

Name:

DOB:

Persons with Disabilities Application Worksheet: Section 1 – Applicant Information

Please describe your disability

1. My physical and mental health disabilities are:

2. The parts of my body affected include:

3. My pain is best described as:

Throbbing Pounding Stabbing Aching Sharp Sensitive to light, sound, or motion

Constant Periodic (comes and goes) Severe

Other:

4. My symptoms are:

5. I require the following medications:

6. I require the following treatments and/or therapies:

7. I require the following assistance devices(s):

- Cane Walker Bath chair Raised toilet Wall bars Transfer pole Medical bed
- Manual wheelchair Power wheelchair Medical scooter Crutches Home oxygen
- Prosthesis. Splints Braces Commode Feeding devices Ostomy supplies
- Urological appliance Hearing aids Aids:
- Communication devices:
- Interpretive services:
- Specially designed adaptive housing (attach description):
- Other:

8. My symptoms or inability to do tasks requires:

- Continuous Assistance:** My condition is constant. affects me to some degree every day or almost every day.
- Periodic Assistance:** I go in cycles where I may have some good days in a row and then when my condition acts up, I need help with daily living activities.

9. I have a... **Severe physical health impairment** **Severe mental health impairment**
...which significantly restricts my ability to perform daily living tasks in the areas I have indicated with checkmarks below.

A. FUNCTIONAL SKILLS

Cognitive and Emotional Function

I have difficulty with:

- Being withdrawn/isolated Being rejected by others Staying focused/concentrating
- Learning disabilities Short-term memory Problem solving Racing thoughts Stuttering
- Rapid speech Disorganized speech Hostility Confusion Orientation to place and time
- Being able to recall information Describing my emotions/experiences Mute
- Being able to plan, organize, sequence calculations, or use appropriate judgements
- Controlling my responses when under stress/experiencing anxiety
- Communicate speaking or writing to express myself Speaking clearly to be understood by others

Activities of Daily Living/Personal Care

I have difficulty with:

- Standing in the shower Maintaining good hygiene Shaving Dressing myself
- Apply lotions/creams Brushing my hair/remembering to brush my hair
- Maintaining good sleep patterns Knowing when to access medical care
- Brushing my teeth/remembering to brush my teeth Taking/remembering to take medications

Physical Mobility Issues

- Reaching my arms above my head
- Reaching arms to body parts
- Kneeling down.
- Pulling/turning
- Reaching arms out in front of body
- Getting up from kneeling position
- Carrying/lifting

Additional information:

Meal Preparation/Cooking

- Chopping
- Peeling
- Standing at skin/stove
- Timing cooking
- Using can opener.
- Opening jars
- Hearing water boil
- Lifting/carrying pots
- Meal planning
- Grocery shopping
- Safe handling and storage of food
- Making good nutritional choices
- Remembering to attend to food on stove/in oven
- Using sharp objects, knives, potato peelers, etc.
- Understanding recipes/cooking instructions
- Other:

Management of Medication

- Dispensing
- Remembering to take medications
- Filling/refilling prescriptions
- Safe medication storage and handling

Managing Finances

- Keeping track of bills
- Reading bills
- Budgeting
- Using bank machine
- Impulse purchases
- Understanding bank statements
- Remembering to pay bills on time
- Setting up automatic payments
- Returning items I don't need or can't afford
- Other:

Housekeeping/Maintenance

- Washing counters and sinks
- Cleaning bathtubs
- Cleaning showers
- Cleaning toilets
- Sweeping floors
- Vacuuming
- Washing floors
- Doing laundry
- Carrying laundry
- Folding laundry
- Washing mirrors/windows
- Washing dishes
- Putting dishes away
- Doing yard work
- Cleaning toilets
- Snow removal
- Maintaining sanitary conditions
- Other:

Mobility Inside the Home

- Getting into bed
- Getting out of bed
- Finding comfortable position to lay in
- Getting into chairs
- Getting out of chairs
- Getting into tub/shower
- Getting out of tub/shower
- Standing in shower
- Climbing stairs
- Descending stairs
- Sitting in one position
- Getting on/off toilet
- Other:

Mobility Outside the Home

- Standing at bus stops Figuring out bus schedule Figuring out where to get off the bus
 Sitting on the bus (agitation, pain, etc.) Climbing stairs/ramps. Descending stairs/ramps
 Walking on uneven pavement or ground Driving Getting in and out of vehicle
 Arranging transportation Walking more than _____ before I have to stop and sit down/rest
 I live _____ km out of town I require a taxi Other:

Shopping

- Walking around the store Being in a store that is crowded Reading/understanding labels and prices
 Moving groceries from shelves to cart. Carrying groceries to transportation Paying for purchases
 Returning purchases if required Buying appropriate, affordable food/supplies/clothing
 Being able to wait in line without becoming frustrated, angry, or anxious
 Other:

I have/need assistance or supervision from:

- Family Friends. Neighbours Volunteers Advocates Mental health workers
 Emotional support/support groups Home support workers Home care nurses
 Tenant support workers Community programs Community counsellors Church/pastoral care
 Assistance animals Other:

Please list all agencies involved in your care:

B. SOCIAL SKILLS

Social Functioning

- Lack of good social judgement Unable to maintain social relationships Unable to problem solve
 Interact inappropriately with others Unable to respond to social cues Poor daily decision making
 Unable to secure assistance from others Getting in situations dangerous to self/others
 Unable to deal appropriately with unexpected demands Problems interacting with others
 Disruptive, aggressive, abusive, withdrawn, or rejected behaviour with family, neighbourhood contacts, acquaintances, storekeepers, public officials, etc.
 Others:

Things that Impact My Ability to Communicate:

- Difficulty completing tasks Experience delusions/thought disorders Confusion. Extreme tension
- Hearing in person Hearing over the phone Coping with anxiety Coping with depression
- Bizarre behaviours Experiencing fear or paranoia Control impulses Experiencing fear/paranoia
- Understanding things on the radio Understanding things on TV Speaking to people I don't know
- Remembering appointments Reducing agitation Repetitive behaviours
- Processing or understanding the written word Processing or understanding the spoken word
- Lack of motivation or loss of initiative/interest Experience auditory or visual hallucinations
- Speaking loud enough to be heard by others

C. ADDITIONAL INFORMATION

Completed by _____ on _____

Date of Birth _____

BC Personal Health Number (PHN) _____