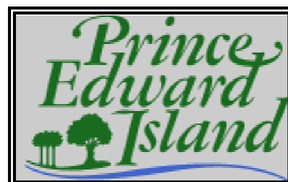
P.E.I.

Disability Support Program

Forms



Appendix B

P.E.I. Disability Support Program Forms

B-1 Application

B-2 Disability Support Program Screening Tool

B-3 Existing and Potential Family and Community Support (Eco-map)

B-4 Contact Note

B-5 Support Plan Summary

B-6 Support Plan

B-7 Individual Support Agreement

B-8 Monthly Worksheet

B-9 Record of Supports Used

B-10 Confidentiality Release

B-11 Life-Time Maximum Record

B-12 Agreement of Trustee

B-13 Wage Subsidy

B -14 Review Checklist

B-15 Notice of Review Hearing

B-16 Notice of Decision Review Hearing

APPLICATION			
Child Supports		**Date of Application**	
Adult Supports		**File Number**	
Employment & Vocational Supports		**PHN**	

Name of Applicant:

Last Name:	SIN:	Birth Date (YY/MM/DD):
Given Names:	Sex:	Marital Status:

Applicant's Address:

Address of Residence	Mailing Address (if different)
Street/Civic:	Address:
City/Town:	City/Town:
Postal Code:	Postal Code:

Home Phone:	Phone/Fax:	E-mail:

Contact:

Name:			Relationship:		
Address (if different)	Street/Civic:		City/Town:		Postal Code:
Numbers	Home:	Work:	Fax:	E-mail:	
PHN (if needed)					

Contact:

Name:			Relationship:		
Address (if different)	Street/Civic:		City/Town:		Postal Code:
Numbers	Home:	Work:	Fax:	E-mail:	
PHN (if needed)					

Nature of Disability:

Verification Required? Yes No

APPLICATION			
Child Supports		**Date of Application**	
Adult Supports		**File Number**	
Employment and Vocational Supports		**PHN**	

Presenting Situation:

Insurances:

Professionals Involved:

Name	Phone Number

Signature:

The above information is accurate to the best of my knowledge. I hereby give the Health System (Department of Health and Social Services and the regional health authorities) permission to obtain any information necessary for the review of this application from the professionals named above, and to share this information internally as necessary.

Personal information on this form is collected under Section 3 (f) of Prince Edward Island's Rehabilitation of Disabled Persons Act and Section 3 (a) of Prince Edward Island's Social Assistance Act and will be used for the purpose of the administration of the PEI (DSP). If you have any questions about the collection of this personal information, you may contact ___________ Regional Health Authority, Telephone Number __________.

Signature of Applicant or parent/guardian/trustee	**Date (YY/MM/DD)**

Disability Support Worker Signature	**Date (YY/MM/DD)**

Prince Edward Island Disability Support Program Screening Tool

Name ________________________________ **File Number** _ _ _ _ _

Disability Support Worker ____

Assessment Date _ _ / _ _ / _ _
MM/DD/YY

Birth Date _ _ / _ _ / _ _
MM/DD/YY

Gender Male _____
Female _____

Lives In: Supervised setting _____
Home _____
Independent Living _____

Diagnosis: _________________ **Date of Onset of Disability:** _ _ / _ _ / _ _
MM/DD/YY

The following questions are to be answered by individual with assistance.

Memory - Ask the individual served the following questions. Fill in "YES" for every correct response and "NO" for an incorrect response.

	Yes (1)	**No (0)**
What year is it?		
What season are we in?		
What is today's date?		
What day of the week is it?		
What month is it?		
What province is this?		
What country are we in?		
What city are we in?		
What building is this?		
What floor are we on right now?		

Memory Total = ____ / 10

Behavior/Psychosocial - With the individual, please indicate how frequently the individual has exhibited each of these behaviors: (Check only one for each behavior.)

	Not exhibited in the last month (3)	**Exhibited once or more in the past month (2)**	**Exhibited daily (1)**
Wandering			
Refuses help when needed			
Verbally abusive			
Physically abusive			

Copyright 2001 - Uniform Data System for Medical Rehabilitation, a Division of UB Foundation Activities Inc., All rights reserved.

Prince Edward Island Disability Support Program Screening Tool

Sexually inappropriate			
Poor sleep			
Self abusive			
Withdrawn, turned inward			
Agitation			
Sadness, tearful, weeping			

Behavior Total = ___ / 30

Function - With the individual, please indicate the average performance over the past four days: (Check only one for each area.)

	Complete Independence (7)	**Modified Independence Device (6)**	**Supervision (5)**	**Minimal Assist Subject 75% or More (4)**	**Moderate Assist Subject 50% or More (3)**	**Maximal Assist Subject 25% or More (2)**	**Total Assist Subject less than 25% or not testable (1)**
Eating							
Grooming							
Bathing							
Dressing - Upper							
Dressing - Lower							
Toileting							
Bladder Control							
Bowel Control							
Bed (wheelchair) Transfer							
Transfer Toilet							
Transfer Tub/Shower							
Walk/Wheelchair							
Stairs							
Comprehension							
Expression							
Social Interaction							
Problem Solving							

Copyright 2001 - Uniform Data System for Medical Rehabilitation, a Division of UB Foundation Activities Inc., All rights reserved.

Prince Edward Island Disability Support Program Screening Tool

	Complete Independence (7)	Modified Independence Device (6)	Supervision (5)	Minimal Assist Subject 75% or More (4)	Moderate Assist Subject 50% or More (3)	Maximal Assist Subject 25% or More (2)	Total Assist Subject less than 25% or not testable (1)
Memory							

Motor Score = _____/91 Cognitive Score = _____/35 Total = _____/126

Instructional Activities of Daily Living (IADL's) - With individual, please indicate the average performance over the past four days: (Check only one for each area.)

	Totally able (3)	Limited participation (2)	Unwilling to perform (1)	Unable to perform at all (0)
Housework/cleaning				
Shopping				
Laundry				
Public Transportation				
Outdoor activities				
Telephone				
Prepare and cook meals				
Self administration of Medications				
Handle personal business/finances				

IADL Score = _____/27

Copyright 2001 - Uniform Data System for Medical Rehabilitation, a Division of UB Foundation Activities Inc., All rights reserved.

Prince Edward Island Disability Support Program Screening Tool

Nutrition - With the individual, please indicate whether they have experienced any of the following:

	Yes (0)	No (1)
Lost or gained more than 10 lbs. In the last 3 months?		
Eats less than 50% of meals per day?		
Has problems swallowing.		
Has tooth or mouth problems that make it hard to eat.		

Nutrition Score = _____/4

Medication - With the individual, please indicate whether they experience the following:

	Yes (0)	No (1)
Takes more than 3 medications at a time.		
Takes medication more than 3 times a day		

Medication Score = _____/2

Safety - With the individual, please indicate whether they have experienced any of the following:

	Not in the last month (3)	Exhibited once or more in past month but less than weekly (2)	Exhibited weekly (1)
Fallen in home			
Fallen outside home			
Safety issue if left alone			

Safety Score = _____/9

Copyright 2001 - Uniform Data System for Medical Rehabilitation, a Division of UB Foundation Activities Inc., All rights reserved.

Community Integration - With the individual, please indicate whether they have experienced any of the following:

	Not in the last month (1)	**Exhibited once or more in the past month but less than weekly (2)**	**Exhibited weekly (3)**
Contact with family			
Family function			
Community activity			
Favorite activity			

Community Integration Score = _____/12

Scoring Summary

Personal information on this form is collected under Section 3 (f) of Prince Edward Island's Rehabilitation of Disabled Persons Act and Section 3 (a) of Prince Edward Island's Social Assistance Act and will be used for the purpose of the administration of the PEI (DSP). If you have any questions about the collection of this personal information, you may contact ___________ Regional Health Authority, Telephone Number __________.

Memory Total = _____/10

Behavior Total = _____/30

Motor Score = _____/91 Cognitive Score = _____/35 Total = _____/126

IADL Score = _____/27

ECO-MAP	Page of
Name:	PHN:
Date of Eco-Map:	File Number:

ECO-MAP

(Assessment of Existing Family and Community Supports)

Individual/
Family/
Household

* The circles outside of the Individual/Family represent their supports in the community and extended family. An individual or family may have more or less than what is provided. Draw in more supports where necessary.

Potential Family and Community Supports/ Additional Information

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

Personal information on this form is collected under Section 3 (f) of Prince Edward Island's Rehabilitation of Disabled Persons Act and Section 3 (a) of Prince Edward Island's Social Assistance Act and will be used for the purpose of the administration of the PEI (DSP). If you have any questions about the collection of this personal information, you may contact ___________ Regional Health Authority, Telephone Number __________.

PEI Disability Support Program

CONTACT NOTE	Page of
Name:	PHN:
Sign after each Contact	File Number:

Date of Contact:

Date of Contact:

SUMMARY PAGE	Page of
Name:	PHN:
Date:	File Number:

SUMMARY PAGE

Disability Support Worker		Support Coordinator	

Number	Issue (brief description)	Review Date (YY/MM/DD)
	General Review Date	

Support Plan Cost

Description	Codes	E & V Federal Cost Shared (✓)	One Time Lump Sum ($)	Recurring Monthly Costs ($)
Totals:				
Total of Authorizations for Technical Aids/Assistive Devices:				
OVERALL TOTAL COSTS PER MONTH:				

SUPPORT PLAN	Page of
Name:	PHN:
Date of Support Plan:	File Number:

ISSUE/GOAL/STRATEGY/ACTIONS

Number	Issue
Goal and Expected Outcome	
Strategy	

Responsibility of:	Action:	Planned Completion/Review Date:	Cost:
Responsibility of:	Action:	Planned Completion/Review Date:	Cost:
Responsibility of:	Action:	Planned Completion/Review Date:	Cost:
Responsibility of:	Action:	Planned Completion/Review Date:	Cost:
Responsibility of:	Action:	Planned Completion/Review Date:	Cost:

Cost Summary for this Issue	Recurring Monthly	
	One Time Lump Sum	

Notes:

Personal information on this form is collected under Section 3 (f) of Prince Edward Island's Rehabilitation of Disabled Persons Act and Section 3 (a) of Prince Edward Island's Social Assistance Act and will be used for the purpose of the administration of the PEI (DSP). If you have any questions about the collection of this personal information, you may contact ___________ Regional Health Authority, Telephone Number __________.

Appendix B-6 Nov./03

INDIVIDUAL SUPPORT AGREEMENT	Page 1 of 2
Name:	PHN:
Date of Support Plan:	File Number:

This document dated

Date:

is a contract agreement between:

____

Individual or Parent/Guardian/Trustee

and

____

Regional Health Authority

for Disability Supports under the P.E.I. (DSP)
which is delivered through the P.E.I. Regional Health Authorities.

1. It will be effective from:

Date		to	Date	

First contact or last review date Next review date

2. This agreement supercedes the previous agreement dated:

Date	

3. Client Contribution Calculation

The client contribution is determined as follows:

Applicable Household Member				Income	
Total				$	a
Number of dependents under age 18		x $3000 =		$	b
Adjusted Net Income	subtract line "b" from line "a"			$	c
Client contribution for Adjusted Net Income (line "c") from the P.E.I. Disability Support Program Client Contribution Schedule	% for Technical Aids and Assistive Devices			Monthly Contribution	
		%	d	$	e

4. Supports

Based on the attached applicable support plan, dated above , for the individual named above, the costs of the supports determined and agreed to are as follows:

Technical Aids and Assistive Devices Costs	$	f
Recurring Monthly Costs	$	g

INDIVIDUAL SUPPORT AGREEMENT	Page 2 of 2
Name:	PHN:
Date:	File Number:

5. Regional Health Authority Contribution

The support contribution from the Regional Health Authority will be:

	Costs from the applicable support plan		client contribution (lines d & e)	Regional Health Authority contribution lump sum = (line h-(line d x line h)) monthly = line i -line e	
a lump sum contribution of (line f)	$	h	%	$	j
and/or a monthly contribution of (line g)	$	i	$	$	k

6. It is understood and agreed by the parties to this agreement that:

I. The individual or Parent/Guardian/Trustee is responsible to carry out the support plan and to contribute their share of the costs;

II. The Regional Health Authority is responsible to pay the one time sum of the amount on line "j" and a monthly support payment in the amount on line "k" to support the attached support plan or such amounts as necessary; and

III. A participant accessing the P.E.I. (DSP) will be expected to participate in program evaluations.

7. Where the Regional Health Authority's contribution for the purchase of technical aids/assistive devices is 75% or more, the parties acknowledge and agree that, upon the participant ceasing to require or use the technical aid/assistive device it becomes the property of the Regional Health Authority and shall be returned to the Regional Health Authority.

