



PERMANENT/LONG TERM DISABILITY ASSESSMENT

This form must be faxed directly from the medical clinic. The named applicant has requested Income Assistance. This request is based on a claim of permanent disability that significantly restricts his/her employability.

APPLICANT INFORMATION (please print)

| | | | |
|---|---------------------------------|------------------------|--|
| Last Name | | First Name | |
| Middle Name(s) | | Previous Last Name(s) | |
| Street Address | | City/Community , NT | |
| Mailing Address (if different than above) | | | |
| Apartment Number | Postal Code | Telephone (Home) () | |
| Social Insurance Number / / | Date of Birth - YY/MM/DD / / | Case Number | |

Your professional opinion will enable us to appreciate the extent of this disability, the limitation this disability imposes on this applicant's functioning, and how we might support him/her.

DISABILITY ASSESSMENT

| |
|---|
| Type/Description of Disability: |
| When was this disability first diagnosed? |
| Treatment Plan: |
| Long term prognosis for maximum medical improvement: |
| Does client require specialized housing? (Wheelchair access, low appliances, support bars, etc.) <input type="radio"/> Yes <input type="radio"/> No |
| If yes, please specify housing needs: |
| Has an application for CPP disability benefits been completed? <input type="radio"/> Yes <input type="radio"/> No |

ACTIVITY ASSESSMENT

| Activity | Ability to Participate | Limitations/obstacles that will interfere with successful participation at this time |
|---|--|--|
| Full-time Employment | <input type="radio"/> Yes <input type="radio"/> No | |
| Part-time Employment | <input type="radio"/> Yes <input type="radio"/> No | |
| Education/Training: Full-time Attendance | <input type="radio"/> Yes <input type="radio"/> No | |
| Education/Training: Part-time Attendance | <input type="radio"/> Yes <input type="radio"/> No | |
| Volunteer Commitment | <input type="radio"/> Yes <input type="radio"/> No | |
| Financial Management of Personal Affairs | <input type="radio"/> Yes <input type="radio"/> No | |
| Regular Daily Household Tasks | <input type="radio"/> Yes <input type="radio"/> No | |

DECLARATION

I hereby agree to release the following information to the Department of Education, Culture and Employment, Government of the Northwest Territories.

Physician's Name (Please Print)

Applicant's Signature

Date - YY/MM/DD

Physician's Signature

Date - YY/MM/DD

This information is being collected under the authority of the Access to Information and Protection of Privacy (ATIPP) Act, Section 41.(1)(g) and the Northwest Territories (NT) Social Assistance Act and Regulations. The privacy provisions of the ATIPP Act protect my information, and all applicants have the right to examine and request correction of his or her records and to request a review by the Information and Privacy Commissioner. If you have any questions about the collection of information, contact the Department of Education, Culture and Employment, Box 1320, Yellowknife, NT X1A 2L9 or call 1-866-973-7252 or 867-920-8921.

All sections are mandatory - Place a dash or line through boxes that do not apply to you.