Income Assistance

Case Number: _____

Form D – Disability Assessment

Applicant Information

Last Name	First Name
Telephone	Date of Birth (YY/MM/DD) / /
Current Mailing Address	
Community	, NT Postal Code

Consent

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

Date (YY/MM/DD): / /	Applicant Signature

Questionnaire – to be completed by Health Care Professional

Applicants may be eligible to receive a Disability Allowance from the Income Assistance Program if they meet certain eligibility criteria including: having a physical or mental impairment that is permanent or recurrent, that is expected to last one year (or more), and presents a substantial barrier to employment.

Your professional opinion will enable us to determine the extent and limitations of this individual's disability and or medical concerns, and how we might support him/her.

1. Please describe the person's physical and/or mental impairment(s):

2. Do the physical and/or mental impairment(s) significantly restrict their ability to perform daily living activities? ○ Yes ○ No

3. Is the physical and/or mental impairment:
   - ○ Permanent (intervention will not resolve impairment)
   - ○ Recurrent (occurs periodically for extended periods of time)
   - ○ Long Term (more than 12 months)
   - ○ Short Term (less than 12 months)

If permanent or recurrent please proceed to questions 6-10. If long term or short term, please respond to questions 4-10.

4. If the impairment is short or long term, is it expected to improve or resolve?
   If yes, please explain: ○ Yes ○ No

This form must be faxed to _____ when complete

Medical Professional Initials: _____

5. If the disability and/or impairment is expected to improve or resolve what is the anticipated recovery time?

6. Please describe how the disability or impairment presents a substantial barrier, if any, to employment (eg. preparing for, obtaining or maintaining employment):

7. Does the applicant have the ability to manage their own financial affairs? ○ Yes ○ No

8. Does the disability and/or impairment(s) require the applicant to reside alone?
If yes, please explain the need? ○ Yes ○ No

9. Does the disability and/or impairment(s) require the applicant to reside with a parent or caregiver? If yes, please explain the need? ○ Yes ○ No

10. Has the applicant applied for CPP-Disability?If no, please explain why? ○ Yes ○ No

11. Additional comments:

Medical Professional Name (Print) Title:

Medical Professional Signature | Date (YY/MM/DD) / /

Medical Clinic Name:

Telephone: | Fax Number:

This form must be faxed to _____ when complete