8. In the event the participant ceases to require funding from the (DSP) for any reason, the parties agree that all (DSP) cheques paid for periods subsequent to the date funding ceased or should have ceased, shall be returned uncashed to the appropriate Regional Health Authority, or, if cashed, the participant or the participant's estate shall indemnify the Province of Prince Edward Island for any losses sustained through the cashing of such cheques.

9. The participant acknowledges that there will be ongoing evaluations of the (DSP) which may include review of information from a participant's file, and consents to the provision of this information from the participant's file for the purposes of evaluation and for no other purpose.

10. The participant acknowledges that there are ongoing studies concerning the Disability Support Program Screening Tool which will require forwarding non-identifying information, and consents to the provision of this information from the participant's file.

11. The parties acknowledge that this agreement, including the attached support plan, constitutes and expresses the entire agreement of the parties.

12. Where the support plan necessitates the hiring of third parties or the utilization of the services of third parties, the client acknowledges and agrees that the participant is the employer and the Regional Health Authority is not responsible for any aspect of hiring or employment of third parties. The participant indemnifies the Regional Health Authority in any and all liability which may arise as a result of the employer/employee relationship.

13. By signing this Agreement, the parties acknowledge and agree that:

I. They have read the Agreement in its entirety and fully understood their rights and obligations under it; and

II. They are signing the Agreement voluntarily.

14. The participant acknowledges that they are aware a Request for Review must be made within 45 days of the decision being disputed.

15. Personal information on this form is collected under Section 3 (f) of Prince Edward Island's Rehabilitation of Disabled Persons Act and Section 3 (a) of Prince Edward Island's Social Assistance Act and will be used for the purpose of the administration of the PEI (DSP). If you have any questions about the collection of this personal information, you may contact ___________ Regional Health Authority, Telephone Number __________.

______________________________________ ______________________

Individual or Parent/Guardian*/Trustee** ***Date

______________________________________ ______________________

Witness ***Date***

______________________________________ ______________________

DS Worker or delegate of the Regional Health Authority ***Date***

______________________________________ ______________________

Witness ***Date***

MONTHLY WORKSHEET	Page 1 of 1
Name:	PHN:
Date of Applicable Support Plan:	File:

This worksheet is required only if the client has a *technical aid or assistive device* which requires a lump sum payment.

	Lump Sum		Divide line	Monthly Amount	
If lump sum less than $1999	$	a	line a ÷ 12 months (one year)	$	f
If lump sum $2000-$2999	$	b	line b ÷ 24 months (two years)	$	g
If lump sum $3000-$3999	$	c	line c ÷ 36 months (three years)	$	h
If lump sum $4000 - $4999	$	d	line d ÷ 48 months (four years)	$	i
If lump sum greater than or equal to $5000	$	e	line e ÷ 60 months (five years)	$	j
Recurring Monthly Amount from Support Plan				$	k
Overall Monthly Amount (add line a, b, c, d or e to line k)				$	
Amortization Completion Date					

TO BE COMPLETED IF THERE IS MORE THEN ONE TECHNICAL AID OR ASSISTIVE DEVICE BEING FUNDED:

OVERALL MONTHLY AMORTIZED AMOUNTS (ADD TOGETHER ALL AMORTIZED AMOUNTS)	$

PEI Disability Support Program

Record of Supports Used

This form is meant to assist you in recalling services you have used. The purpose of this form is to help you with future planning.

Name:	
From (Date):	To (Date):

Date	Service	Service Provider	Cost
Oct. 1, 20__	Respite	Name of Service Provider	$

Date	Service	Service Provider	Cost

Signature: ________________________________

AUTHORIZATION TO OBTAIN AND/OR RELEASE CONFIDENTIAL INFORMATION

After the form has been completed, signed, and witnessed, and depending on circumstance, it is to be A) given to the person providing the information and a copy placed in the client's file; or B) the original is to be placed in the client's file.

