND PROCEDURE MANUAL

Specific Requirements for each Individual Type of Medical Equipment and Device

In addition to meeting the general requirements for all medical equipment and devices, a client must also meet the specific requirements for the requested type of item:

Equipment	Specific Requirements	Replacement Time Period
Canes, Crutches, Walkers	• the minister is satisfied that the cane, crutch, walker or related accessory is **medically essential to achieve or maintain basic mobility**	As needed
Manual and Power Wheelchairs	• the minister is satisfied that the wheelchair, upgraded component, or attached accessory is **medically essential to achieve or maintain basic mobility**	5 years
Wheelchair Seating Systems	• the minister is satisfied that the wheelchair seating system or accessory is **medically essential to achieve or maintain a person's positioning in a wheelchair**	2 years
Scooters	• the minister is satisfied that the scooter, upgraded component, or attached accessory	5 years

	is **medically essential to achieve or maintain basic mobility** • the total cost of the scooter and any accessories does not exceed $3,500 • an assessment by an occupational therapist has confirmed that it is unlikely that the person for whom the scooter has been prescribed will have a medical need for a wheelchair during the 5 years following the assessment	
Bathing and Toileting Aids	• the bathing or toileting aid is one of the following items: o a grab bar in a bathroom o a bath or shower seat o a bath transfer bench with hand held shower o a tub slide o a bath lift o a bed pan or urinal o a raised toilet seat o a toilet safety frame o a floor to ceiling pole in a bathroom o a portable commode chair • the minister is satisfied that the item is **medically essential to facilitate transfers of a person or to achieve or maintain a person's positioning**	5 years
Hospital Beds	• the minister is satisfied that the hospital bed, upgraded component, or attached accessory is **medically essential to facilitate transfers of a person to and from bed or to adjust a person's positioning in bed**	5 years
Pressure Relief Mattresses	• the minister is satisfied that the pressure relief mattress is **medically essential to prevent skin breakdown and maintain skin integrity**	5 years
Floor or Ceiling Lift Devices	• a floor or ceiling lift device means a device that stands on the floor or is attached to the ceiling that uses a sling system to transfer a person • the minister is satisfied that the floor or ceiling lift device is **medically essential to facilitate transfers of a person in a bedroom or a bathroom** • the cost of the floor or ceiling lift device does not exceed *$4,200*, or if the cost of the floor or ceiling lift device does exceed $4,200, the minister is satisfied that the excess cost is a result of unusual installation expenses	5 years
Positive Airway Pressure Devices	• the minister is satisfied that the positive airway pressure device or supply or accessory to operate the device is **medically essential for the treatment of moderate to severe sleep apnea**	5 years

Accessories or supplies required to operate a positive airway pressure device	• the minister is satisfied that the positive airway pressure device or supply or accessory to operate the device is **medically essential for the treatment of moderate to severe sleep apnea**	1 year
Apnea monitors, suction units, percussors, nebulizers, medical humidifiers	• the ministry is satisfied that the apnea monitor, accessory, or supply is **medically essential to monitor breathing**. • the ministry is satisfied that the suction unit, accessory, or supply is **medically essential for clearing respiratory airways**. • the ministry is satisfied that the percussor, accessory, or supply is **medically essential for clearing respiratory airways** • the ministry is satisfied that the nebulizer, accessory, or supply **is medically essential to avoid an imminent and substantial danger to health** • the ministry is satisfied that the medical humidifier, accessory or supply is medically **essential to moisturize air in order to allow a tracheostomy patient to breathe**	5 years
Inhalers Accessory Device (e.g. spacer)	• the ministry is satisfied that the inhaler accessory device, accessory, or supply **is medically essential to deliver medication**	1 year
Accessories or supplies required to operate an apnea monitor, suction unit, percussor, nebulizer, or medical humidifier		1 year
Non-Conventional Glucose Meters	• the ministry is satisfied that the item is medically essential to test blood glucose levels • the person is unable to use a conventional glucose meter	5 years

When clients no longer require the equipment and it cannot be exchanged or traded to meet a current need, they should be encouraged to donate the item to an agency that would benefit from that item.

FROM THE LEGISLATION – See the EA and EAPWD Regulations, Sections 3.1 to 3.9

6. How does the ministry define *medically essential for basic mobility*? Where can you find this information?

You can find this information on the POLICY AND PROCEDURE MANUAL.

Guidelines for Determining Medically Essential to Achieve or Maintain Basic Mobility: April 1, 2010

April 1, 2010
The following guidelines outline factors considered by the ministry when determining if medical equipment requests for canes, crutches, walkers, manual wheelchairs, power wheelchairs, or scooters are medically essential to achieve or maintain basic mobility. These guidelines assist ministry staff when reviewing the assessment provided by the client's Occupational Therapist (OT) or Physical Therapist (PT) and/or the prescription provided by the client's *medical practitioner* or *nurse practitioner*.

"Medically essential to achieve or maintain basic mobility" refers to a client's need for equipment due to a mobility impairment which is necessary to perform their day-to-day activities in their home and/or community.

Each equipment request is reviewed on an individual basis and the client's needs are taken into consideration. If the factors suggest that the equipment is medically essential to achieve or maintain basic mobility, and all other eligibility requirements have been met, the client is eligible for the requested equipment.

Note: the information to be considered under each factor is not all-inclusive as it is important to preserve the discretion of the ministry decision maker and allow for flexibility to assess uncommon or unexpected circumstances.

When assessing the information provided to determine if the equipment is **medically essential to achieve or maintain basic mobility**, the two factors to be considered are:

Factor 1: The client's mobility impairment
Information regarding the client's mobility impairment provides the medical basis for the equipment and the reason why it is being requested. The mobility impairment may result from a number of different medical conditions that restrict the client's functional ability.
When considering this factor, the following information is reviewed:

- The diagnosis provided by the medical practitioner or nurse practitioner to assist in determining if it is reasonable to expect that there are limitations to mobility and whether the medical condition presented is likely to need equipment.
- The assessment provided by the OT or PT to assist in determining the applicant's level of functioning. This includes information regarding:
    - The cause of the equipment request.
    - How the client mobilizes and performs day-to-day activities in their home and/or community.

- The client's ability to mobilize once reaching a destination point.
- Whether the medical condition would deteriorate without the equipment.
- Physical skills or limitations (e.g., head control, range of motion, vision, ambulation, endurance, coordination and strength) in relation to the equipment requested. Safety issues may also be identified such as a risk of falling without a walker or not having sufficient hand functional ability to operate a power wheelchair.
- Cognitive skills (e.g., visual spatial skills, judgment) in relation to the equipment request to identify if the client can safely use the equipment recommended.

Factor 2: The equipment requested

The type of equipment requested is reviewed to confirm that due to a mobility impairment, the product and components are required for the client's basic mobility.

When considering this factor, the following information is reviewed:

- Description of the recommended equipment that is being requested.

- The type and condition of the client's present equipment (if applicable) to determine its appropriateness and why it is no longer meeting the needs of the client. This may indicate if repairs or modifications can be done to the existing equipment or if a replacement is needed.
- The product specifications of each piece of equipment that has been trialed and the outcome of the trial to provide information regarding if the equipment recommended meets the client's needs and is the most cost effective.
- Details of the client's immediate environment if it contributes to the need for the equipment or the type of equipment requested (e.g., narrow door frames may necessitate a specific model of walker or wheelchair; hilly terrain may necessitate a walker with brakes.
- The adaptability of the equipment if the client's functional status is likely to change to determine if the equipment is sustainable in meeting their anticipated needs. For example, is the requested mobility equipment able to accommodate future modifications such as specialized seating or upgraded electronics for sip and puff control?
- Upgraded components may be considered if they are medically essential to achieve or maintain basic mobility.

Examples where a request **may be considered** medically essential to achieve or maintain basic mobility:

- A client with multiple sclerosis experiences excessive fatigue, unsteadiness, and occasional falls. A walker is requested to prevent falls and provide stability.
- A client with cerebral palsy who experiences impaired motor control is requesting a scooter. The OT recommends a scooter instead of a power wheelchair as the client's impairment is not likely to deteriorate and require custom seating in the near future. The client's goal is to use the scooter for grocery shopping as she does not have sufficient mobility to walk to the store.
- A manual wheelchair with a lighter weight frame is requested for a client. The information from the OT indicates that the lighter weight frame is required as the client cannot propel a heavier wheelchair due to ongoing shoulder injuries and pain.

Examples where a request **may not be considered** medically essential for basic mobility:

- The client does not have a medical condition or mobility impairment requiring equipment but wants a scooter.
- A client with diabetes is requesting a scooter. Although the client has a medical condition, the information from the medical practitioner, nurse practitioner or OT indicates that the diabetes is controlled and there are no symptoms that impair the client's mobility.
- A manual wheelchair with a lighter weight frame is requested for a client. Although the medical practitioner, nurse practitioner or OT indicates that the client needs a manual wheelchair, there is no reason identified why a lighter weight frame is required or why a manual wheelchair with a standard frame would not be sufficient. The client would be eligible for a manual wheelchair, but not the lighter weight frame.

7. How does the ministry define "moderate to severe sleep apnea"?

FROM THE POLICY AND PROCEDURE MANUAL:

Guidelines for Determining Medically Essential for Treatment of Moderate to Severe Sleep Apnea: April 1, 2010
April 1, 2010
Sleep apnea occurs when a person regularly stops breathing for 10 seconds or longer during sleep. It can be mild, moderate, or severe, based on the number of times an hour that the person stops breathing (apnea) or that airflow to the lungs is reduced.
The ministry will consider funding positive airway pressure devices when medically essential for treatment of **moderate to severe sleep apnea** based on information provided by the Respiratory Therapist.
To determine whether sleep apnea is moderate to severe, ministry staff use guidelines determined by Ministry of Health Services [see Contacts – Ministry of Health Services].

FROM THE MINISTRY OF HEALTH WEBSITE

Stages of Sleep Apnea

Topic Overview

Sleep apnea occurs when you regularly stop breathing for 10 seconds or longer during sleep. It can be mild, moderate, or severe, based on the number of times an hour that you stop breathing (apnea) or that airflow to your lungs is reduced (hypopnea). This is called the apnea-hypopnea index (AHI).

- **Mild apnea.** Mild apnea is defined as 5 to 14 episodes of apnea or reduced airflow to the lungs every hour. Symptoms may include drowsiness or falling asleep during activities that do not require much attention, such as watching television or reading. These symptoms may cause only minor problems at work or while spending time with friends or family.

- **Moderate apnea.** Moderate apnea is defined as 15 to 29 episodes of apnea or reduced airflow to the lungs every hour. Symptoms may include drowsiness or falling asleep during activities that require some attention, such as attending a concert or a meeting. These symptoms may cause moderate problems with work or social functioning.
- **Severe apnea.** Severe apnea is defined as 30 or more episodes of apnea or reduced airflow to the lungs every hour. Symptoms may include drowsiness or falling asleep during activities that require active attention, such as eating, talking, driving, or walking. These symptoms may cause severe problems with work or social functioning.

Sleep apnea may be classified differently in children, because they are still developing and they normally breathe at a faster rate than adults do.

By	Healthwise Staff
Primary Medical Reviewer	Anne C. Poinier, MD - Internal Medicine
Primary Medical Reviewer	Donald Sproule, MD, CM, CCFP, FCFP - Family Medicine
Specialist Medical Reviewer	Mark A. Rasmus, MD - Pulmonology, Critical Care Medicine, Sleep Medicine
Last Revised	August 19, 2011

Last Revised: August 19, 2011

Author: Healthwise Staff

Medical Review: Anne C. Poinier, MD - Internal Medicine & Donald Sproule, MD, CM, CCFP, FCFP - Family Medicine & Mark A. Rasmus, MD - Pulmonology, Critical Care Medicine, Sleep Medicine

8. What items are not considered medical equipment and devices for purposes of Schedule C, section 3.10? Cite legislation please.

FROM THE POLICY AND PROCEDURE MANUAL & LEGISLATION

Non-Eligible Items: April 1, 2010
April 1, 2010
The ministry does not provide medical equipment and devices that do not meet the eligibility criteria above. For example:

- walking poles [EA & EAPWD Regulations, Schedule C, subsection 3.1(2)]

- strollers [EA & EAPWD Regulations, Schedule C, subsection 3.2(1)]
- high performance wheelchair for recreational or sports use [EA & EAPWD Regulations, Schedule C, subsection 3.2(4)]
- scooters intended primarily for recreational or sports use [EA & EAPWD Regulations, Schedule C, subsection 3.4(5)]
- automatic turning beds [EA & EAPWD Regulations, Schedule C, subsection 3.6(3)(a)]
- containment type beds [EA & EAPWD Regulations, Schedule C, subsection 3.6(3)(b)]
- ventilators [EA & EAPWD Regulations, Schedule C, subsection 3.9(4)]
- lift chairs

9. What are the requirements for *replacement* of medical equipment and devices? Cite legislation please. Will the ministry *automatically* replace medical equipment and devices when the time period set out in the legislation for replacement has expired? If not, why not? Are there any exceptions? Where do you find this information?

The EAPWD Regulation, Schedule C, subsection 3(3) sets out that subjection to subsection 3(6), the minister may provide as a health supplement a replacement of medical equipment or medical device previously provided by the minister under that section that is damaged, worn out or not functioning if

(a) it is more economical to replace than to repair the medical equipment or device previously provided by the minister, and
(b) the period of time, if any, set out I sections 3.1 to .12 of this Schedule, as applicable, for the purposes of this paragraph, has passed.

Yes, in the Policy and Procedure Manual it states that
Note: The replacement time period does not apply when an item is required due to *changes in a person's medical condition or growth.*

10. What are the requirements for *repairs* of medical equipment or a medical device previously provided by the minister? What are the requirements for repairs to medical equipment or a medical device that was not previously provided by the minister? Cite legislation please.

The EA and EAPWD Regulations, Schedule C, subsection 3(4) sets out that subject to subsection (6), the minister may provide as a health supplement repairs of medical equipment or a medical device that was previously provided by the minister if it is more economical to repair the medical equipment or device than to replace it.

The EA and EAPWD Regulation, Schedule C, subsection 3(5) sets out that subject to subsection (6), the minister may provide as a health supplement repairs of medical equipment or a medical device that was not previously provided by the minister if

(a) at the time of the repairs the requirements in this section and section 3.1 to 3.12 of this Schedule, as applicable, are met in respect of the medical equipment or device being repaired, and
(b) it is more economical to repair the medical equipment or device than to replace it.

MEDICAL SUPPLIES

1. **What categories of clients are eligible for medical supplies? Where can you find this information? Please cite legislation for each category.**

- Dependent child of income assistance recipient.
- Dependent child and income assistance recipient classified PPMB
- Dependent child and recipient residing in Special Care
- Dependent child of recipient of hardship assistance
- Dependent child and recipient with Medical Services Only
- Dependent child of ETW recipient in Transitional Health Services
- Dependent child and recipient in Transitional Health Services with PPMB
- Life-Threatening Health Need

Eligible Categories	**Legislation (to be updated)**
All adults in family unit have PPMB status.	EA Regulation, section 67(1)(a)(i)(ii)
One adult in family with PPMB designation and one adult is employable and under 65.	EA Regulation, section 67(1)(a)(i)(ii)
One adult with PWD designation and one adult is employable and under 65.	EAPWD Regulation, section 62(1)(a)and(d)
All adults in family unit with PWD designation.	EAPWD Regulation, section 62(1)(a)
Adults in a *Special Care Facility* and their adult dependants.	EA Regulation, section 67(1)(b)and(c)
Medical Services Only (MSO)	EA Regulation, section 66.1(b)(i)(ii) EA Regulation, section 67(1)(f) EAPWD Regulation, section 61.1
Persons eligible for health supplements for persons with a life-threatening health need.	EA Regulation, section 76 EAPWD Regulation, section 69
Dependent children of recipients of income assistance, hardship assistance, or disability assistance.	EA Regulation section 67(1)(e) EAPWD Regulation, section 62(1)(d)and (e)
Children in the home of a relative if coverage is not available through the child's parents.	Was repealed but transitional legislation is in place **Child in home of relative transition** 1. The provisions referring to a child in the home of a relative, or otherwise applying in

	relation to such a child or the relative with whom such a child resides, of the Employment and Assistance Regulation, B.C. Reg. 263/2002, and of the Employment and Assistance for Persons with Disabilities Regulation, B.C. Reg. 265/2002, as those regulations read on March 31, 2010, continue to apply in relation to 1. (a) a child in the home of a relative who was eligible to receive income assistance under section 6 of the Employment and Assistance Regulation, on March 31, 2010, 2. (b) a child whose application under section 6 of the Employment and Assistance Regulation was received on or before March 31, 2010 and approved on or after that date, and 3. (c) the family unit of a relative with whom a child referred to in paragraph (a) or (b) was residing on March 31, 2010, until the date the child ceases to be eligible for income assistance under section 6 of the Employment and Assistance Regulation as it read on March 31, 2010. (B.C. Reg. 48/2010)

This information can be found in the OnLine Resource – Health Supplement Survey/Resources for Staff

Categories not eligible for medical supplies include:

- All adults in family unit are under 65 and employable.
- Adult recipients of hardship assistance.
- Dependent children of families in receipt of Premium Assistance through MOH

2. What are the general requirements for medical supplies? Where can you find this information? Please cite legislation.

FROM THE POLICY AND PROCEDURE MANUAL

Effective: October 1, 2012

Medical or surgical supplies are provided only to clients who are eligible for general health supplements. [see Related Links - Health Supplement Summary]

Medical or surgical supplies may be provided to eligible clients when the ministry is satisfied that **all** of the following requirements are met:

- the supplies are prescribed by a *medical practitioner* or *nurse practitioner*
- the supplies are the least expensive and appropriate for the purpose
- the supplies are disposable or reusable where appropriate
    - **reusable where appropriate** means a reusable medical supply may be considered when its purpose and use is more suitable than a disposable supply. Reusable medical supplies may have a lower environmental impact and be more cost effective in the long term. For example, cloth diapers may be more appropriate in some circumstances than disposable diapers.
- the request is pre-approved by the ministry (the ministry does **not** accept payment responsibility, except in cases of a life-threatening emergency, for medical supplies purchased prior to approval)
- **only** the following can be considered:
    - wound care
    - ongoing bowel care required due to loss of muscle function
    - catheterization
    - incontinence
    - skin parasite care
    - limb circulation
    - food thickeners
    - lancets
    - needles and syringes
    - ventilator supplies
    - tracheostomy supplies

'he supplies are necessary to avoid an imminent and substantial danger to health

- **imminent and substantial danger to health** refers to an immediate need for medical supplies where, without the medical supplies, the person is at risk for compromised health. For example, a person requires bandages for a serious burn. The bandages are required immediately, and without them the person is at risk for infections and poor healing.

- no resources are available to the *family unit* to cover the cost of the supplies (for details see below)

Clients are responsible for providing required documentation. The ministry is not responsible for any fees associated with documentation.

Medical supplies may be approved for the period of time indicated on the prescription, up to a maximum of 2 years. For ongoing medical supply requests, the ministry's Health Assistance Branch will assign a review date at the time of approval. Three months prior to this review date, clients will receive a letter requesting confirmation to renew their request for ongoing medical supplies. Additional medical documentation will only be requested where necessary (for example, a new medical supply item is required or there is a significant change in quantities).

LEGISLATION

Requirements for Medical Supplies (EA and EAPWD Regulations, Schedule C, subsection 2(1))

2 (1) The following are the health supplements that may be paid for by the minister if provided to a family unit that is eligible under section 62 *[general health supplements]* of this regulation:

(a) medical or surgical supplies that are, at the minister's discretion, either disposable or reusable, if the minister is satisfied that all of the following requirements are met:

(i) the supplies are required for one of the following purposes:

(A) wound care;
(B) ongoing bowel care required due to loss of muscle function;
(C) catheterization;
(D) incontinence;
(E) skin parasite care;
(F) limb circulation care;

(ii) the supplies are

(A) prescribed by a medical practitioner or nurse practitioner,
(B) the least expensive supplies appropriate for the purpose, and
(C) necessary to avoid an imminent and substantial danger to health;

(iii) there are no resources available to the family unit to pay the cost of or obtain the supplies.

(B.C. Reg. 66/2010)

(b) Repealed (B.C. Reg. 236/2003)

(1.1) For the purposes of subsection (1)(a), medical and surgical supplies do not include nutritional supplements, food, vitamins, minerals or prescription medications. (B.C. Reg. 66/2010)

3. What types of medical supplies does the ministry provide? Where can you find this information?

You can find this information on the POLICY AND PROCEDURE MANUAL – Medical Supplies – Policy

Effective: October 1, 2012

The following medical or surgical supplies may be considered when all eligibility criteria are met. This is a general guide and is **NOT** all-inclusive.

Note: Rubber gloves may be provided to either the client or a non-employed care provider when required as part of the care of the client.

- Wound care
  - Bandages and dressings may be considered for wound care including, but not limited to, skin ulcer products, gel pads, protectors, burn treatment garments. Wound care supplies do not include band aids for minor wounds.
- Ongoing bowel care required due to loss of muscle function
  - Bowel stimulants may be considered for persons with impaired bowel function. For example, a person who is quadriplegic may have lost use of bowel muscles requiring laxatives. Items include, but are not limited to, dulcolax, lactulose, senokot, fleet enemas, and skin care products. Bowel stimulants are not intended for persons requiring laxatives due to an insufficient diet.
- Catheterization
  - Medical supplies required for draining the bladder may be considered. Items include, but are not limited to, catheters, urinary drainage bags, skin care products, and powder.
- Incontinence
  - Medical supplies required for involuntary excretion of urine and the inability to control bowels may be considered. Items include, but are not limited to, diapers, pads, leg bags, and skin care products.
- Skin parasite care
  - Medicated shampoo may be considered for parasitic skin infections, such as scabies and lice.
- Limb circulation
  - Compression stockings may be considered to support limb circulation.
- Food thickeners
  - Food thickeners may be considered to thicken food texture to assist with swallowing difficulties.
- Lancets

    - Lancets may be considered for obtaining blood samples for persons with diabetes. Fair Pharmacare provides other diabetic supplies, including needles, syringes, test strips, and insulin.
- Needles and syringes
    - Needles and syringes may be considered for delivering medication and feeding. Needles and syringes for persons with diabetes are provided by Fair Pharmacare, and are therefore, not provided by the Ministry of Social Development and Poverty Reduction.
- Ventilator supplies
    - Items such as vinegar, hydrogen peroxide, and distilled water may be considered for the essential operation or sterilization of a ventilator.
- Tracheostomy supplies
    - Items such as tubes and bandages may be considered for persons with a tracheostomy.

4. Where should you check for items that may be provided by the ministry that are not set out in the legislation or listed in the POLICY AND PROCEDURE MANUAL?

Effective: April 1, 2010

The ministry does not provide medical or surgical supplies that do not meet the eligibility criteria above, including the following:

- nutritional supplements
- food
- vitamins or minerals
- prescription medications

5. How does the ministry define *imminent and substantial danger to health*? Where can you find this information?

You can find this information on the POLICY AND PROCEDURE MANUAL, under policy.

imminent and substantial danger to health refers to an immediate need for medical supplies where, without the medical supplies, the person is at risk for compromised health. For example, a person requires bandages for a serious burn. The bandages are required immediately, and without them the person is at risk for infections and poor healing.

6. What items are not considered medical supplies? Cite legislation please.

FROM THE POLICY AND PROCEDURE MANUAL & LEGISLATION

Non-Eligible Items: April 1, 2010
April 1, 2010
The ministry does not provide medical equipment and devices that do not meet the eligibility criteria above, including the following:.

- nutritional supplements
- food
- vitamins or minerals
- prescription medications

LEGISLATION

EA & EAPWD REGULATIONS, SCHEDULE C, SUBSECTION 2(1)
(1.1) For the purposes of subsection (1)(a), medical and surgical supplies do not include nutritional supplements, food, vitamins, minerals or prescription medications. (B.C. Reg. 66/2010)

7. What does the ministry mean by "no other resources available" Where do you find this information?

No Other Resources: April 1, 2010

April 1, 2010
By regulation, the ministry is the payer of last resort and requires that all other available resources must first be considered before requesting funding. For *income assistance* and *disability assistance* clients, other resources include (but are not limited to) accessing medical supplies or funding through:

- other government programs (e.g., Fair PharmaCare, Health Authorities, ICBC, WorkSafeBC, Veterans Affairs Canada),
- private insurance,
- publicly subsidized residential care facilities (when it is the client's place of residence). Clients living in facilities funded by the Ministry of Health Services (MHS) are not eligible for medical supplies from the ministry. These needs must be met through the facility. **Facility staff should be contacted to determine the funding source.**

If there are other resources available, the individual is not eligible for medical supplies from the ministry.
Co-funding may be considered when other resources cannot pay the entire cost. For example, if an insurance company will pay $500 for an item that costs $1,000, the ministry may consider funding the remaining $500 if all other eligibility criteria are met.
Note: When assessing medical supplies eligibility for income or disability assistance clients, exempt assets are not considered. When assessing other resources for persons with a life-threatening health need or persons who are medical services only, see Related Links – Life Threatening Health Need and Medical Services Only.

FOR NON-CLIENTS WITH LIFE-THREATENING HEALTH NEED
April 1, 2010
By regulation, the ministry is the payer of last resort. All other resources should first be considered when determining eligibility. Other resources include (but are not limited to) meeting health-related needs or accessing funding through:

- other government programs (e.g., PharmaCare, Health Authorities, ICBC, WorkSafeBC, Veterans Affairs Canada)
- private insurance
- charitable organizations (e.g., Red Cross Loan Cupboard)
- family and friends
- Publicly subsidized residential care facilities (when it is the client's place of residence). Clients living in facilities funded by the Ministry of Health (MoH) are not eligible for medical supplies from the ministry. These needs must be met through the facility. Facility staff should be contacted to determine the funding source.

In addition, individuals who are not ministry clients must use assets in excess of the *Persons with Disabilities* asset limits [see Rate Table – Assets] before they will be eligible under life-threatening health needs. Assets considered include (but are not limited to) cash balances, RRSPs and non-discretionary trusts.
Note: Bank loans, lines of credit and credit cards are not considered assets for the purposes of determining eligibility under life-threatening health needs.
If there are other resources available, the person will not be eligible under life-threatening health needs. Co-funding may be considered when other available resources cannot pay the entire cost.

This information is found in the POLICY AND PROCEDURE MANUAL.

8. For what length of time can medical supplies be approved? Where can you find this information?

Medical supplies may be approved for the period of time indicated on the prescription, up to a maximum of 2 years. For ongoing medical supply requests, the ministry's Health Assistance Branch will assign a review date at the time of approval. Three months prior to this review date, clients will receive a letter requesting confirmation to renew their request for ongoing medical supplies. Additional medical documentation will only be requested where necessary (for example, a new medical supply item is required or there is a significant change in quantities). This information is available on the POLICY AND PROCEDURE MANUAL.

9. Where can you find the client's medical supplies history?

Currently, you can find the client's medical supplies history in their Benefit Plans History in ICM.

10. Why would you need to review this information?

If the ministry has provided the supplies in the past, it is difficult to argue that the client is not eligible for them now, particularly if the client's circumstances have not changed. For instance, a client is denied incontinence supplies because it is determined that he/she is residing in a publically-subsidized residential care facility and the facility should be providing them. This is deemed to be a "resource" available to the client to cover the cost of the supplies. However, the client was previously provided with incontinence supplies while residing at the same address. So it may be legitimate to ask – what has changed?

The legislation was changed on April 1, 2010. However, prior to April 1, 2010, there was a similar "no resources available" requirement. That being said, if the ministry made a mistake in providing the supplies in the past, there is no need to compound the error.

11. How can you tell if a client is residing in a publically subsidized residential care facility?

The best option is to contact the facility to determine if they can fund the item. We do realize that there is a risk that the facility may say they do not fund the item (even if they do) but we are relying on their professionalism to be honest. HAB staff should always be checking with the facility before making a decision. "

There is a list of Registered Assisted Living Residences in the Medical Supplies file in the Health Supplements Training Folder. However, this list was last updated on April 1, 2008. For a current list of registered Community Care Facilities go to http://www.health.gov.bc.ca/ccf/survey/index.php/displayhealthauthority/index

This will only give you an idea about whether the facility could be a registered publically subsidized residential care facility. The best practice is to call the manager at the facility itself.

EXTENDED MEDICAL THERAPIES

1. What categories of clients are eligible for extended medical therapies? Where can you find this information? Please cite legislation for each category.

- Dependent child of income assistance recipient
- Dependent child and income assistance recipient with PPMB classification
- Dependent child and person residing in Special Care
- Dependent child and disability assistance recipient
- Dependent child of recipient of hardship assistance
- Dependent child and recipient with Medical Services Only
- Dependent child of ETW income assistance recipient with Transitional Health Services
- Dependent child and PPMB recipient with Transitional Health Services
- Life-Threatening Health Need

Eligible Categories	**Legislation (to be updated)**
All adults in family unit have PPMB status.	EA Regulation, section 67(1)(a)(i)(ii)
One adult in family with PPMB designation and one adult is employable and under 65.	EA Regulation, section 67(1)(a)(i)(ii)
One adult with PWD designation and one adult is employable and under 65.	EAPWD Regulation, section 62(1)(a)and(d)
All adults in family unit with PWD designation.	EAPWD Regulation, section 62(1)(a)
Adults in a *Special Care Facility* and their adult dependants.	EA Regulation, section 67(1)(b)and(c)
Medical Services Only (MSO)	EA Regulation, section 66.1(b)(i)(ii) EA Regulation, section 67(1)(f) EAPWD Regulation, section 61.1
Dependent children of recipients of income assistance, hardship assistance, or disability assistance.	EA Regulation section 67(1)(e) EAPWD Regulation, section 62(1)(d)and (e)
Children in the home of a relative if coverage is not available through the child's parents.	Was repealed but transitional legislation is in place **Child in home of relative transition** 1. The provisions referring to a child in the home of a relative, or otherwise applying in relation to such a child or the relative with

	whom such a child resides, of the Employment and Assistance Regulation, B.C. Reg. 263/2002, and of the Employment and Assistance for Persons with Disabilities Regulation, B.C. Reg. 265/2002, as those regulations read on March 31, 2010, continue to apply in relation to 1. (a) a child in the home of a relative who was eligible to receive income assistance under section 6 of the Employment and Assistance Regulation, on March 31, 2010, 2. (b) a child whose application under section 6 of the Employment and Assistance Regulation was received on or before March 31, 2010 and approved on or after that date, and 3. (c) the family unit of a relative with whom a child referred to in paragraph (a) or (b) was residing on March 31, 2010, until the date the child ceases to be eligible for income assistance under section 6 of the Employment and Assistance Regulation as it read on March 31, 2010. (B.C. Reg. 48/2010)

This information can be found in the OnLine Resource – Health Supplement Survey/Resources for Staff

Categories not eligible for extended medical therapies include:

- All adults in family unit are under 65 and employable.
- Adult recipients of hardship assistance.

2. **How many visits does the Medical Services Plan (MSP) premium assistance cover per calendar year for recipients of income assistance or disability assistance?**

The Medical Services Plan covers extended medical therapies to a combined limit of up to 10 visits per calendar year.

3. **What happens if a therapist has opted out of MSP or charges above the MSP fee schedule?**

The ministry does **not** pay for any extra billing charges.

4. **What are the general requirements for extended medical therapies? Where can you find this information? Please cite legislation.**

FROM THE POLICY AND PROCEDURE MANUAL

Extended Medical Therapies: November 25, 2008

The ministry may consider extension of extended medical therapies for recipients eligible for general health supplements when:

- Recipients have exhausted their 10 visits for the year authorized under MSP
- A medical practitioner or nurse practitioner has confirmed an acute need, not chronic (acute means severe and immediate, whereas chronic refers to ongoing conditions)
- No other resources, including local hospital out-patient facilities, are available

LEGISLATION

2 (1) The following are the health supplements that may be paid for by the minister if provided to a family unit that is eligible under section 62 [or 67 for EA] *[general health supplements]* of this regulation:

(c) subject to subsection (2), a service provided by a person described opposite that service in the following table, delivered in not more than 12 visits per calendar year,

(i) for which a medical practitioner or nurse practitioner has confirmed an *acute* need, (B.C. Reg. 317/2008)

(ii) if the visits available under the Medical and Health Care Services Regulation, B.C. Reg. 426/97, for that calendar year have been provided and for which payment is not available under the *Medicare Protection Act*, and

(iii) for which there are no resources available to the family unit to cover the cost:

Item	Service	Provided by	Registered with
1	acupuncture	acupuncturist	College of Traditional Chinese Medicine under the *Health Professions Act*
2	chiropractic	chiropractor	British Columbia College of Chiropractors under the *Chiropractors Act*
3	massage therapy	massage therapist	College of Massage Therapists of British Columbia under the

			Health Professions Act
4	naturopathy	naturopath	College of Naturopathic Physicians of British Columbia under the *Health Professions Act*
5	non-surgical podiatry	podiatrist	British Columbia Association of Podiatrists under the *Podiatrists Act*
6	physical therapy	physical therapist	College of Physical Therapists of British Columbia under the *Health Professions Act*

(B.C. Reg. 75/2008) (B.C. Reg. 318/2008) (B.C. Reg. 85/2012)
(2) No more than 12 visits per calendar year are payable by the minister under this section for any combination of physical therapy services, chiropractic services, massage therapy services, non-surgical podiatry services, naturopathy services and acupuncture services. (B.C. Reg. 10/2004) (B.C. Reg. 75/2008) (B.C. Reg. 318/2008) (B.C. Reg. 85/2012)
(2.1) If eligible under subsection (1) (c) and subject to subsection (2), the amount of a general health supplement under section 62 of this regulation for physical therapy services, chiropractic services, massage therapy services, non-surgical podiatry services, naturopathy services and acupuncture services is $23 for each visit. (B.C. Reg. 318/2008) (B.C. Reg. 85/2012)

5. How many therapy visits over the 10 provided by MSP will the ministry provide?

The ministry will provide funding for 12 visits over the 10 provided by MSP.

6. What will the ministry pay per visit?

The ministry will pay $23 per visit.

7. What if a person is receiving therapy services from more than one practitioner?

The ministry provides coverage for 12 visits at $23 per visit. The 12 visits can be for any combination of services, but cannot exceed 12.

8. Where can you find the client's medical therapies history?

You can find the client's medical therapies history in their Health Case Benefit Plans History in ICM.

OPTICAL SUPPLEMENTS (EYE EXAMS)

1. **What categories of clients are eligible for the Optical Supplements (Eye Exams)? Where can you find this information? Please cite legislation for each category.**

- Adult recipient of income assistance
- Adult recipient of income assistance with PPMB classification
- Adult persons residing in Special Care
- Dependent child and adult disability recipients
- Adult recipient of hardship assistance
- Adult with Medical Services Only
- Adult ETW recipient with Transitional Health Services
- Adult PPMB recipient with Transitional Health Services

Effective: September 1, 2017

The ministry covers routine eye examinations once every two years, through Pacific Blue Cross, for:

- adults aged 19 to 64 who are in receipt of *income assistance, disability assistance* or *hardship assistance*
- recipients of Medical Services Only (MSO) or Transitional Health Services (THS) if between ages 19 and 64

Routine eye examinations for children under 19 years of age and seniors continue to be covered by Medical Services Plan (MSP), as do medically necessary eye exams for everyone registered with *MSP*, regardless of age.

Payment for eye exams may not exceed the amounts shown in Rate Table: Health Supplements and Programs – Optical Services.

Eligible Categories	**Legislation (to be updated)**
Eye Exams	
EA A recipient of income assistance	EA Regulation, subsection 67.2(1)(a)
A recipient of hardship assistance, other than under section 42	EA Regulation, subsection 67.2 (1)(b)

[applicants who do not meet citizenship requirements]	
A person referred to in section 67(1)(c)(iv) or (h) if (i) the person is under age 65 and the family unit is receiving premium assistance under the Medicare Protection Act, or (ii) the person is aged 65 or more and any other person in the family unit is receiving the federal spouse's allowance or guaranteed income supplement. Section 67(1)(h): is part of a family unit that ceased to be eligible for income assistance as a result of an award of compensation under the *Criminal Injury Compensation Act* or an award of benefits under the *Crime Victim Assistance Act* made to the person or another member of the person's family unit; was eligible for health supplements under section 2 or 3 of Schedule C on the day the person's family unit ceased to be eligible for income assistance and either (a) if the person is under age 65, the family unit is receiving premium assistance under the *Medicare Protection Act*, or (b) if the person is aged 65 or more, any person in the family unit is receiving the federal spouse's allowance or the federal guaranteed income supplement. Section 67(1)(c)(iv) – a dependent of a person referred to in subsection 67(1)(h)	EA Regulation, subsection 67.2(1)(c)
EAPWD	
A recipient of disability assistance	EAPWD Regulation, subsection 62.2(1)(a)
A recipient of hardship assistance, other than under section 38 *[applicants who do not meet citizenship requirements]*	EAPWD Regulation, subsection 62.2(1)(b)
A person with disabilities who has not reached 65 years of age and who has ceased to be eligible for disability assistance because of (i) employment income earned by the person or the person's spouse, if either the person or the person's spouse (a) is under age 65 and the family unit is receiving premium assistance under the Medicare Protection Act, or (b) is aged 65 or more and a person in the family unit is receiving the federal spouse's allowance of the federal guaranteed income supplement, or (ii) a pension or other payment under the *Canada Pension Plan*.	EAPWD Regulation, subsection 62.2(1)(c)
A dependant of a person referred to in paragraph (c)(i) if (i) the dependant was a dependant of the person on the day the person ceased to be eligible for disability assistance and remains a	EAPWD Regulation, subsection 62.2(1)(d)

dependant of that person, and (ii) the family unit is receiving premium assistance under the *Medicare Protection Act.*	
A dependent of a person referred to in paragraph (c)(ii),if the dependant was a dependant of the person on the day that person ceased to be eligible for disability assistance and remains a dependant of that person	EAPWD Regulation, subsection 62.2(1)(d.1)
A dependant of a person who, on that person's 65th birthday, is receiving disability assistance, if the dependant was a dependant of that person (i) on the date that person ceased to be eligible for disability assistance and remains a dependant of that person, and (ii) while any person in the family unit is receiving the federal spouse's allowance or the federal guaranteed income supplement, for a maximum of one year from the date on which the family unit ceased to be eligible for medical services only.	EAPWD Regulation, subsection 62.2(1)(e)
A person referred to in section 62(1)(f), if (i) the person is under age 65 and the family unit is receiving premium assistance under the *Medicare Protection Act*, or (ii) the person is aged 65 or more and any person in the family unit is receiving the federal spouse's allowance or the federal guaranteed income supplement) (This is a person who is no longer eligible for disability assistance because of an award under the *Criminal Injury Compensation Act* or benefits under the *Crime Victim Assistance Act*.)	EAPWD Regulation, subsection 62.2(1)(f)
A person whose family unit ceases to be eligible for disability assistance because of financial assistance provided through an agreement under section 12.3 of the *Child, Family and Community Service Act*, during the term of the agreement.	EAPWD Regulation, subsection 62.2(1)(g)

Who is not eligible for the Optical Supplement of Eye Exams?
Persons eligible for health supplements for persons with a life-threatening health need. Healthy Kids

EA Supplementary Eligibility Requirements
A person who was eligible to receive an eye examination supplement under subsection 67.2(1)(c) ((ceased to receive income assistance because of an award under the *Criminal Injury Compensation Act* or a benefit under the *Crime Victim Assistance Act*) but ceases to be eligible for medical services only may continue to receive the supplement for a maximum of one year from the date o which the family unit cased to be eligible for medical services only. [EA Regulation, subsection 67.2(4)]

An eye examination supplement under the EA Regulation, Schedule C, section 2.2, may be provided only if payment for the service is not available under the *Medicare Protection Act*. [EA Regulation, subsection 67.2(3)

EAPWD: Supplementary Eligibility Requirements:

If a person is eligible to receive an eye examination supplement because they have ceased to be eligible for disability assistance due to a pension or other payment under the *Canada Pension Plan,* or they are the dependant of such a person, they may receive the supplement: (a) while any person in the family unit is (i) under age 65 and receiving a pension or other payment under the *Canada Pension Plan*, or (ii) aged 65 or more and receiving the federal spouse's allowance or the federal guaranteed income supplement, and (b) for the maximum of one year from the date on which the family unit ceased to be eligible for medical services only. [EAPWD Regulation, subsection 62.2(1.1)]

A person who was eligible to receive an eye examination supplement under subsection 62.1(1)(c)(i)(ceased to receive disability assistance because of employment income) or (f) (ceased to receive disability assistance because of an award under the *Criminal Injury Compensation Act* or a benefit under the *Crime Victim Assistance Act*) but ceases to be eligible for medical services only may continue to receive the supplement for a maximum of one year from the date on which the family unit cased to be eligible for medical services only. [EAPWD Regulation, subsection 62.2(1.2)]

An eye examination supplement under the EAPWD Regulation, Schedule C, section 2.2, may be provided only if payment for the service is not available under the *Medicare Protection Act*. [EAPWD Regulation, subsection 62.2(4)]

2. Is there a limit to the number of eye examinations a person can have?

Yes. A person is not eligible for more than one eye examination in any 24 calendar month period. [EA Regulation, subsection 67.2(2) and EAPWD Regulation, subsection 67.2(3)

3. What are the eye examination supplements that may be paid for by the minister? Cite legislation please.

EA and EAPWD Regulations, Schedule C, section 2.2 – The ministry may pay for any eye examination that,

(a) if provided by an optometrist, is provided for a fee that does not exceed $44.83, or

(b) if provided by an ophthalmologist, is provided for a fee that does not exceed $48.90.

4. What is an "eye examination"? Cite legislation please.

EA and EAPWD Regulations, Schedule C, section 1

"**eye examination**" a full diagnostic examination of a person's eyes by an optometrist or an ophthalmologist, that includes

(a) a determination of the refractive status of the eyes and of the presence of any observed abnormality in the person's visual system;

(b) any necessary tests connected to making determinations under paragraph (a); and

(c) the provision of a written prescription for lenses if necessary.

5. What are an "ophthalmologist", "optician", and an "optometrist"?

"ophthalmologist" means a medical practitioner who practices ophthalmology.
"optician" means an optician registered with the College of Opticians of British Columbia established under the *Health Professions Act*
"optometrist" means an optometrist registered with the British Columbia Association of Optometrists under the *Optometrists Act*

OPTICAL SUPPLEMENTS (Basic and Pre-Authorized Eyewear)

1. **What categories of clients are eligible for the Optical Supplements (Eyeglasses)? Where can you find this information? Please cite legislation for each category.**

- Everyone except Life-Threatening Health Need.

Eligible Categories	Legislation (to be updated)
Optical Supplement	
EA A *recipient of income assistance* under section 2 *[monthly support allowance]*, 4 *[monthly shelter allowance]*, 6 *[people receiving room and board]*, 8 [*people receiving special care]* **or** 9 *[people in emergency shelters]* of Schedule A.	EA Regulation, subsection 67.1(1)(a)
A *recipient of hardship assistance*, other than under section 42 [applicants who do not meet citizenship requirements]	EA Regulation, subsection 67.1(1)(b)
A dependent child of a recipient referred to in paragraph (a) or (b)	EA Regulation, subsection 67.1(1)(c)
A person who was a *recipient of income assistance* under section 2 *[monthly support allowance]*, 4 *[monthly shelter allowance]*, 6 *[people receiving room and board]*, 8 *[people receiving special care]* or 9 *[people in emergency shelters]* of Schedule A on the day he or she *reached 65 years of age and was eligible for supplements* under section 2 *[general health supplements]* or 3 *[medical equipment and devices]* of Schedule C on that day	EA Regulation, subsection 67.1(1)(e)
A *dependent of a person referred to in paragraph (e)*, if the dependant was a dependant of the person on the day the person reached 65 years of age and remains a dependant of that person,	EA Regulation, subsection 67.1(1)(f)
A person referred to in section 67(1)(c)(iv) or (h) if (i) the person is under age 65 and the family unit is receiving premium assistance under the Medicare Protection Act, or (ii) the person is aged 65 or more and any other person in the family unit is receiving the federal spouse's allowance or guaranteed income supplement. Section 67(1)(h): is part of a family unit that ceased to be eligible for	EA Regulation, subsection 67.1(1)(g) *Good grief!*

income assistance as a result of an award of compensation under the *Criminal Injury Compensation Act* or an award of benefits under the *Crime Victim Assistance Act* made to the person or another member of the person's family unit; was eligible for health supplements under section 2 or 3 of Schedule C on the day the person's family unit ceased to be eligible for income assistance and either (a) if the person is under age 65, the family unit is receiving premium assistance under the *Medicare Protection Act*, or (b) if the person is aged 65 or more, any person in the family unit is receiving the federal spouse's allowance or the federal guaranteed income supplement. Section 67(1)(c)(iv) – a dependent of a person referred to in subsection 67(1)(h)	
EAPWD	
A recipient of disability assistance	EAPWD Regulation, subsection 62.1(1)(a)
A recipient of hardship assistance, other than under section 38 *[applicants who do not meet citizenship requirements]*	EAPWD Regulation, subsection 62.1(1)(b)
A dependent child of a recipient referred to in paragraph (a) or (b)	EAPWD Regulation, subsection 62.1(1)(c)
A person with disabilities who has not reached 65 years of age and who has ceased to be eligible for disability assistance because of (i) employment income earned by the person or the person's spouse, if the family unit is receiving premium assistance under the *Medicare Protection Act*, or (ii) a pension or other payment under the *Canada Pension Plan* (Canada)	EAPWD Regulation, subsection 62.1(1)(d)
A dependent of a person referred to in paragraph (d)(i) if (i) the dependent was a dependant of the person on the day the person ceased to be eligible for disability assistance and remains a dependant of that person, and (ii) the family unit is receiving premium assistance under the *Medicare Protection Act*	EAPWD Regulation, subsection 62.1(1)(e)
A dependent of a person referred to in paragraph (d)(ii),if the dependant was a dependant of the person on the day the person ceased to be eligible for disability assistance and remains a dependant of that person	EAPWD Regulation, subsection 62.1(1)(e.1)
A person who was in receipt of disability assistance on the day he or she reached 65 years of age	EAPWD Regulation, subsection 62.1(1)(f)
A dependant of a person referred to in paragraph (f) if the dependant was a dependant of the person on the day the person reached 65	EAPWD Regulation, subsection 62.1(1)(g)

years of age and remains a dependant of that person	
A person referred to in section 62(1)(f), if the person's family unit is receiving premium assistance under the *Medicare Protection Act* (a person with disabilities who has ceased to be eligible for disability assistance because of an award of compensation under the *Criminal Injury Compensation Act* or an award of benefits under the *Crime Victim Assistance Act* made to the person or the person's spouse, if (i) the person is under age 65 and the family unit is receiving premium assistance under the *Medicare Protection Act*, or (ii) the person is aged 65 or more and any person in the family unit is receiving the federal spouse's allowance or the federal guaranteed income supplement)	EAPWD Regulation, subsection 62.1(1)(h)
A person whose family unit ceases to be eligible for disability assistance because of financial assistance provided through an agreement under section 12.3 of the *Child, Family and Community Service Act*, during the term of the agreement.	EAPWD Regulation, subsection 62.1(1)(i)

Who is not eligible for the Optical Supplement of Eyeglasses?
Persons eligible for health supplements for persons with a life-threatening health need.

2. What are the optical supplements that may be paid for by the minister? Cite legislation please.

EA and EAPWD Regulations, Schedule C, section 2.1
(a) basic eyewear and repairs,
(b) pre-authorized eyewear and repairs

3. What are "basic eyewear and repairs"? Cite legislation please.

EA and EAPWD Regulations, Schedule C, section 1
"**basic eyewear and repairs**" means any of the following items that are provided by an optometrist, ophthalmologist or optician:
(a) for a child who has a new prescription, one pair of eye glasses per year consisting of the *least expensive appropriate*
(i) single-vision or bifocal lenses, and
(ii) frames;
(b) for any other person who has a new prescription, one pair of eye glasses every 3 years consisting of the least expensive appropriate
(i) single-vision or bifocal lenses, and
(ii) frames;

(c) for a child or other person,
(i) new lenses at any time if an optometrist, ophthalmologist or optician confirms a change in refractive status in either eye,
(ii) a case for new eye glasses or lenses, and
(iii) necessary repairs to lenses or frames that come within this definition

4. How often can a child receive new eye glasses? How often can an adult receive new eye glasses?

Children can receive new eye glasses once a year with a valid prescription. Adults can receive new eye glasses once every three years.

For information about the last time a client received new eye glasses, contact Leslie Paterson at PBC. ldpaterson@pac.bluecross.ca

5. What if a child or adult's prescription changes before the time period to receive new eye glasses expires? What other items can children and adults receive before the time period expires?

They can get new lenses any time if an optometrist, ophthalmologist or optician confirms a change in refractive status in either eye. Refer to the definition of change of refractive status in the legislation. There is no need to interpret the prescription. The SME at PBC can do that and will be able to tell you whether the change in refractive status is enough to warrant new lenses. ldpaterson@pac.bluecross.ca

They can receive a case for new eye glasses or lenses and necessary repairs to lenses or frames.

6. What is a "change in refractive status"? Cite legislation please.

EA and EAPWD Regulations, Schedule C, section 1

"**change in refractive status**" means a change of not less than 0.5 dioptres to the spherical or cylinder lens, or a change in axis that equals or exceeds

(a) 20 degrees for a cylinder lens of 0.5 dioptres or less,
(b) 10 degrees for a cylinder lens of more than 0.5 dioptres but not more than 1.0 dioptre, and
(c) 3 degrees for a cylinder lens of more than 1.0 dioptre.

7. What is pre-authorized eyewear and repairs? Cite legislation please. Where can you find a description of what items might be considered pre-authorized eyewear and repairs?

EA and EAPWD Regulations, Schedule C, section 1

Means eyewear and repairs provided by an optometrist, ophthalmologist or optician and for which pre-authorization is given by the minister, but does not include basic eyewear and repairs.

From the POLICY AND PROCEDURE MANUAL:

Pre-authorized eyewear and repairs include changeable colored lenses or tints, special lenses or lens material, special or oversized frames, and contact lenses. Health Assistance Branch only considers these special supplements when confirmed as *medically essential by an*

optometrist or ophthalmologist. Pre-authorized optical supplements *also include replacement glasses without a significant change in prescription or outside the time limitations set by the ministry*.

8. Are there any financial limits to what the ministry will pay for eye glasses?

The ministry does have Schedules of Fee Allowances for Optometrists and for Opticians. This will give you some idea about what the ministry considers "least expensive, appropriate". However, unlike the dental fee schedules, the optical are not directly referenced in the legislation. Therefore, we do not have the legislative authority to apply these rates. Theoretically, the cost of basic eyeglasses should be decreasing because of new technology. We have a right to question the optician or optometrist if the lenses or frames seem to be more than "basic" – there must be a medical justification for "extras", such as tinted lenses, lenses with UV coating or transitional lenses, or for a specialized frame.

ORTHOTICS & BRACING

1. **What categories of clients are eligible for orthotics and bracing? Where can you find this information? Please cite legislation for each category.**

- Dependent child of recipient of income assistance
- Dependent child and recipient of income assistance with PPMB designation
- Persons residing in Special Care
- Dependent child of recipient of hardship assistance
- Dependent child and recipients receiving Medical Services Only
- Dependent child of IA recipient eligible for Transitional Health Services
- Dependent child and PPMB recipient eligible for Transitional Health Services
- Life-Threatening Health Need

Eligible Categories	**Legislation (to be updated)**
All adults in family unit have PPMB status.	EA Regulation, section 67(1)(a)(i)(ii)
One adult in family with PPMB designation and one adult is employable and under 65.	EA Regulation, section 67(1)(a)(i)(ii)
One adult with PWD designation and one adult is employable and under 65.	EAPWD Regulation, section 62(1)(a)and(d)
All adults in family unit with PWD designation.	EAPWD Regulation, section 62(1)(a)
Adults in a *Special Care Facility* and their adult dependants.	EA Regulation, section 67(1)(b)and(c)
Medical Services Only (MSO)	EA Regulation, section 66.1(b)(i)(ii) EA Regulation, section 67(1)(f) EAPWD Regulation, section 61.1
Persons eligible for health supplements for persons with a life-threatening health need.	EA Regulation, section 76 EAPWD Regulation, section 69
Dependent children of recipients of income assistance, hardship assistance, or disability assistance.	EA Regulation section 67(1)(e) EAPWD Regulation, section 62(1)(d)and (e)
Children in the home of a relative if coverage is not available through the child's parents.	Was repealed but transitional legislation is in place **Child in home of relative transition** 1. The provisions referring to a child in the home of a relative, or otherwise applying in relation to such a child or the relative with

	whom such a child resides, of the Employment and Assistance Regulation, B.C. Reg. 263/2002, and of the Employment and Assistance for Persons with Disabilities Regulation, B.C. Reg. 265/2002, as those regulations read on March 31, 2010, continue to apply in relation to 1. (a) a child in the home of a relative who was eligible to receive income assistance under section 6 of the Employment and Assistance Regulation, on March 31, 2010, 2. (b) a child whose application under section 6 of the Employment and Assistance Regulation was received on or before March 31, 2010 and approved on or after that date, and 3. (c) the family unit of a relative with whom a child referred to in paragraph (a) or (b) was residing on March 31, 2010, until the date the child ceases to be eligible for income assistance under section 6 of the Employment and Assistance Regulation as it read on March 31, 2010. (B.C. Reg. 48/2010)

This information can be found in the OnLine Resource – Health Supplement Survey/Resources for Staff

Categories not eligible for orthotics include:

- All adults in family unit are under 65 and employable.
- Adult recipients of hardship assistance.

2. Does the ministry provide a definition of "orthoses"? If so, what is it and where can you find it?

There are two places:

In the EA and EAPWD Regulations, Schedule C, section 3.10(1). This sets out that the following are orthoses for the purposes of section 3.10:
(a) a custom-made or off-the-shelf foot orthotic;
(b) custom-made footwear;
(c) a permanent modification to footwear;
(d) off-the-shelf footwear required for the purpose set out in subsection (4.1) (a);
(e) off-the-shelf orthopaedic footwear;
(f) an ankle brace;
(g) an ankle-foot orthosis;
(h) a knee-ankle-foot orthosis;
(i) a knee brace;
(j) a hip brace;
(k) an upper extremity brace;
(l) a cranial helmet used for the purposes set out in subsection (7);
(m) a torso or spine brace;
(n) a foot abduction orthosis; (B.C. Reg 197/2012);
(o) a toe orthosis. (B.C. Reg. 197/2012)

(B.C. Reg. 144/2011)

In addition, subsection **3.10(12)** sets out that an accessory or supply that is medically essential to use an orthosis that is a health supplement under subsection (2) is a health supplement for the purposes of section 3 of this Schedule. [i.e. stockings to use under a Knee Ankle Foot Orthosis]

The POLICY AND PROCEDURE MANUAL (see Medical Equipment and Devices – Orthosis) also provides a definition: *Orthoses are items that are applied externally to the limb or body to provide support, protection or replacement of lost function. They are also commonly known as an orthosis, orthotic, brace, or splint.*

3. What are the general requirements for *all* types of orthoses? Please cite legislation.

General Requirements for all Medical equipment and devices (EA and EAPWD Regulations, Schedule C, section 3)

3 (1) Subject to subsections (2) to (5) of this section, the medical equipment and devices described in sections 3.1 to 3.11 of this Schedule are the health supplements that may be provided by the minister if
(a) the supplements are provided to a family unit that is eligible under section 67 (or section 62 for EAPWD) *[general health supplements]* of this regulation, and
(b) all of the following requirements are met:
(i) the family unit has received the pre-authorization of the minister for the medical equipment or device requested;
(ii) there are no resources available to the family unit to pay the cost of or obtain the medical equipment or device;
(iii) the medical equipment or device is the least expensive appropriate medical equipment or device.

General Requirements for <u>All</u> Orthoses (From the POLICY AND PROCEDURE MANUAL)

A client requesting orthoses must meet the general requirements that apply to **all** orthoses:

- there are no resources available to the *family unit* to pay the cost of or obtain the item;
- the item is the least expensive, appropriate orthosis;
- only one orthosis per part of the body may be considered;
  Note: one "resting" orthosis may also be considered for each part of the body.
- the item must be prescribed by a *medical practitioner* or *nurse practitioner*;
- the request must be pre-approved by the ministry prior to purchase;
  Note: the ministry will **not** accept payment responsibility, **except in cases of a life-threatening emergency**, for orthoses purchased without prior approval.
- the minister is satisfied that the item is medically essential to achieve or maintain basic functionality;
- the item is required for one or more of the following purposes:
  - to prevent surgery
  - for post-surgical care
  - to assist in physical healing from surgery, injury or disease
  - to improve physical functioning that has been impaired by a neuro-musculo-skeletal condition
- custom-made items will be considered when the following are met:
  - a medical practitioner or nurse practitioner confirms that a custom-made orthosis is medically required;
  - the custom-made orthosis is fitted by a certified orthotist, certified pedorthist, occupational therapist, physical therapist, or podiatrist.

Legislation (EA and EAPWD Regulation, Schedule C, section 3.10)

(2) Subject to subsections (3) to (12) of this section, an orthosis is a health supplement for the purposes of section 3 of this Schedule if

(a) the orthosis is prescribed by a medical practitioner or a nurse practitioner,
(b) the minister is satisfied that the orthosis is medically essential to achieve or maintain ***basic functionality***,
(c) the minister is satisfied that the orthosis is required for one or more of the following purposes:
    (i) to prevent surgery;
    (ii) for post-surgical care;
    (iii) to assist in physical healing from surgery, injury or disease;
    (iv) to improve physical functioning that has been impaired by a neuro-musculo-skeletal condition, and
(d) the orthosis is off-the-shelf unless
(B.C. Reg. 144/2011)
    (i) a medical practitioner or nurse practitioner confirms that a custom-made orthosis is medically required, and
    (ii) the custom-made orthosis is fitted by an orthotist, pedorthist, occupational therapist, physical therapist or podiatrist.

4. How does the ministry define *basic functionality*? Where can you find this information?

You can find this information on the POLICY AND PROCEDURE MANUAL.

Guidelines for Determining Medically Essential to Achieve or Maintain Basic Functionality: April 1, 2010 **(From the POLICY AND PROCEDURE MANUAL)**

April 1, 2010

The following guidelines outline factors considered by the ministry when determining if orthoses requests are medically essential to achieve or maintain ***basic functionality***.
These guidelines assist ministry staff when reviewing the information provided by the client's *medical practitioner* or *nurse practitioner* and, when required, information from an orthotist, pedorthist, podiatrist, occupational therapist or physical therapist.
"Medically essential to achieve or maintain basic functionality" refers to a client's need for orthoses due to an impairment which is necessary to perform their day-to-day activities in their home and/or community.
Each orthosis request is reviewed on an individual basis and the client's needs are taken into consideration. If the factors confirm that the item is medically essential to achieve or maintain basic functionality, and all other eligibility requirements have been met, the client is eligible for the requested item.

Note: the information to be considered under each factor is not all-inclusive as it is important to preserve the discretion of the ministry decision maker and allow for flexibility to assess uncommon or unexpected circumstances.
When assessing the information provided to determine if the orthoses is **medically essential to achieve or maintain basic functionality**, the two factors to be considered are:

Factor 1: The client's impairment

Information regarding the client's impairment provides the medical basis for the item and the reason why it is being requested. The impairment may result from a number of different medical conditions that restrict the client's functional ability.
When considering this factor, the following information is reviewed:

- The diagnosis provided by the medical practitioner or nurse practitioner to assist in determining if it is reasonable to expect that there are functional limitations and whether the medical condition presented is likely to need orthoses.
- The medical information provided to assist in determining the applicant's level of functioning. This includes information regarding:
    - the reason for the orthosis request
    - how the client performs day-to-day activities in their home and/or community
    - whether the medical condition would deteriorate without the orthoses
    - physical skills or limitations (e.g., range of motion, ambulation, endurance, coordination and strength) in relation to the item requested

Factor 2: The orthosis requested

The type of orthosis requested is reviewed to confirm that due to an impairment, the item is required for basic functionality.
When considering this factor, the following information is reviewed:

- Description of the item that is being requested.
- The type and condition of the client's present orthosis (if applicable) to determine its appropriateness and why it is no longer meeting the needs of the client. This may indicate if repairs or modifications can be done to the existing item or if a replacement is needed.
- The adaptability of the orthosis if the client's functional status is likely to change, to determine if the item is sustainable in meeting their anticipated medical needs. For example, is the requested knee-ankle-foot orthosis able to accommodate future modifications such as specialized knee hinges?

Examples where a request **may be considered** medically essential to achieve or maintain basic functionality:

- A client with a torn anterior cruciate ligament (ACL) is requesting a custom knee brace. The brace is prescribed by a medical practitioner and fitted by an orthotist. It is required to achieve walking ability to carry out basic activities such as grocery shopping, cooking and housekeeping.
- A client with severe osteoarthritis is requesting an off-the-shelf wrist brace. The brace is prescribed by a medical practitioner and required to maintain joint motion so the client can carry out personal care and housekeeping.

Examples where a request **may not be considered** medically essential to achieve or maintain basic functionality:

- A client with a torn anterior cruciate ligament (ACL) is requesting an off-the-shelf knee brace prescribed by a nurse practitioner. The brace is only for use in playing soccer. Sports are not considered "day-to-day activities."
- The client does not have a medical condition or impairment requiring orthoses but wants custom-made shoes.

