Government of
Northwest Territories

Income Security Programs

FORM D – DISABILITY ASSESSMENT

Une version française de ce document est disponible.

ATTENTION HEALTH CARE PRACTITIONER
Provide the completed form via Secure File Transfer (https://sft.gov.nt.ca/) to the applicable Regional Education, Culture and Employment Service Centre.

Beaufort-Delta:
Toll-free Phone Number: 1-855-283-9311
Email: BD_ECE_FormD@gov.nt.ca

Dehcho:
Toll-free Phone Number: 1-833-995-7338
Email: DC_ECE_FormD@gov.nt.ca

Sahtú:
Toll-free Phone Number: 1-866-814-9840
Email: ST_ECE_FormD@gov.nt.ca

North Slave:
Toll-free Phone Number: 1-866-768-8145
Email: NS_ECE_FormD@gov.nt.ca

South Slave:
Toll-free Phone Number: 1-833-926-2110
Email: SS_ECE_FormD@gov.nt.ca

For purposes of the Income Assistance for Seniors and Persons with Disabilities program, an individual would be considered a person with a disability if it is in the medical opinion of a medical practitioner or nurse practitioner that an individual has a physical, mental, intellectual, cognitive, learning, communication or sensory impairment that significantly restricts their ability to perform daily-living activities and meet their basic financial needs:

a) Permanently; or
b) That is persistent/prolonged and is expected to last for a continuous basis of more than 12 months

Daily-living activities may include an individual's ability to:

- Maintain employment.
- Manage finances (ability to pay bills, rent, etc.).
- Participate in community activities.
- Be able to get around unassisted (without caregiver/family member).

Definitions:

Impairment: Is a problem in body function or structure such as a significant deviation or loss.

Continuously: Is a regular occurrence and not expected to resolve for months at a time during the next 12 months and is not episodic in nature.

Episodic: Is a medical condition or disease that is prolonged and lifelong but has unpredictable episodes of illness and disability. The episodes of disability can vary in severity and duration and are often followed by periods of wellness.

Note: The Disability Assessment form must be completed by a licensed medical practitioner, nurse practitioner or registered nurse.

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 Social Assistance Act* and *Income Assistance for Seniors and Persons with Disabilities Regulations*. The privacy provisions of the *ATIPP Act* protect information, and all applicants have the right to examine and request correction of their records and to request a review by the Information and Privacy Commissioner. If you have any questions about the collection of information, contact the Program Specialist, Income Security Programs at the Department of Education, Culture and Employment, Box 1320, Yellowknife, NT X1A 2L9 by calling 1-866-973-7252 or 867-767-9355.

SECTION 1: To be completed by the Applicant

Applicant Information

Last Name:	First Name:
Telephone:	Date of Birth (yyyy/mm/dd):
Current Mailing Address:	
Community: , NT	Postal Code:

*Last Name, First Name and Date of Birth must be filled in **PRIOR** to the form being completed by the Health Care Professional.

Consent

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

X _____ _____

Applicant Signature | Date (yyyy/mm/dd)

SECTION 2: To be completed by a Medical Practitioner or Nurse Practitioner only

If you are not a Medical Practitioner or a Nurse Practitioner please complete Section 3.

A. Degree/Severity of Disability or Impairment

My medical opinion is that this impairment significantly restricts their ability to perform daily-living activities and meet their financial basic needs and is considered to be (**only check one**):

☐ Permanent

☐ Long-term (expected to impact the individual continuously for next 12 months)

☐ Episodic or Recurrent (not expected to impact the individual continuously for next 12 months)

☐ Short-term (expected to impact the individual for less than 12 months)

Comments

Please provide any additional information that may be relevant in understanding the nature or severity of the impairment and how it impacts the individual's ability to meet their basic financial needs:

B. Diagnoses

If the individual has a diagnosis to support their disability/impairment please list it below. This is not required, if unknown.

Client Name: _____

Medical Practitioner/Nurse Practitioner Initial: _____

C. Impact of Disability or Impairment

1. How does the health condition impair this individual?

2. If the disability/impairment is expected to improve or resolve, what is the anticipated timeframe?

3. Is there treatment readily available?

4. Does the disability/impairment require the individual to reside with a parent or caregiver?

D. Additional Comments

Please provide any additional information that you consider relevant to understanding the significance of the individual's health condition, the nature and extent of the impairment and the impact these have on their daily functioning.

E. Certification

I, _____ , am a **Medical Practitioner** and my Registration Number is _____	I, _____ , am a **Nurse Practitioner** and my Registration Number is _____

This form contains my findings and considered opinion at this time.

X _____ _____

Signature Date (yyyy/mm/dd)

Telephone Number:	Fax Number:	Email (optional):
Name of Clinic:		

Client Name: _____

Medical Practitioner/Nurse Practitioner Initial: _____

SECTION 3: To be completed by a Registered Nurse licensed to practice in the NWT

A Registered Nurse may sign the Disability Assessment form if there is no access to a medical practitioner or nurse practitioner in the next 3 months.

A. Degree/Severity of Disability or Impairment

Based on the medical information in the patient chart, I can confirm this individual has an impairment that significantly restricts their ability to perform daily-living activities and meet their basic financial needs and is considered to be (**only check one**):

☐ Permanent

☐ Long-term (expected to impact the individual continuously for next 12 months)

☐ Episodic or Recurrent (not expected to impact the individual continuously for next 12 months)

☐ Short-term (expected to impact the individual for less than 12 months)

Comments

Please provide any additional information that may be relevant in understanding the nature or severity of the impairment and how it impacts the individual's ability to meet their basic financial needs:

B. Diagnoses

If the patient chart indicates the disability/impairment diagnosis, please indicate it here. This is not required, if unknown.

C. Impact of Disability or Impairment

1. How does the health condition impair this individual?

2. If the disability/impairment is expected to improve or resolve, what is the anticipated timeframe?

Client Name: _____

Registered Nurse Initial: _____

3. Is there treatment readily available?

4. Does the disability/impairment require the individual to reside with a parent or caregiver?

D. Additional Comments

Please provide any additional information, and attach further medical documentation (as necessary), that may be relevant in understanding the nature and severity of the impairment.

E. Certification

I, _____ , am a **Registered Nurse** and my Registration Number is _____

☐ I confirm that this individual is unable to have a Medical Practitioner or Nurse Practitioner complete this form.

This form contains my findings and considered opinion at this time.

X _____ _____

Signature Date (yyyy/mm/dd)

Telephone Number:	Fax Number:	Email (optional):
Name of Clinic:		

Client Name: _____

Registered Nurse Initial: _____