I, ____
Client's Name

of____
Client's Address

authorize:____
Name of Worker

to share/obtain information with/from: ______________________________

____

concerning the following specific matters:______________________________

____

____

I UNDERSTAND THAT THE INFORMATION SPECIFIED ABOVE WILL BE SHARED IN ACCORDANCE WITH THIS AUTHORIZATION AND BE USED ONLY FOR THE PURPOSE OF PROVIDING SERVICES TO ME OR MY DEPENDENTS. THIS AUTHORIZATION WILL EXPIRE IMMEDIATELY UPON TERMINATION OF THE SERVICE TO WHICH IT RELATES OR ONE YEAR AFTER THE DATE OF SIGNATURE, WHICHEVER OCCURS FIRST. PERSONAL INFORMATION ON THIS FORM IS COLLECTED UNDER SECTION 3 (F) OF PRINCE EDWARD ISLAND'S REHABILITATION OF DISABLED PERSONS ACT AND SECTION 3 (A) OF PRINCE EDWARD ISLAND'S SOCIAL ASSISTANCE ACT AND WILL BE USED FOR THE PURPOSE OF THE ADMINISTRATION OF THE PEI (DSP). IF YOU HAVE ANY QUESTIONS ABOUT THE COLLECTION OF THIS PERSONAL INFORMATION, YOU MAY CONTACT ___________ REGIONAL HEALTH AUTHORITY, TELEPHONE NUMBER __________.

Signature of Witness	**Signature of Client**
Signature of Witness	**Signature of Spouse(if applicable)**
Date	**Date**

Please forward the information requested to:______________________________
at the Regional Health Authority at the address checked below:

☐	☐	☐	☐	☐
West Prince	**East Prince**	**Queens Regional Health**	**Southern Kings**	**Eastern Kings**
P.O. Box 8	**243 Harbour Dr**	**P.O. Box 2000**	**P.O. Box 1500**	**P.O. Box 550**
O'Leary, PEI	**Summerside, PEI**	**Charlottetown, PEI**	**Montague, PEI**	**Souris, PEI**
C0B 1V0	**C1N 5P5**	**C1A 7N8**	**C0A 1R0**	**C0A 2B0**

Appendix B-10 Nov./03

Name: ________________________ File#: ____________

Name: ________________________ **File#:** ____________

DATE	VEHICLE MODIFICATIONS TO A LIFE-TIME MAXIMUM OF $2000.00	COST	BALANCE
DATE	**HOME MODIFICATIONS TO A LIFE-TIME MAXIMUM OF $2000.00**	**COST**	**BALANCE**
DATE	**HUMAN SUPPORTS SUCH AS NOTE TAKERS, OR INTERPRETERS TO A LIFE-TIME MAXIMUM OF $6000.00**	**COST**	**BALANCE**

This form is a tool to maintain a record of funding items that have a life-time maximum according to DSP policy Sections 8.7.2.

AGREEMENT OF TRUSTEE	Page 1 of 1
Applicant:	PHN:
Date:	File Number:

I, the undersigned, agree to receive supports under the P.E.I. Disability Support Program payable to the applicant named above and undertake

1. **to act on behalf of the said Applicant and, to administer and expend the financial supports in the manner and for the purposes for which the financial supports are intended;**

2. **to account in such form and at such times as P.E.I. Disability Support Program Policy may indicate, for all support payments received and the disbursements made therefrom;**

3. **to notify the Disability Support Worker should the Applicant change his or her address, absent himself or herself from Prince Edward Island, die, or cease to be incapable of managing his or her own affairs, and to furnish any other information or evidence and to do anything that the P.E.I. Disability Support Policy thereunder require the Applicant to furnish or do, and**

4. **to return uncashed to the appropriate Regional Health Authority, if the said Applicant should die, all of the Disability Support cheques on behalf of the said Applicant which remain uncashed at the time of his/her death, and to indemnify the Province of Prince Edward Island for any loss sustained through the cashing of such cheques.**

Personal information on this form is collected under Section 3 (f) of Prince Edward Island's Rehabilitation of Disabled Persons Act and Section 3 (a) of Prince Edward Island's Social Assistance Act and will be used for the purpose of the administration of the PEI (DSP). If you have any questions about the collection of this personal information, you may contact ___________ Regional Health Authority, Telephone Number __________.

IN WITNESS WHEREOF I execute this document this ________________________ day of ____________________________, 2_____. A.D.

Signed in the Presence of
WITNESS
Signature: ____________________
Name (Print): _________________

TRUSTEE
Signature:___________________________________
Name (Print):________________________________
Mailing Address:______________________________
Relationship, if any, to Applicant:________________ Phone Number:______________________________

PEI Disability Support Program

WAGE SUBSIDY	Page 1 of 1
Name:	PHN:
Date:	File Number:

Employer Name:	Employer Address/Contact Person/Phone Number:
Disability Support Worker Address/Contact Information:	Position:
# of Weeks:	Hours per Week:
List other funding partners for Wage Subsidy and their funding contribution:	Hourly Reimbursement Rate from the Disability Support Program:
Start Date & End Date:	Total Cost for Disability Support Program:

Personal information on this form is collected under Section 3 (f) of Prince Edward Island's Rehabilitation of Disabled Persons Act and Section 3 (a) of Prince Edward Island's Social Assistance Act and will be used for the purpose of the administration of the PEI (DSP). If you have any questions about the collection of this personal information, you may contact ___________ Regional Health Authority, Telephone Number __________.

______________________________ ______________________________
Employer **Witness**

______________________________ ______________________________
Disability Support Program Participant **Witness**

______________________________ ______________________________
Disability Support Worker **Witness**

A copy of this form goes to the DSP participant and the Employer. The original goes on the DSP file attached to Support Plan.

Review Checklist	Page 1 of 2
Name:	PHN:
Date of Review:	File Number:
Disability Support Worker:	New Review:

The following are items to be reviewed/completed at a supports review:

- ❑ **Client Contribution Calculation**
- ❑ **Disability Support Program Screening Tool (to be completed once per year)**
- ❑ **Eco-Map Reviewed/Revised**
- ❑ **Record of Supports Used Form Reviewed**
- ❑ **Support Plan Reviewed, Redeveloped and/or Modified**
- ❑ **New Individual Support Agreement Form Competed**
- ❑ **Monthly Worksheet**

REVIEW NOTES (Progress or change since last review):

Personal information on this form is collected under Section 3 (f) of Prince Edward Island's Rehabilitation of Disabled Persons Act and Section 3 (a) of Prince Edward Island's Social Assistance Act and will be used for the purpose of the administration of the PEI (DSP). If you have any questions about the collection of this personal information, you may contact ___________ Regional Health Authority, Telephone Number __________.

____

____

____

____

____

____

Review Checklist Notes /2

Department of Health and Social Services

P.E.I. Disability Support Program Review Committee

Notice of Hearing

File#: ____________

The P.E.I. Disability Support Program Review Committee will convene on:__________,
Day

__________________, _______________, _________________, at ______________
Month Date Year Time

at: ____, P.E.I.

to hear the case of: ____ (Appellant)

and: ____ Health Region (Respondent)

The Appellant or any other person of his/her choosing acting on his/her behalf must appear at the hearing to present his/her request for review. The Appellant or any other person acting on his/her behalf is required to present evidence and have available at the hearing any applicable documents or records pertaining to the matter under the review process.

The Respondent is required to have a regional representative(s) present and must have available at the hearing:

All documents and records pertaining to the matter under review including all relevant documentation from the P.E.I. Disability Support Program work processes.

Date: ______________________ Signature: _______________________
Provincial Coordinator or Designate

Appellant:

If for any reason you do not wish to proceed with this hearing, or you cannot attend on this date, it is essential you telephone or write to: Provincial Coordinator, P.O. Box 2000, 16 Garfield Street, Charlottetown, PE C1A 7N8, Telephone, (902) 368-6256 at least 12 hours before the scheduled hearing.
Note: If you reach Voice Mail when calling, please identify yourself by leaving your full name, the area in which you live, and a brief message as to the reason why you do not wish to proceed or cannot attend this hearing.

Department of Health and Social Services

P.E.I. Disability Support Program Provincial Review Committee

Notice of Decision
Review Hearing

File#:

BEFORE: **Chairperson**
Member
Member

BETWEEN: **(Appellant)**

AND: **(Respondent)**

DATE OF REVIEW HEARING:

Decision

Given under the signature of the Provincial Review Committee this ____________________ day of

________________________ A.D. 20__

_____________________________ _______________________________
Member **Member**

____
Chairperson

Appendix B-16 Feb./03