5. What items are not considered orthoses for purposes of Schedule C, section 3.10? Cite legislation please.

(11) The following items are not health supplements for the purposes of section 3 of this Schedule:
(a) a prosthetic and related supplies;
(b) a plaster or fiberglass cast;
(c) a hernia support;
(d) an abdominal support;
(e) a walking boot for a fracture;
(f) Repealed (B.C. Reg. 144/2011)
(B.C. Reg. 61/2010)

6. Please complete the table. Where do you find this information?

ORTHOSES - SPECIFIC ELIGIBILITY REQUIREMENTS

Orthosis Schedule C, section 3.10(1)	Specific Eligibility Requirements (cite legislation)	Quantity Limits (cite legislation) S.3.10(9)	Frequency Limits (cite legislation) S3.10(10)	Financial Limits (cite legislation)
Custom Made Foot Orthotic	**EA & EAPWD Regulations, Schedule C, section 3.10(3)** a) a medical practitioner or nurse practitioner confirms that a custom-made foot orthotic is medically required; (b) the custom-made foot orthotic is fitted by an orthotist, pedorthist, occupational therapist, physical therapist or podiatrist; d) the custom-made foot orthotic must be made from a hand-cast mold; e)the cost of one pair, including the assessment fee, must not exceed $450	1 or 1 pair	3 years	$450.00
Off-the-Shelf Foot Orthotic				
Custom Made Footwear	**EA & EAPWD Regulations, Schedule C, section 3.10(4)** (4) For an orthosis that is custom-made footwear, in addition to the requirements in subsection (2) of this section, the cost of the custom-made footwear, including the assessment fee, must not exceed $1 650.	1 or 1 pair	1 year	$1650.00
Permanent		1 or 1 pair	1 year	

Modification to Footwear				
Off-the-Shelf Footwear Required for Purpose specified in legislation	**EA & EAPWD Regulations, Schedule C, section 3.10(4.1)** 4.1) For an orthosis that is off-the-shelf footwear, in addition to the requirements in subsection (2) of this section, (a) the **footwear is required to accommodate a custom-made orthosis,** and (b) the cost of the footwear must not exceed $125. "off-the-shelf footwear" means conventional, non-orthopaedic footwear	1 or 1 pair	1 year	$125.00
Off-the-shelf Orthopaedic footwear	**EA & EAPWD Regulations, Schedule C, section 3.10(4.2)** (4.2) For an orthosis that is off-the-shelf orthopaedic footwear, in addition to the requirements in subsection (2) of this section, the cost of the footwear must not exceed $250. (B.C. Reg. 144/2011) "off-the-shelf orthopaedic footwear" means footwear **intentionally designed to accommodate a medical condition**	1 or 1 pair	1 year	$250.00
An ankle brace		1 per ankle	2 years	
An ankle-foot orthosis		1 per ankle	2 years	
A knee-ankle-foot orthosis		1 per leg	2 years	
A knee brace	**EA & EAPWD Regulations, Schedule C, section 3.10(5)** (5) For an orthosis that is a knee brace, in addition to the requirements in subsection (2) of this section, the medical practitioner or nurse practitioner who prescribed the knee brace must have recommended that the knee brace be worn at least 6 hours per day.	1 per knee	4 years	
A hip brace		1	2 years	
An upper extremity brace	**EA & EAPWD Regulations, Schedule C, section 3.10(6)** (6) For an orthosis that is an upper extremity brace, in addition to the requirements in subsection (2) of this section, the upper extremity brace must be intended to provide hand, finger, wrist, elbow or shoulder support.	1 per hand, finger, wrist, elbow or shoulder	2 years	
A cranial helmet used for purposes set out in legislation	**EA & EAPWD Regulations, Schedule C, section 3.10(7)** (7)For an orthosis that is a cranial helmet, in addition to the requirements in subsection (2) of this section, the cranial helmet must be a helmet prescribed by a medical practitioner or nurse practitioner and recommended for daily use in cases of self abusive behavior, seizure disorder, or to protect or facilitate healing of chronic wounds or cranial defects.	1	2 years	
A torso or spine brace	**EA & EAPWD Regulations, Schedule C, section 3.10(8)**	1	2 years	

	8) For an orthosis that is a torso or spine brace, in addition to the requirements in subsection (2) of this section, the brace must be intended to provide pelvic, lumbar, lumbar-sacral, thoracic-lumbar-sacral, cervical-thoracic-lumbar-sacral, or cervical spine support.			
Foot abduction orthosis		1 or 1 pair		
Toe orthosis		1	1 year	

7. Are there any exceptions to the frequency limits? What are they? Where can you find this information?

You can find this information on the POLICY AND PROCEDURE MANUAL, which states: **Note: The replacement time period does not apply when an item is required due to changes in a person's medical condition or growth.**

SHORT-TERM NUTRITIONAL SUPPLEMENT

1. What categories of clients are eligible for the Short Term-Nutritional Supplement? Where can you find this information? Please cite legislation for each category.

- Dependent child and recipient of income assistance.
- Dependent child and recipient of income assistance with PPMB classification.
- Dependent child and recipient residing in Special Care facility
- Dependent child and recipient of disability assistance

Eligible Categories	Legislation (to be updated)
All adults in family unit are under 65 and employable	EA Regulation, section 74
All adults in family unit have PPMB status	EA Regulation, section 74
One adult in family with PPMB designation and one adult is employable and under 65	EA Regulation, section 74
One adult with PWD designation and one adult is employable and under 65	EAPWD Regulation, section 67(3)
All adults in family unit with PWD designation	EAPWD Regulation, section 67(3)
Dependent children of recipients of income assistance, hardship assistance, or disability assistance	EA Regulation, section 74 EAPWD Regulation, section 67(3)
Children in the home of a relative if coverage is not available through the child's parents	Was repealed but transitional legislation is in place **Child in home of relative transition** 1. The provisions referring to a child in the home of a relative, or otherwise applying in relation to such a child or the relative with whom such a child resides, of the Employment and Assistance Regulation, B.C. Reg. 263/2002, and of the Employment and Assistance for Persons with Disabilities Regulation, B.C. Reg. 265/2002, as those regulations read on March 31, 2010, continue to apply in relation to 1. (a) a child in the home of a relative

	who was eligible to receive income assistance under section 6 of the Employment and Assistance Regulation, on March 31, 2010, 2. (b) a child whose application under section 6 of the Employment and Assistance Regulation was received on or before March 31, 2010 and approved on or after that date, and 3. (c) the family unit of a relative with whom a child referred to in paragraph (a) or (b) was residing on March 31, 2010, until the date the child ceases to be eligible for income assistance under section 6 of the Employment and Assistance Regulation as it read on March 31, 2010. (B.C. Reg. 48/2010)

2. **What categories of clients are not eligible for the Short-Term Nutritional Supplement?** Dependent child and recipient of hardship assistance

Dependent child and recipient with Medical Services Only
Dependent child and ETW recipient of income assistance with Transitional Health Services
Dependent child and PPMB recipient of income assistance with Transitional Health Services
Life-threatening health need
Healthy Kids

1.
Section 1 of the *EA Act* defines "income assistance" as an amount for shelter and support provided under section 4 *[income assistance and supplements]*;
Section 1 of the *EAPWD Act* defines "disability assistance" as an amount for shelter and support provided under section 5 *[disability assistance and supplements]*;
Clients in special care facilities receive assistance under the EA and EAPWD Regulation, Schedule A, section 8.
Clients in receipt of hardship assistance do not receive *income assistance under section 4 of the EA Act or section 5 of the EAPWD Act.* They receive assistance under section 5(1) of the *EA Act* and section 6(1) of the *EAPWD Act.*

3. What are the types of items provided by the ministry as Short-Term Nutritional Supplements? Where can you find this information?

Nutritional supplements such as Boost, Ensure, Glucerna, etc. You can find this information in the POLICY AND PROCEDURE MANUAL. The legislation does not describe exactly what is meant by the term Short-Term Nutritional Supplement.

4. List the eligibility requirements for receipt of Short-Term Nutritional Products.

(a) Basic eligibility (receipt of income or disability assistance or dependent child of recipient)
(b) A medical or nurse practitioner confirms *in writing* that the recipient has
(c) an *acute short-term need* for *caloric supplementation* to a *regular dietary intake*
(d) to *prevent critical weight loss*
(e) while *recovering* from any of the following
- surgery
- a severe injury
- a serious disease
- side effects of medical treatment

5. For what period of time is the ministry authorized to provide Short-Term Nutritional Products? Can they be issued for longer?

By regulation, short-term nutritional supplements can be provided to eligible recipients for a maximum of three calendar months.

No. If after the three months has passed, the recipient has another acute need for short-term nutritional supplementation, such as they have now had surgery, a second request can be made to Health Assistance Branch.

6. Where can you find out how many times the client has applied for and received Short-Term Nutritional Products? Why would you need this information?

You would check the client's benefit history on ICM.

If the client is designated as PWD, you may suggest that she/he complete an application for MNS. You may enclose information from the Policy and Procedure Manual about MNS, and an application form. This would be placed under the heading "For Information Purposes", after your decision.

If the client is not designated as PWD, you may suggest a diet supplement if they are not already receiving one.

If the problem is poor dentition or the need for dentures, you may outline what dental supplements are available to them, i.e., emergency dental, dentures, $1000 available for basic dental services; etc.

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7. Are clients who are receiving the MNS of nutritional items eligible for Short-Term Nutritional Supplements?

No. The legislation specifies that the minister may provide STNS if "the recipient or dependent child is not receiving a supplement under subsection (1) of this section (EAPWD Regulation, s. 67). However, clients who are in receipt of the MNS of nutritional items can elect to suspend receipt of this supplement in order to receive Short-Term Nutritional Supplements. The MNS of nutritional items can be reinstated at the client's request after the client no longer requires Short-Term Nutritional Supplements. **Note:** A client can continue to receive the MNS of Vitamin/Mineral Supplements when receiving Short-Term Nutritional Supplements.

8. Are clients who are receiving the Tube Feed Supplement eligible for Short-Term Nutritional Supplements?

No. The EA Regulation, s. 74.01 and the EAPWD Regulation, s. 67.01 set out that the minister may provide a tube feed nutritional supplement under these sections if

> (b) the person is not receiving a supplement under section 66 [diet supplement] or 67 [nutritional supplement], or a diet, nutritional or tube feed nutritional supplement under section 2(3) of Schedule C.

Note: Section 2(3) of Schedule C deals with supplements that have been "grandfathered" by past tribunal awards or legislation.

9. Would it be likely that a person suffering from anorexia would be approved for Short-Term Nutritional Supplements?

No. The purpose of the Short-Term Nutritional Supplement is to provide *caloric supplementation* to a *regular dietary intake*. The Short-Term Nutritional Supplement is not intended as a *meal replacement*. If there was evidence that a regular dietary intake was being attempted, then it could be provided. There would also have to be evidence that there was an *acute short-term need* for the supplement, and the condition was not chronic.

TUBE FEED SUPPLEMENT

1. **What categories of clients are eligible for the Tube Feed Supplement? Where can you find this information? Please cite legislation for each category.**

- Dependent child and recipient of income assistance
- Dependent child and recipient of disability assistance
- Dependent child and recipient with Medical Services Only – if individual was already receiving Tube Feed Supplement prior to family unit transitioning to MSO or THS coverage
- Dependent child and adult ETW recipient with Transitional Health Services - if individual was already receiving Tube Feed Supplement prior to family unit transitioning to MSO or THS coverage
- Dependent child and adult PPMB recipient with Transitional Health Services - if individual was already receiving Tube Feed Supplement prior to family unit transitioning to MSO or THS coverage

Eligible Categories	**Legislation (to be updated)**
All adults in family unit are under 65 and employable	EA Regulation, section 74.01(2)(a), Schedule A
All adults in family unit have PPMB status	EA Regulation, section 74.01(2)(a), Schedule A
One adult in family with PPMB designation and one adult is employable and under 65	EA Regulation, section 74.01(2)(a), Schedule A
One adult with PWD designation and one adult is employable and under 65	EAPWD Regulation, section 67.01(2)(a), Schedule A
All adults in family unit with PWD designation	EAPWD Regulation, section 67.01(2)(a), Schedule A
Adults in a *special care facility* and their adult dependants. *Recipients residing in an alcohol and drug special care facility are eligible.* Recipients residing in a long term special care facility are **not** eligible.	EA Regulation, section 74.01(2)(f), Schedule A(8)(2) EAPWD Regulation, section 67.01(2)(f), Schedule A(8)(2)
Medical Services Only (MSO). *Only if the recipient is receiving the tube feed supplement at the time their family unit transitions to MSO.*	EA Regulation, section 74.01(2)(d)(e)(e.1)(g) EAPWD Regulation, section 67.01(2)(c)(c.1)(c.2)
Dependent children of recipients of income assistance or disability assistance. Dependent children of recipients of income assistance and disability assistance are eligible. *Dependent children of recipients of hardship assistance are **not** eligible.*	EA Regulation, section 74.01(2)(b), Schedule A EAPWD Regulation, section 67.01(2)(b)
Children in the home of a relative if coverage is not available through	Was repealed but transitional legislation is in place

the child's parents	**Child in home of relative transition** 1. The provisions referring to a child in the home of a relative, or otherwise applying in relation to such a child or the relative with whom such a child resides, of the Employment and Assistance Regulation, B.C. Reg. 263/2002, and of the Employment and Assistance for Persons with Disabilities Regulation, B.C. Reg. 265/2002, as those regulations read on March 31, 2010, continue to apply in relation to 1. (a) a child in the home of a relative who was eligible to receive income assistance under section 6 of the Employment and Assistance Regulation, on March 31, 2010, 2. (b) a child whose application under section 6 of the Employment and Assistance Regulation was received on or before March 31, 2010 and approved on or after that date, and 3. (c) the family unit of a relative with whom a child referred to in paragraph (a) or (b) was residing on March 31, 2010, until the date the child ceases to be eligible for income assistance under section 6 of the Employment and Assistance Regulation as it read on March 31, 2010. (B.C. Reg. 48/2010)

2. What is the definition of "tube feed supplement"?

"Tube Feed Nutritional Supplement" means a liquid nutritional product that is fed to a person via a tube to the stomach or intestines of the person *and the pumps, tubes, bags and other medical equipment or supplies that are required to feed the liquid nutritional product to the person*. EA Regulation, subsection 74.01(1). EAPWD Regulation, subsection 67.01(1)

From the POLICY AND PROCEDURE MANUAL: The tube feed supplement is intended to provide liquid nutritional product, equipment and supplies to recipients of income assistance or disability assistance who are unable to take food orally or process it through the gastrointestinal system. The supplement includes nutritional products, as well as related medical equipment or medical supplies (such as pumps, tubes and bags).

The supplement can be provided for acute short-term or chronic long-term conditions.

3. Aside from basic eligibility, what are the eligibility criteria for receipt of a tube feed supplement.

The EA Regulation, subsection 74.01(3) and the EAPWD Regulation, subsection 67.01(3) set out that:

The minister may provide a tube feed nutritional supplement under this section if:

(a) a medical practitioner, nurse practitioner or registrant of the College of Dieticians of British Columbia established under the *Health Professions Act* confirms in writing that the person's primary source of nutrition is through tube feeding.

(b) the person is not receiving a supplement under section 73 (EA) *[diet supplement]* or 74 *[nutritional supplement]* or section 66 (EAPWD) *[diet supplement]* or 67(3) *[nutritional supplement]* or a diet, nutritional or tube feed supplement under section 2(3) of Schedule C, and

(c) there are no resources available to the person to pay for the tube feed nutritional supplement.

4. Based on all the information above, what categories of clients are not eligible for the tube feed supplement?

- Persons in receipt of hardship assistance and their dependent children
- Persons residing in a long term care facility and their dependent children
- Persons who qualify for a health supplement due to having a life-threatening health need
- Persons receiving a grandparented tribunal award under Schedule C, section 2(3)
- Persons who were not in receipt of the tube feed supplement at the time their family unit transitioned to Medical Services Only (MSO)
- Persons in receipt of the monthly nutritional supplement (MNS)
- Persons in receipt of the short-term nutritional supplement
- Persons in receipt of the diet supplement

5. Based on all the information above, what categories of clients are eligible for the tube feed supplement?

- Persons receiving income assistance or disability assistance and their dependants
- Children in the Child in Home of a Relative (CIHR) Program
- Persons residing in a licensed drug and alcohol facility and their dependants
- Persons who were in receipt of the tube feed supplement at the time their family unit transitioned to Medical Services Only (MSO)

6. Would it be possible to approve the equipment and supplies required for tube feed as medical supplies but deny the liquid nutritional product?

No. The "tube feed supplement" includes the equipment, supplies **and** the nutritional product

7. What would you do if someone who was receiving the MNS of nutritional items had an acute short-term need for the tube feed supplement?

Complete a decision denying them the tube feed supplement but suggesting that they can elect to temporarily suspend receipt of the MNS of nutritional items to receive the tube feed supplement and have it reinstated when they no longer needed the tube feed supplement.

8. Individuals who require the tube feed supplement are often in a life-threatening situation. Can you provide the tube feed supplement under sections 76 or 69 of the EA and EAPWD Regulations *[life-threatening health need]*? Please give an explanation.

Unfortunately, you cannot provide the tube feed supplement under sections 76 or 69 of the Regulations. These sections only apply to items set out under Schedule C, sections 2(1)(a) and (f) (*medical supplies and medical transportation*) and 3 (*medical equipment*). The tube feed supplement is not set out in Schedule C.

DIET SUPPLEMENT

1. What categories of clients are eligible for the Diet Supplement? Where can you find this information

Health Supplement Summary Table

- **Income Assistance Recipients**
- **Dependent Child (person under 19 years of age) – of Income Assistance Recipients**
- **Adult & Child – PPMB**
- **Adult & Child - PWD**

Eligible Categories	**Legislation (to be updated)**
All adults in family unit are under 65 and employable	EA Regulation, section 73, Schedule C, section 8
All adults in family unit have PPMB status	EA Regulation, section 73, Schedule C, section 8
One adult in family with PPMB designation and one adult is employable and under 65	EA Regulation, section 73, Schedule C, section 8
One adult with PWD designation and one adult is employable and under 65	EAPWD Regulation, section 66, Schedule C, section 6
All adults in family unit with PWD designation	EAPWD Regulation, section 66, Schedule C, section 6
Dependent children of recipients of income assistance, hardship assistance, or disability assistance	EA Regulation, section 73 EAPWD Regulation, section 66
Children in the home of a relative if coverage is not available through the child's parents	Was repealed but transitional legislation is in place **Child in home of relative transition** 1. The provisions referring to a child in the home of a relative, or otherwise applying in relation to such a child or the relative with whom such a child resides, of the Employment and Assistance Regulation, B.C. Reg. 263/2002, and of the Employment and Assistance for Persons with Disabilities Regulation, B.C. Reg. 265/2002, as those regulations read on March 31, 2010, continue to apply in relation to 1. (a) a child in the home of a relative

	who was eligible to receive income assistance under section 6 of the Employment and Assistance Regulation, on March 31, 2010, 2. (b) a child whose application under section 6 of the Employment and Assistance Regulation was received on or before March 31, 2010 and approved on or after that date, and 3. (c) the family unit of a relative with whom a child referred to in paragraph (a) or (b) was residing on March 31, 2010, until the date the child ceases to be eligible for income assistance under section 6 of the Employment and Assistance Regulation as it read on March 31, 2010. (B.C. Reg. 48/2010)

What other categories of clients are eligible to receive diet supplements? Where do you find this information?

- Persons receiving a natal supplement if the dietary needs are unrelated to pregnancy.
- Persons receiving a grandparented tribunal award under Schedule C, section 2(3)

This information is found in the Policy and Procedure Manual.

Can a person who is receiving the MNS of nutritional items receive a diet supplement? Cite legislation.
No. The EAPWD Regulation, section 67(1)(d) sets out that the MNS is only available if the person is not receiving a supplement set out under section 61.01., which defines a supplement under section as another "nutrition-related supplement.

Can a person who is receiving a Short-Term Nutritional Supplement receive a diet supplement? Cite legislation.
No. Persons eligible for short-term nutritional supplement products are not eligible for diet supplements. The EAPWD Regulation, subsection 66(2) sets out that the minister may only provide a diet supplement to a person not receiving another nutrition-related supplement. A list of nutrition-related supplements is provided in subsection 61.01. These include a short-term nutritional supplement. The same applies to the EA Regulation, under subsection 73(2).

2. **What categories of clients are not eligible for the Diet Supplement? Why not? Where can you find this information? Please provide legislative rationale for each category.**

- **Persons residing in a special care facility.**
- **Persons receiving hardship assistance.**
- **Persons receiving Medical Services Only.**
- **Persons receiving Transitional Health Services**
- **Persons applying on basis of Life-Threatening Health Need.**
- **Persons applying under the Healthy Kid Program.**

Eligible Categories	Legislation
Adults in a special care facility and their adult dependants	[1]Adults in a special care facility receive assistance under s.8 Schedule A of the EA and EAPWD Regulation. They do not receive income or disability assistance under the sections set out in the EA Regulation, section 73(1) or EAPWD Regulation, section 66(1).
Medical Services Only (MSO)	People in receipt of MSO are not in receipt of income or disability assistance, as set out in the EA Regulation, section 73(1) or EAPWD Regulation, section 66(1)
Persons eligible for health supplements for persons with a life-threatening health need	Persons eligible for health supplements due to a life-threatening health need are not in receipt of income or disability assistance as set out in the EA Regulation, section 73(1) or EAPWD Regulation, section 66(1).
Dependent children of families in receipt of Premium Assistance through MOH	Not in receipt of income or disability assistance as set out in the EA Regulation, section 73(1) or EAPWD Regulation, section 66(1)
Recipients of hardship assistance	Not in receipt of income or disability assistance as set out in the EA Regulation, section 73(1) or EAPWD Regulation, section 66(1).
Persons receiving the tube-feed supplement.	Persons receiving the diet supplement are not eligible to receive the tube feed supplement. The EA Regulation, subsection 74.01(3)(b) sets out that the

	minister may provide a tube feed supplement if the person is not receiving a supplement under section 73 [diet supplement]. The EAPWD Regulation, subsection 67.01 sets out that the minister may provide a tube feed supplement if the person is not receiving a supplement under section 66 [diet supplement].

Clients in special care facilities receive assistance under the EA and EAPWD Regulation, Schedule A, section 8. The special care facility is expected to provide for the client's nutritional needs under the *Community Care and Assisted Living Act* as per the Home and Community Care Policy Manual.

3. What is the purpose of the diet supplement? Where do you find this information?

Diet supplements assist recipients to meet costs associated with an unusually expensive therapeutic diet that is required as a result of a specific medical condition or a special dietary need. This information is found in the Policy and Procedure Manual.

4. Aside from basic eligibility, what are the general eligibility requirements for receipt of a diet supplement?

The applicant requires
(a) a special diet for a specific medical condition described in EA Regulation, section 8 or EAPWD Regulation, section 6 of Schedule C, or
(b) a special diet described in EA Regulation, section 8 of Schedule C or EAPWD Regulation, section 6 of Schedule C

EA Regulation, section 73(1)
EAPWD Regulation, section 66(1)

The need for the special diet is confirmed in writing by
(a) a medical practitioner, or
(a.1) a nurse practitioner
(b) a registrant of the College of Dietitians of British Columbia established under the *Health Professions Act*.

EA Regulation, section 73(2)
EAPWD Regulation, section 66(2)

5. What are the special diets for specific medical conditions described sections 8 (EA) and 8 (EAPWD) of Schedule C?

Special Diet	Amount Paid by Ministry
Restricted Sodium Diet	$10 for each calendar month
Diabetes	$35 for each calendar month
Kidney Dialysis if the person is not eligible under the kidney dialysis service provided by the Ministry of Health	$30 for each calendar month
High protein diet	$40 for each calendar month
Gluten-Free diet	$40 for each calendar month
Dysphagia	$40 for each calendar month
Cystic Fibrosis	$50 for each calendar month
Ketogenic diet	$40 for each calendar month
Phenylalanine diet	$40 for each calendar month

What is dysphagia?
Dysphagia is the medical term for the symptom of difficulty in swallowing.

What is a ketogenic diet?
The **ketogenic diet** is a high-fat, adequate-protein, low-carbohydrate diet that in medicine is used primarily to treat difficult-to-control (refractory) epilepsy in children. The diet mimics aspects of starvation by forcing the body to burn fats rather than carbohydrates. Normally, the carbohydrates contained in food are converted into glucose, which is then transported around the body and is particularly important in fuelling brain function. However, if there is very little carbohydrate in the diet, the liver converts fat into fatty acids and ketone bodies. The ketone bodies pass into the brain and replace glucose as an energy source. An elevated level of ketone bodies in the blood, a state known as ketosis, leads to a reduction in the frequency of epileptic seizures.[1]

What is a Phenylalanine diet?
THIS IS THE DIET FOR PKU.
The diet for PKU consists of a phenylalanine-free medical formula and carefully measured amounts of fruits, vegetables, bread, pasta, and cereals. Many people who follow a low phenylalanine (phe) food pattern eat special low protein breads and pastas. They are nearly free of phe, allow greater freedom in food choices, and provide energy and variety in the food pattern.

What is *Not* Included in a Low Phenylalanine Food Pattern?

Foods that contain large amounts of phe must be eliminated from a low phe diet. These foods are high protein foods, such as milk, dairy products, meat, fish, chicken, eggs, beans, and nuts. These foods cause high blood phe levels for people with PKU.

6. A diet supplement for a high protein diet is only provided for specific medical conditions and circumstances. What are they?

The EA Regulation, Schedule C, subsection 8(2) and the EAPWD Regulation, Schedule C, subsection (6)(2) set out that:
A diet supplement under subsection 1(d) may only be provided if the diet is confirmed by a medical practitioner or nurse practitioner as being necessary for one of the following medical conditions:

(a) cancer that requires nutritional support during
  (i) radiation therapy
  (ii) chemotherapy
  (iii) surgical therapy, or
  (iv) ongoing medical treatment;

(b) chronic inflammatory bowel disease
(c) Crohn's disease
(d) ulcerative colitis
(e) HIV positive diagnosis
(f) AIDS
(g) chronic bacterial infection
(h) tuberculosis
(i) osteoporosis
(k) hepatitis B
(l) hepatitis C

7. Persons who require a high protein diet or a dysphagia diet are also eligible for assistance with something else. What is it? Cite legislation. How many times can a person receive this particular supplement? Where can you find that information?

A person who is eligible for a supplement under subsection 1(d) or (f) is also eligible for a $30 payment towards the purchase of a blender. EA Regulation, Schedule C, subsection 8(3) and EAPWD Regulation, Schedule C, subsection 6(3).

Rationale: The amount available towards the purchase of a blender for a person who is eligible for a diet supplement under the EAPWD Regulation, Schedule C; subsection 6(1)(d) is limited by subsection 6(3) to $30.00. This is the amount set out in the Rate Table. There is no provision for exceeding this maximum, as would occur if a blender were purchased more than once.

This is a one-time supplement [see Rate Table: Health Supplements and Programs – Diet Supplements]. This information is from the POLICY AND PROCEDURE MANUAL.

8. If a person has more than one of the medical conditions set out in subsection (1), is the person paid for both?

No. The person may receive only the amount of the highest diet supplement for which he or she is eligible. EA Regulation, Schedule C, subsection 8(4) and EAPWD Regulation, Schedule C, subsection 6(4).

9. Is there a legislated time limit for receipt of a diet supplement? For what period of time can a diet supplemented be authorized? Where can you find this information?

No. The POLICY AND PROCEDURE MANUAL states that a diet supplement may be authorized for the period it is expected to last based on the medical information received up to a maximum of 12 months for acute (short-term) conditions and 24 months for chronic (ongoing, recurring, long-term) conditions. Prior to the discontinuance of any diet supplement, a review of existing medical information will be conducted to confirm the continuing need and updated medical documentation will only be requested where necessary. In cases where the medical documentation confirms the diet supplement is required for chronic or ongoing medical conditions the need for updated documentation may be waived. This information is in the POLICY AND PROCEDURE MANUAL (Policy).

10. Would it be likely that a person suffering from irritable bowel syndrome would be approved for a diet supplement?

No. Inflammatory bowel disease (IBD) and irritable bowel syndrome (IBS) are different disorders. IBD is a collective term that refers to chronic, autoimmune, inflammatory diseases of the bowel, mainly ulcerative colitis and Crohn's disease, although it may also be referred to as colitis, enteritis, ileitis, and proctitis. IBS is a gastrointestinal disorder causing increased contractions or spasms of the colon or rectum. It is a syndrome or collection of symptoms rather than a disease.

MEDICAL EQUIPMENT AND DEVICES

1. Who is eligible for hearing aids? Where can you find this information?

- Child of recipient of income assistance
- Recipients and dependent child with PPMB classification
- Persons residing in Special Care
- Recipients of disability assistance and dependents
- Child of recipient of hardship assistance
- Medical Assistance Only
- Dependent Child of Transitional Health Services recipient
- Life-Threatening Health Need
- Healthy Kids

Eligible Categories	**Legislation or Policy?**
A recipient who is eligible for General Health Supplements: All adults in family unit have PPMB status One adult in family with PPMB designation and one adult is employable and under 65 One adult with PWD designation and one adult is employable and under 65 All adults in family unit with PWD designation Adults in a special care facility and their adult dependants Medical Services Only Persons eligible for health supplements for persons with a life-threatening health need Dependent children of recipients of income assistance, hardship assistance, or disability assistance Children in the home of a relative if coverage is not available through the child's parents	Same as for all medical equipment
A hearing impaired parent of a *dependent child*	
A recipient involved in ministry-approved training or who, in the opinion of the Supervisor, requires an instrument to obtain employment and where failure to provide represents a direct barrier	

to employment	
A recipient who is both registered with the Canadian National Institute for the Blind (CNIB) and is hearing impaired	
A person with a hearing impairment who is the sole homemaking support for an adult who has a cognitive impairment	

This information can be found in the Policy and Procedure Manual – Health Supplement Survey/Resources for Staff

Who is not eligible for hearing aids?

Categories not eligible for medical equipment and devices include:

- All adults in family unit are under 65 and employable.
- Adult recipients of hardship assistance.

2. What are the eligibility criteria for the provision of hearing instruments?

The general requirements that must be met for the provision of hearing instruments are the same as those for other types of medical equipment and devices as set out in Schedule C, sections 3(1) to (6) of the Regulations.

The specific eligibility requirements are set out in the EAPWD Regulation, Schedule C, section 3.11, which sets out that a hearing instrument is a health supplement for the purposes of section 3 of Schedule C, if

(a) the hearing instrument is prescribed by an audiologist or hearing aid dealer or hearing instrument practitioner, and
(b) an audiologist or hearing instrument practitioner has performed an assessment that confirms the need for a hearing instrument

And

The ministry pre-approves the hearing instrument (the ministry will not accept payment responsibility for hearing instruments purchased without prior approval). **Name the legislation for pre-authorization**: EAPWD Regulation, Schedule C, subsection 3(1)(b)(i)
The hearing instruments are the least expensive and appropriate. **Name the legislation about no resources available:** EAPWD Regulation, Schedule C, subsection 3(1)(b)(ii)
There are no resources available to the family unit to pay the cost of or obtain the hearing instruments. **Name the legislation about the least expensive appropriate**: EAPWD Regulation, Schedule C, subsection 3(1)(b)(iii)

3. What is the definition of a hearing instrument? Where can you find this information?

The EAPWD Regulation, Schedule C, section 1 defines a **"hearing instrument"** as having the same meaning as the Speech and Hearing Health Professionals Regulation, BC Reg. 413/2008.

The Speech and Hearing Health Professionals Regulation sets out that

"hearing instrument" means an appliance or device designed or offered for a hearing condition,

(a) including any ear molds, boots or other acoustic couplers and any parts or accessories for the appliance or device intended to affect the sound pressure level at the eardrum, and

(b) excluding direct audio input accessories, batteries and any accessories that are attachable to the appliance or device by the wearer and not intended too affect the sound pressure level at the eardrum

4. What is the definition of "audiologist"? Where can you find this information?

In the EAPWD Regulation, Schedule C, section 1, an "**audiologist"** is defined as an audiologist registered with the College of Speech and Hearing Health Professionals of British Columbia established under the Health Professions Act (BC Reg53/2007)
The Speech and Hearing Health Professionals Regulation sets out that

"**audiologist**" means a registrant who is authorized under the bylaws to practice **audiology**
"**audiology**" means the health profession in which a person provides, for the purposes of promoting and maintaining communicative, auditory and vestibular health, the services of assessment, treatment, rehabilitation and prevention of

(a) auditory and related communication disorders and conditions,

(b) peripheral and central auditory system dysfunction and related peripheral and central vestibular system dysfunction

5. What is the definition of "hearing instrument practitioner"? Where can you find this information?

The EAPWD Regulation, Schedule C, section 1 defines a **"hearing instrument practitioner"** as a hearing instrument practitioner registered with the College of Speech and Hearing Health Professionals of British Columbia established under the *Health Professions Act*, (BC Reg 52/2007)

The Speech and Hearing Health Professionals Regulation sets out that

"hearing instrument practitioner" means a registrant who is authorized under the bylaws to practice hearing instrument dispensing.
"**hearing instrument dispensing"** means the health profession in which a person provides the services of

(a) assessment of hearing using an audiometer, or other methods, to identify hearing loss, and

(b) recommending, selection, preparing, altering, adapting, verifying, selling and offering to sell hearing instruments.

6. What other resources may be available to income assistance and disability assistance clients to access funding for hearing aids?

- Other government programs (e.g., PharmaCare, Health Authorities, ICBC, WorkSafeBC, Veterans Affairs Canada)
- Private insurance
- If there are other resources available, the individual is not eligible for hearing instruments from the ministry
- Co-funding may reconsidered when other resources cannot pay the entire cost. For example, if an insurance company will pay $500 for an item that costs $1,000, the ministry may consider funding the remaining $500 if all other eligibility criteria are met.

Name the legislation that deals with other resources: EAPWD Regulation, subsection 3(1)(b)(ii)

Note: When assessing hearing instruments eligibility for income or disability assistance clients, exempt assets are not considered. When assessing other resources for persons with a life-threatening health need or persons who are medical services only, see Related Links – Life-Threatening health Need and Medical Services Only.

7. When can repairs to hearing instruments be considered?

If all of the following are met:

- It is more economical to repair, rather than replace, the hearing instruments
- The hearing instruments have not been damaged by misuse
- If the hearing instruments were not previously provided by the ministry, all other eligibility requirements must be met (e.g., prescription)

Name the legislation: EAPWD Regulation, Schedule C, subsection 3((5)

8. When can replacements of hearing instruments be considered?

If the following are met:
It is more economical to replace, rather than repair, the hearing instrument
The hearing instruments have not been damaged by misuse.

Name the legislation: EAPWD Regulation, Schedule C, subsection 3(6)

9. What is the purchasing authority of the Employment and Assistance Worker?

- Approving repairs and supplies up to $500
- Approving single hearing instruments up to $2,000 per instrument
- Approving bilateral (two) hearing instruments up to $2,000 per instrument (total $4,000)

10. What is the purchasing authority of a Supervisor?

- Approving hearing instrument repairs up to $1,000.

11. What is the purchasing authority of the Health Assistance Branch?

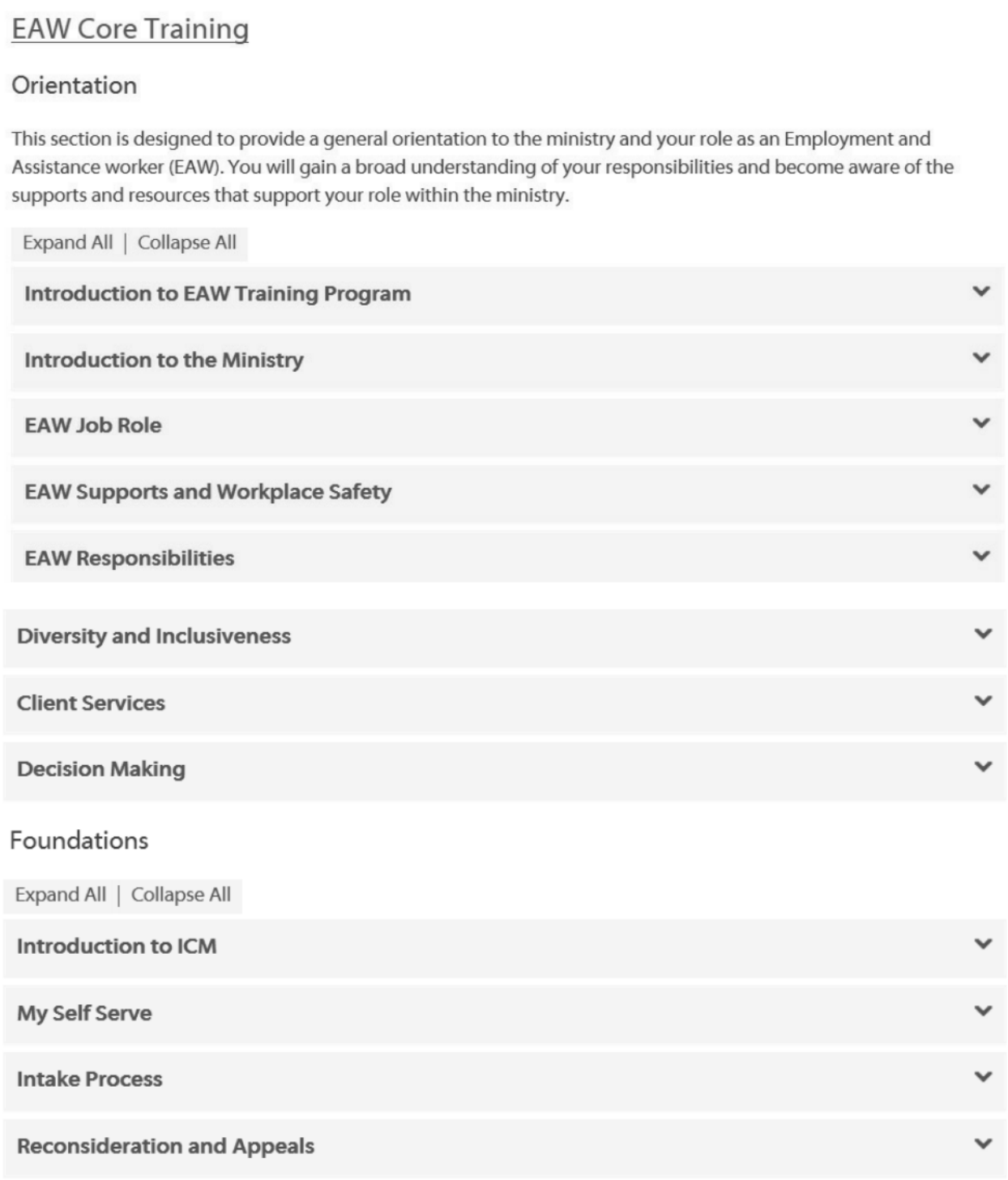
- Approving single hearing instrument requests over $2,000
- Approving bilateral hearing requests over $4,000
- Approving Bone Anchored Hearing instruments (BAHI) or cochlear implant supplies and services.

12. Where can you find more information about other resources that may be available to applicants for hearing instruments?

In the Policy and Procedure Manual

Employment & Assistance Worker Core Training Progam

*screen snip of the 3 main sections:



EAW Core Training

Orientation

This section is designed to provide a general orientation to the ministry and your role as an Employment and Assistance worker (EAW). You will gain a broad understanding of your responsibilities and become aware of the supports and resources that support your role within the ministry.

Expand All | Collapse All

- Introduction to EAW Training Program
- Introduction to the Ministry
- EAW Job Role
- EAW Supports and Workplace Safety
- EAW Responsibilities
- Diversity and Inclusiveness
- Client Services
- Decision Making

Foundations

Expand All | Collapse All

- Introduction to ICM
- My Self Serve
- Intake Process
- Reconsideration and Appeals

Employment & Assistance Worker Core Training Progam

*screen snip of the 3 main sections:

Families with Children

Employment Planning

Persons with Disabilities

Citizenship and Immigration

Expense Authority

Service Delivery

Expand All | Collapse All

Managing Your Work

General Supplements

Health Supplements

Persons with Persistent Multiple Barriers

Managing and Preventing Loss

PWD Supplements and Services

EAW Core Training Program

Foundations: chapter outlines

Introduction to ICM

Study Guide

- Study Guide

Process to Practice

1. ICM Basic Navigation
2. Contacts and Cases
3. Service Requests & Activities
4. Attachments
5. Creating Service Requests: the Matrix
6. Querying Service Requests: the Provincial Queue
7. Coach Real Time Demo of the Matrix

Review Questions

- Review Questions

Digging Deeper Resources

- ICM Practice Environment
- MIS Training

My Self Serve

Have you ever struggled to get to an office to conduct business such as obtaining financial information or submitting a document? There is an alternative to coming into the office for service; it's called My Self Serve.

My Self Serve provides a convenient and secure option for users to communicate with the Ministry. They can submit documents and requests from any computer or mobile device. They can access their account information and review Ministry messages. This saves time by minimizing wait times on the phone or in office lineups, and by reducing delays in service during peak hours. It is cost effective – no money spent on postage, transportation or minutes on the phone. Not to mention, no need to worry about packing up the kids for an office visit!

This My Self Serve overview module will introduce you to:

- What MySS is all about
- How our clients use it
- What you can do to help users when they have questions about the MySS portal

Study Guide

- Study Guide

Introductory Lessons

- Overview

Practice and Interactive Activities

- Practice Quiz

EAW Core Training Program

Foundations: chapter outlines

Intake Process

Study Guide

- Study Guide

Introductory Lessons

- Lesson 1: Intake Interview
- Lesson 2: Determining Eligibility
- Lesson 3: Benefit Plans
- Lesson 4: Third Party Checks

Process to Practice

1. Determining Eligibility
2. Eligibility Interview
3. Benefit Plans
4. Third Party Checks

- ICM Practice Environment

BCEA PPM Reference

1. Identification Requirements
   Application & Intake > Identification Requirements > Policy > Proof of Identity
2. Third Party Checks
   Eligibility > Information & Verification > Policy > Third Party Checks
3. START
   Application & Intake > BCEA Application – Stage 2 Eligibility Interview > Procedures > Conducting an Application Stage 2 Eligibility Interview
4. Hardship
   Hardship Assistance > Overview
5. Payment of Assistance
   Support & Shelter > Support, Shelter & Special Care Facilities > Policy

Standard Operating Procedures

1. Intake - Centralized Prospecting
2. Intake - Eligibility Interview

Review Questions

- Review Questions

Supplementary Materials

- Application Part 1 HR0080A
- Application Part 2 HR0080
- Rights & Responsibilities Brochure
- EI Assignment of Benefits (SD2528)
- ICM Job Aid - Benefit Plans
- Direct Deposit Brochure

EAW Core Training Program

Foundations: chapter outlines

Reconsideration and Appeals

Study Guide

- Study Guide

Introductory Lesson

- Lesson 1: Reconsideration and Appeals

BCEA PPM Reference

1. Original Decisions
   Decisions, Reconsideration and Appeal > Original Decisions > Policy
2. Communicating Decisions
   Decisions, Reconsiderations and Appeal > Original Decisions > Procedures > Communicating Decision Five Steps

Standard Operating Procedures

1. Reconsideration - Supplement Only
2. Reconsideration Initiation without Supplement
3. Reconsideration Initiation with Supplement

Supplementary Materials

- Reconsideration form HR0100
- Reconsideration and Appeal Brochure

Families with Children

Study Guide

- Study Guide

Introductory Lesson

- Lesson 1: Federal Payments for Children

BCEA PPM Reference

1. Family Bonus
   General Supplements & Programs > Family Bonus Supplement

Standard Operating Procedures

1. Family Bonus Temporary Top-Up
2. Family Bonus Automatic Top-Up
3. Family Bonus Hardship Top-up
4. Family Bonus Lost/Stolen Repayable Advance

Review Questions

- Review Questions

Supplementary Materials

- ICM Job Aid: Case - Update Case Name

EAW Core Training Program

Foundations: chapter outlines

Employment Planning

Study Guide

- Study Guide

Introductory Lesson

- Lesson 1: Employment Planning

Process to Practice

1. Employment Planning

BCEA PPM Reference

1. Employment Planning
   Employment Programs Planning & Exemptions > Employment Plan
2. Employment Programs and Community Services
   Employment Programs, Planning & Exemptions > Employment Program of BC > Overview

Standard Operating Procedures

1. Employment Plan of BC (EPBC) SDD Program Referral
2. EPBC-SDD POC Employment Plan Requests

Review Questions

- Review Questions

Supplementary Materials

- Employment Readiness Information Questionnaire HR3485
- Employability Profile HR2865
- Employment Program of BC - Ministry of Social Development & Social Innovation (ELMSD)

Persons with Disabilities

Study Guide

- Study Guide

Introductory Lesson

- Lesson 1: Introduction to Persons with Disabilities

BCEA PPM Reference

1. PWD Definition
   PWD Designation & Application > Designation Application > Policy > Eligibility
2. Income Assistance while waiting for PWD
   PWD Designation & Application > Designation Application > Policy > Receiving Income Assistance While Waiting for PWD Designation
3. 17 Year Old Applicants
   PWD Designation & Application > Designation Application > Policy > 17-Year-Old Applicants
4. Prescribed Classes
   PWD Designation & Application > Designation Application > Policy > Persons with Disabilities Designation – Prescribed Classes

EAW Core Training Program

Foundations: chapter outlines

Review Questions

- Review Questions

Supplementary Materials

- Persons with Disabilities Brochure
- Persons with Disabilities Designation Application HR2883
- PWD Rate Tables

Citizenship and Immigration

Study Guide

- Study Guide

Introductory Lesson

- Lesson 1: Citizenship and Immigration
- Lesson 2: Sponsorship Breakdown

BCEA PPM Reference

1. Citizenship Requirements
   Application & Intake > Citizenship Requirements > Policy > Eligibility
2. Refugee Claimants
   Application & Intake > Citizenship Requirements > Policy > Refugee Claimants
3. Sponsorship Undertaking Default
   Hardship Assistance > Sponsorship Undertaking Default > Policy > Eligibility

Review Questions

- Review Questions

Supplementary Materials

- Sponsorship Undertaking Letter – Applicant/Client (HR2771)
- Sponsorship Undertaking Letter – Sponsor (HR2772)

EAW Core Training Program

Foundations: chapter outlines

Expense Authority

Study Guide

- Study Guide

Introductory Lessons

- Lesson 1: Legislative Authority
- Lesson 2: Payment Authority

Public Service Agency Course

- PSA Course Registration
  - IM111: BC Government Expense Authority Fundamentals

BCEA PPM Reference

1. Legislative Authority
   Ministry Overview > Legislative Authority > Policy

Review Questions

- Review Questions

EAW Core Training Program

Orientation: chapter outlines

Introduction to EAW Training Program

Study Guide
- Study Guide

Introductory Lessons
- Lesson 1: Introduction to EAW Training

Mandatory Public Service Agency Training
- Corporate Orientation Checklist

Review Questions
- Review Questions

Digging Deeper Resources
- Standards of Conduct

Introduction to the Ministry

Study Guide
- Study Guide

Introductory Lessons
- Live Webinar: Welcome to Social Development and Poverty Reduction (SDPR)
- Live Webinar: Welcome to the Service Delivery Division (SDD)

Watch the following two videos to get an inside look at the work we do in the SDD:
- Director of Service Delivery: Dave Jagpal
- Supervisor of Outreach and Integration: Rainer Nicdao

Review Questions
- Review Questions

Digging Deeper Resources
- Human Resources (MyHR) for the BC Public Service
- BC Government and Service Employees' Union

EAW Job Role

Study Guide
- Study Guide

Introductory Lessons
- Lesson 1: Welcome to the EAW Job Role

Review Questions
- Review Questions

EAW Core Training Program

Orientation: chapter outlines

EAW Supports and Workplace Safety

Study Guide

- Study Guide

Introductory Lessons

- Lesson 1: BCEA Policy and Procedure Manual Training
- Lesson 2: Alerts
- Lesson 3: Incident and Tracking (IRT) - Level 1 - Employees

Suicide and Self-Harm Awareness Training

This is a ministry-specific, self-directed course

- Take the course

Public Service Agency Course

- PSA Course Registration
  - OSH Violence Prevention Seminar: Practical Skills

Review Questions

- Review Questions

EAW Responsibilities

Study Guide

- Study Guide

Introductory Lesson

- Lesson 1: Confidentiality and Conflict of Interest
- Lesson 2: Recognizing and Reporting Child Abuse & Neglect

Public Service Agency Course

- PSA Course Registration
  - Information Sharing and Privacy Awareness Training for Employees

Review Questions

- Review Questions

EAW Core Training Program

Orientation: chapter outlines

Diversity and Inclusiveness

Study Guide

- Study guide

Introductory Video

- Diversity

Public Service Agency Courses

The following courses are required within the first six months from start date. Check with your supervisor to find the best date that works for you and your work unit. Register for the courses on the Public Service Agency (PSA) Learning Centre:

- Building a Respectful Workplace
- Discrimination Prevention Workshop

Review Questions

- Review Questions

Digging Deeper Resources

- Diversity and Accommodation in the BC Public Service

Client Services

Study Guide

- Study Guide

Introductory Lessons

- Lesson 1: Client Service – Active Listening
- Lesson 2: Duty to Accommodate
- Lesson 3: Assisting Persons with Communication Disabilities
- Lesson 4: Communicating Difficult Decisions: Building the Bridge

Public Service Agency Course

The following courses are required within the first six months from start date. Check with your supervisor to find the best date that works for you and your work unit. Register for the courses on the Public Service Agency (PSA) Learning Centre:

- Service Excellence - A Citizen Centred Approach

Review Questions

- Review Questions

Digging Deeper Resources

- Basic Communication Skills
- Suicide Threat Guidelines for Staff

EAW Core Training Program

Orientation: chapter outlines

Decision Making

Study Guide

- Study Guide

A guest speaker, the Policy and Program Implementation Manager (PPIM), may be available to provide a 90-minute webinar or in-person presentation.

Online Lessons

The following four cases direct a trainee to specific pieces of ministry legislation, and provide direction on how an EAW will apply the legislation to determine eligibility for income assistance. Each case should be taken in sequence as their level of difficulty increases.

- Reading Legislation
- Case 1
- Case 2
- Case 3
- Case 4

Training for New Supervisors

The following "Training for New Supervisors" provides a guide of the required and recommended formal training opportunities that are considered important for the success of new supervisors, and can be used by supervisors to develop learning goals in their MyPerformance Profiles.

This plan is focussed on formal learning (i.e. classroom training or eLearning) and can be incorporated into the on-the-job training plans that some service delivery streams have for their supervisors. In addition, some of the courses listed may be appropriate to include in a succession plan for staff who are developing into the role of a supervisor.

The courses listed on page 2 are hyperlinked; click on the course name to be linked to a more fulsome course description.

Supervisors who were hired from another ministry, or from outside the public service, should also consider the foundational corporate and ministry training identified on pages 3 and 4

Since enrolment into the **Supervisor Development Certificate Program** is limited, you will receive credit for all required or elective courses (indicated by **) taken within three years of being accepted into the program.

Training for New Supervisors

Required (within first 6 months)	Required (7-12 months)	Recommended
Labour Relations 101 **	Labour Relations 201: Advanced Labour Relations	Coaching Approach to Conversations**
Role of the Supervisor **	Labour Relations 301: Investigative Skills Workshop	Fierce Conversations
Standards of Conduct **	Supervisor Development Certificate Program	Diversity in the BC Public Service**
OHS Orientation for Managers and Supervisors **	Supervisor Essentials**	Leading a Safe and Healthy Workplace**
OHS Committee Training	OHS Mitigating Work Related Violence	Health and Well-being: Allies for a Safe and Healthy Workplace**
IRT level 2 Training for Supervisors	OHS Incident Investigation	
Early Intervention & Return to Work	Performance Management 125: Having Effective MyPerformance Conversations **	
Time and Leave: Leave Approver	Early Intervention and Return-to-Work: Supporting Employees in the Workplace	
Time and Leave: Time Approver		
Building a Respectful Workplace**		

eLearning Classroom

**included in Supervisor Development Certificate Program

Unless otherwise indicated, the following courses are to be registered through the Learning System

For more information: Training & Development for Managers & Supervisors See also: Supervisor Playbook

Training for New Supervisors

The following training is considered core training for ministry employees. Supervisors who were hired from another ministry should consider the following training, as well.

Corporate Training for BC Public Service Employees

Lean 101: (ITEM-21) e-Learning**
This course provides an overview of Lean in a BC Public Service context. The goal of Lean methodology is to improve customer service, create efficiencies and provide better value to the taxpayer.

FM 111: BC Government Expense Authority Fundamentals (ITEM-59) e-Learning**
This course explains why expense authorities exist, what their defined roles and responsibilities are, the tools available to assist them in doing their jobs, and finally, their role in managing the financial resources entrusted to them

IM 117: Protection of Privacy, Access to Information and Records Management (ITEM-652) e-Learning
A comprehensive Information Management training module for all government employees, focusing on Privacy, Access and Records Management

GOV 101: Government Essentials (ITEM-603) e-Learning
This course is your introduction to the role of government and how it has evolved, what governance and financial governance are, government participants and your role as a public servant.

Ministry Specific Training for MSDSI employees

IRT Level 1 e-Learning
This module provides an overview of the Incident Reporting and Tracking (IRT) system and demonstrates create and event report to report a health and safety concern.

Discrimination Prevention Workshop (ITEM-66) Classroom
To understand the roles, rights and responsibilities of all employees for maintaining a respectful working environment, preventing workplace discrimination, and addressing it when it occurs.

Training for New Supervisors

Suicide and Self-Harm Awareness Training
This training has been designed to address the growing concern of client self-harm and suicide. Three video simulations illustrate how active Listening skills can be used to assess the level of danger facing a client, and to make appropriate referrals to resources in the community.

OSH Violence Prevention Seminar: Practical Skills (ITEM-145) Classroom
This half-day seminar covers the essential elements of assessing and dealing with potentially violent situations in the workplace

The following training is offered periodically and is coordinated through the ministry. Please connect with a Manager of Organizational Health and Development to learn more about upcoming course offerings.

Service Excellence - A Citizen Centred Approach (classroom)

Reporting and Recording Child Abuse & Neglect (e-Learning)

Deaf and Hard of Hearing Awareness (virtual learning)

Human Trafficking Prevention (virtual learning)

Domestic Violence (e-Learning)

Mental Health Training (classroom)

Training for New Supervisors

Required (within first 6 months)	Required (7-12 months)	Recommended

Click here to return to main course menu

LABOUR RELATIONS	LABOUR RELATIONS	PERFORMANCE
Labour Relations 101 (ITEM-70) Classroom** This course gives Managers and Supervisors a basic, general understanding of the structure of the Collective Agreement, the legislation behind it and how to use the Collective Agreement. Restricted to Managers and Supervisors only	**Labour Relations 201: Advanced Labour Relations (ITEM -71) Classroom** The interactive workshop provides the participant with skills and knowledge to manage and minimize possible repercussions from on-going issues of performance, absenteeism or behaviour of individual employees	**Fierce Conversations (ITEM-605) Classroom** To create a culture of higher performing teams of trusted feedback
SUPERVISOR DEVELOPMENT	**Labour Relations 301: Investigative Skills Workshop (ITEM -73) Classroom** This workshop provides the essential information and tools for managers and supervisors to investigate routine workplace issues in a fair and productive manner	**Coaching Approach to Conversations** (ITEM-65) Classroom** Take your supervisory skills to a whole new level and learn how to maximize the performance of yourself and others. Explores the fundamentals of the coaching approach to conversations in supervision and in life
Role of the Supervisor (ITEM-35) e-Learning** This 15-minute course briefly introduces the 10 key areas of responsibility for all BC Public Service Supervisors, and characteristics of high-performing supervisors.		
Standards of Conduct ** (ITEM-49) e-Learning This course enables supervisors to engage staff in a discussion on the Standards of Conduct. The Case Studies approach facilitates discussion with the intention of increasing collective understanding through conversation and real-life examples	**SUPERVISOR DEVELOPMENT**	**WORKPLACE CULTURE**
	Supervisor Development Certificate Program The Supervisor Development Certificate Program is available to permanent supervisors in the BC Public Service. This two-year comprehensive developmental program helps participants to be more effective in their role as supervisors.	**Diversity in the BC Public Service** (ITEM-51) e-Learning** Participants will learn to understand diversity and recognize how important this understanding is to our work both within the BC Public Service and for the citizens of British Columbia
OCCUPATIONAL HEALTH AND SAFETY	**Supervisor Essentials** (ITEM-112) Classroom** This 2 day course provides new and experienced supervisors with a common understanding of their role as supervisory leaders in the BC Public Service	
OHS Orientation for Managers and Supervisors (ITEM-14) e-Learning** Assists supervisors and managers in recognizing their roles and responsibilities and understanding the legislation and policies that relate to Occupational Health and Safety and WorkSafeBC		

Training for New Supervisors

Required (within first 6 months)	Required (7-12 months)	Recommended

Click here to return to main course menu

OHS Committee Training (ITEM-141) Classroom Two day training for supervisors who are employer reps on their office's joint OHS Committee. This is a mandatory course for all new JOHSC members within six months of appointment.	**OCCUPATIONAL HEALTH AND SAFETY**	**HEALTH AND WELL-BEING**
	OHS Mitigating Work Related Violence (ITEM-146) Classroom This course is designed to provide the knowledge, skills and tools to conduct effective workplace violence risk assessments. The participant will be able to recommend control measures to eliminate or reduce the potential for workplace violence.	**Leading a Safe and Healthy Workplace** (ITEM-116) Classroom** This course provides managers and supervisors with helpful reminders and new strategies aimed at supporting them to make their workplace, and the employees who work there, safer and healthier.
IRT level 2 Training for Supervisors e-Learning This module demonstrates how to create an incident report and a joint incident investigation report	**OHS Incident Investigation (ITEM-142) Classroom** This course is designed to meet the needs of the ministry's OSH program and the WC Act and WCB OHSR requirements by providing participants with the knowledge, skills and tools to conduct effective accident/incident investigations.	**Allies for a Safe and Healthy Workplace (ITEM-6) e-Learning** To raise awareness of the importance of health and safety issues at work and at home, and to demonstrate how every individual has a role to play in creating a safe and healthy workplace
ABSENCE AND LEAVE MANAGEMENT	**PERFORMANCE**	
Early Intervention & Return to Work e-Learning These e-learning modules are designed for supervisors and cover a range of topics related to supporting employees who have an illness or injury to stay at work or return to work as soon as possible after a period of illness or injury	**Performance Management 125: Having Effective MyPerformance Conversations ** (ITEM-92) Classroom** Employees will be more aware of how their performance conversations impact productivity and engagement, and will be better equipped to improve those conversations and other fundamental performance management skills	
Time and Leave: Leave Approver (ITEM-488) e-Learning This Time and Leave course contains videos demonstrating actions for Leave Approvers	**Early Intervention and Return-to-Work: Supporting Employees in the Workplace (ITEM-534) e-Learning** Supervisors will understand their role and responsibilities, practise decision-making when dealing with employees struggling with health issues and returning to work and identify resources.	

Training for New Supervisors

Required (within first 6 months)	Required (7-12 months)	Recommended

Click here to return to main course menu

Time and Leave: Time Approver (ITEM-489) e-Learning This Time and Leave course contains videos demonstrating actions for Time Approvers
WORKPLACE CULTURE
Building a Respectful Workplace (ITEM-63) Classroom** The purpose of this workshop is to give supervisors and staff the skills, knowledge and confidence they need to create and maintain a respectful workplace

EAW Core Training Program

Service Delivery: chapter outlines

Managing Your Work

Study Guide

- Study Guide

Introductory Lessons

- Lesson 1: Case Management
- Lesson 2: Finding and Organizing Your Work
- Lesson 3: Monthly Reports and Signal

ICM Practice Environment

BCEA PPM Reference

1. Monthly Reporting Requirement
   Eligibility > Monthly Reporting Requirements > Overview
2. How To Process a Stub HR0081
   Eligibility > Monthly Reporting Requirements > Procedures > Steps For Reviewing and Processing The Monthly Report (HR0081)

Standard Operating Procedures

1. Stub Processing - No Changes
2. Stub Processing - With Changes
3. Stub Processing - With Changes after Cut-Off

Review Questions

- Review Questions

Supplementary Materials

- Monthly Stub HR0081
- Incomplete Stub Template Letter HR321
- ICM Job Aid - Activities and Notifications

General Supplements

Study Guide

- Study Guide

Introductory Lessons

- Lesson 1: General Supplements
- Lesson 2: Crisis Supplement

Process to Practice

1. Crisis Supplement: Clothing
2. Crisis Supplement: Food
3. Crisis Supplement: Shelter
4. General Supplement: Replacement of Lost or Stolen Cheque
5. General Supplement: Security Deposit
6. General Supplement: Pre-natal Shelter Allowance

EAW Core Training Program

Service Delivery: chapter outlines

BCEA PPM Reference

1. Crisis Supplement
   General Supplements & Programs > Crisis Supplement > Policy > Requirements
2. Security Deposit Supplement
   General Supplements & Programs > Security Deposits > Policy > Eligibility/Exceptions
3. Replacement of Lost or Stolen Cheque
   General Supplements & Programs > Replacement of Lost or Stolen Cheque

Standard Operating Procedures

1. Crisis Supplement - Clothing
2. Crisis Supplement - Shelter
3. General Supplement - Residential Security Deposit

Review Questions

- Review Questions

Health Supplements

Study Guide

- Study Guide

Introductory Lesson

- Lesson 1: Health Supplements

Process to Practice

1. Health Supplement: SRs and The Matrix
2. Health Supplement: Natal
3. General Supplement: Pre-natal Shelter Allowance

BCEA PPM Reference

1. Medical Supplies
   Health Supplements & Programs > Medical Supplies > Policy > Eligibility
2. Health Assistance Branch Authorization
   Health Supplements & Programs > Medical Supplies > Authorities & Responsibilities >Autho
3. Diet Supplement
   Health supplements & Programs > Diet Supplements > Policy

Review Questions

- Review Questions

Supplementary Materials

- Application for Monthly Nutritional Supplement HR2847
- Request for Non-Local Medical Transportation Assistance Form HR3320
- Medical Transportation Checklist: Information for Clients
- Life-Threatening Health Need Applicant Inquiry Letter HR3322

EAW Core Training Program

Service Delivery: chapter outlines

Persons with Persistent Multiple Barriers

Study Guide

- Study Guide

Introductory Lesson

- Lesson 1: Persons with Persistent Multiple Barriers (PPMB)

BCEA PPM Reference

1. PPMB Policy Criteria
   Employment Programs, Planning & Exemptions > Persons with Persistent Multiple Barriers > Policy > Criteria
2. Steps to Overcome Barriers
   Employment Programs, Planning & Exemptions > Persons with Persistent Multiple Barriers > Policy > Steps to Overcome Barriers

Standard Operating Procedures

1. PPMB - New Application

Review Questions

- Review Questions

Supplementary Materials

- Medical Report - PPMB HR2892
- PPMB Approved - Single Person HR3241
- First Appointment - PPMB Review HR3232

Managing and Preventing Loss

Study Guide

- Study Guide

Introductory Lessons

- Lesson 1: Sanctions
- Lesson 2: Fraud Allegation and Reporting System (FARS)
- Lesson 3: Recovery and Overpayments
- Lesson 4: PLMS Job Roles

BCEA PPM Reference

1. Sanctions
   Eligibility > Sanctions > Policy > Reasons for Sanctions
2. Referral for PLMS Review or Investigation
   Compliance & Debt Management > Referral for PLMS Review or Investigation
3. Recoveries
   Compliance & Debt Management > Recoveries > Policy > Types of Assistance That May Be Recovered
4. Overpayments

EAW Core Training Program

Service Delivery: chapter outlines

Standard Operating Procedures

- Overpayment Process - EAW Activities

Review Questions

- Review Questions

Supplementary Materials

- ICM Job Aid - Allegation Fraud Incident
- Overpayment Process Training
- Overpayment Calculator Training
- Assignment of Benefits/Employment Insurance (HR2528)
- Overpayment Notification Form (HR3092)

PWD Supplements and Services

Study Guide

- Study Guide

Online Lessons

- Lesson 1: PWD and Supplements
- Lesson 2: CPPE/CPPD
- Lesson 3: Medical Services Only MSO
- Lesson 4: Health Supplements (Repeat)

BCEA PPM Reference

1. Persons with Disabilities
   PWD Designation & Application
2. Persons with Disabilities Application (HR2883)
   PWD Designation > Designation Application > Forms and Letters
3. Health Supplements and Programs
   Health Supplements & Programs > Monthly Nutritional Supplement > Policy
4. Medical Services Only
   Health Supplements & Programs > Medical Services Only > Policy > Eligibility for MSO

Review Questions

- Review Questions

Supplementary Materials

- Persons with Disabilities Brochure
- PWD Designation Application (HR2883)
- Trust Query Cover Letter (HR2999)
- Application for Monthly Nutritional Supplement (HR2847)
- Accomodation Confirmation Letter (HR3327)
- CPP Early Retirement Client Information Checklist