Government of
Northwest Territories

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

* Last Name, First Name and Date of Birth fields must be filled in **PRIOR** to the Questionnaire 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.

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 them.

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

Medical Professional Initials: _____

This form must be emailed to when complete

when complete

This form must be emailed 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: