# 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. **Personal Information** (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 $18^{th}$ 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)<br>• how far they can walk,<br>• how many stairs they can climb unaided,<br>• how much they can lift,<br>• how long they can remain seated | Section 3 B (page 15)<br>• brief description of how impairments restrict functioning<br>• speaking, hearing, reading, writing<br>• walking, climbing stairs, standing, lifting, carrying/holding |
| Section 2 C (page 9)<br>• prostheses or aids required | Section 3 B, C (page 15, 17-19)<br>• assistive devices needed |
| Section 2 F (page 12)<br>• additional information | Section 3 E (page 21)<br>• 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)<br>• cognitive and emotional functioning<br>Section 2 E (page 11)<br>• social functioning | Section 3 B (page 15, 16)<br>• brief description of how impairments restrict functioning<br>• degree of cognitive and emotional function impairments |
| Section 2 C (page 9)<br>• prostheses or aids required | Section 3 C (page 19)<br>• assistive devices needed<br>• support/supervision required |
| Section 2 F (page 12)<br>• additional information | Section 3 E (page 21)<br>• 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)<br>• DLAs affected by impairment<br>• is the activity restricted<br>• is restriction periodic or continuous | Section 3 C(page 17-19)<br>• assistance needed with DLAs restricted (independent, periodic, continuous)<br>• how much longer it takes to perform DLAs |
| Section 2 E (page 11)<br>• assistance needed<br>• type of assistance needed | Section 3 C (page 17-19)<br>• assistive devices used<br>• support/supervision required |
| Section 2 F (page 12)<br>• additional information | Section 3 E (page 21)<br>• 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)<br>• assistance required with DLA<br><br>Section 2 B (page 9)<br>• prostheses or aids required | Section 3 C(page 17-19)<br>• assistive devices used<br>• support/supervision required |
| Section 2 F (page 12)<br>• additional information | Section 3 E (page 21)<br>• 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 15$^{th}$ and January 21$^{st}$.
- 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.

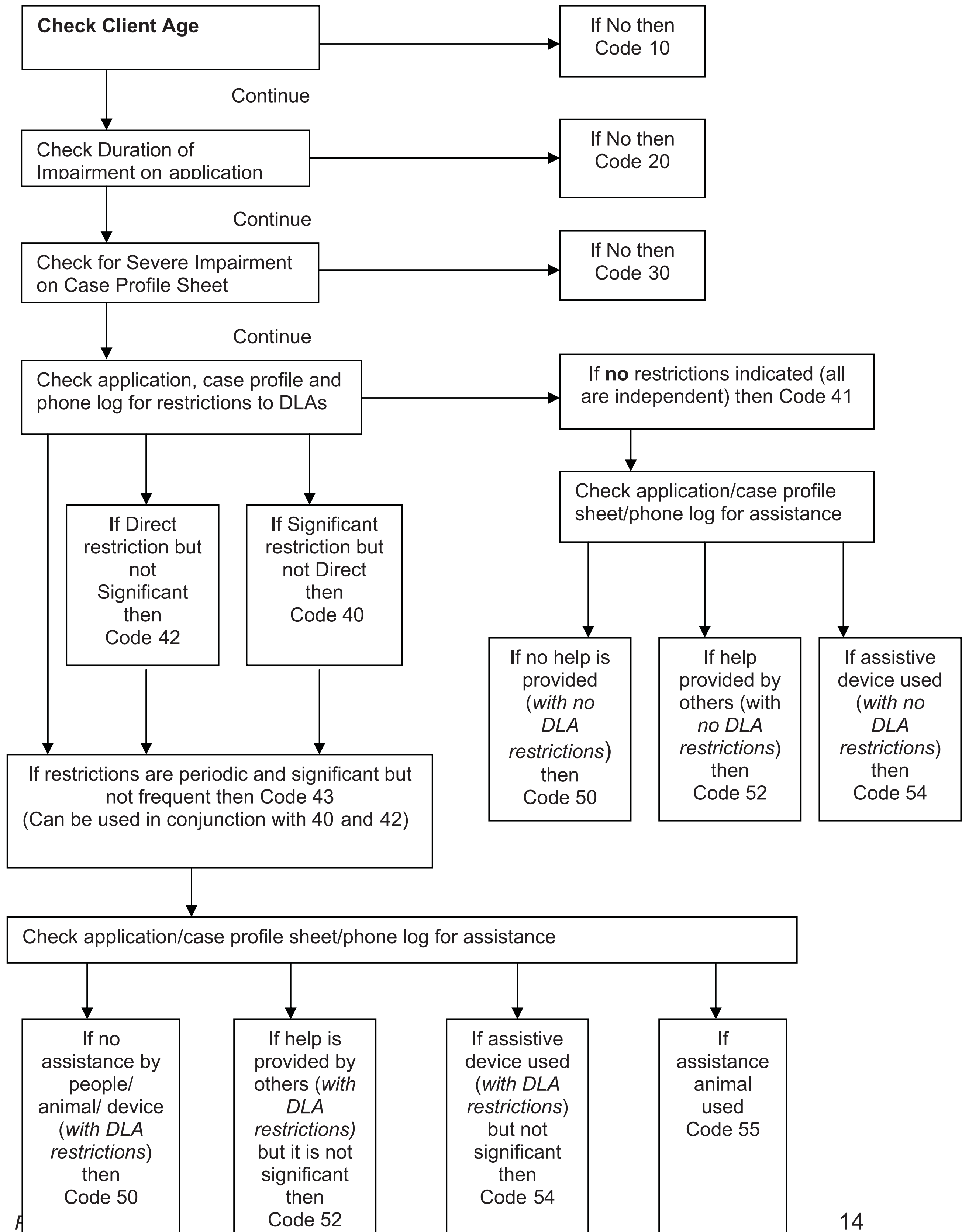
For example do not code the following:

- 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.

<table>
<tr><th>APPROVALS</th><th>DENIALS</th></tr>
<tr><td>

**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

</td><td>

**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

</td></tr>
</table>

## ICM

<table>
<tr><th>Approvals</th><th>Denials</th></tr>
<tr><td>

**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.

</td><td>

**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**”.

</td></tr>
</table>

## 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<br>• Change "**Under Review/New Info Received**" to "**Approved**" (today's date will automatically come up)<br>• Enter appropriate date under "**Review Date**"<br>• 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.<br>• Hit "**Save**" button.<br>• Select "**Generate Letter**"<br>• Select "**New Application Approved**" letter – MHR T01<br>• Ensure effective date is correct (blue box)<br>• Select "**Generate Letter**"<br>• Select "**Letters**" on top tab bar<br>• Print Letter<br>• Sign Letter with blue ink | • Go to the application screen<br>• Change "**Under Review/New Info Received**" to "**Denied**" (today's date will automatically come up)<br>• Select "**Generate Letter**"<br>• Select "**New Application Denied**" letter – MHR T02<br>• 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.<br>• Select "**Generate Letter**"<br>• Select "**Letters**" on top tab bar<br>• Print Letter<br>**Very Important: check each printed letter to ensure all applicable denial codes are present.**<br>• 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:<br>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** | |



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