



Income Assistance

Case Number: _____

Form D – Disability Assessment

when complete

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.

- Please describe the person's physical and/or mental impairment(s):
- Do the physical and/or mental impairment(s) significantly restrict their ability to perform daily living activities?

Yes	No
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- 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.
- If the impairment is short or long term, is it expected to improve or resolve?

If yes, please explain: Yes No

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Medical Professional Initials: _____

when complete

This form must be faxed to

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: