Ontario

Ministry of Children, Community and Social Services

Ontario Disability Support Program

Ontario Disability Support Program Instruction Sheet for Applicant

The Disability Determination Package (DDP) is the package of forms the ministry uses to decide if you qualify for the Ontario Disability Support Program (ODSP). These instructions will tell you about:

1. The items in this package
2. Applying using the paper DDP or online
3. How and when to send in your package
4. How to contact the Disability Adjudication Unit
5. Which health care professionals can complete your forms
6. Asking for supporting medical information
7. What will happen after you send us your forms

1. The items in this package

Name of item	What you need to know
Consent to the Release of Medical and Related Information	Complete and sign this form.
Self Report	This form is your chance to tell us how you feel your disability affects your life. You do not have to complete this form – it is your choice. We encourage you to fill it out so we can better understand your situation.
Disability Determination Form (Health Status Report and Activities of Daily Living)	Take this form to a health care professional to complete (see below for a list of who can fill this form out).
Information for Health Care Professional	Give this to your health care professional to read. It tells them more about ODSP and how to complete the Disability Determination Package.

2. Applying using the paper DDP or online

Your health care professional may complete the paper DDP or the online DDP.

If applying using the paper DDP, please have your health care professional complete the Health Status Report and Activities of Daily Living form.

- Please complete your Consent to the Release of Medical and Related Information and Self Report. Mail your paper application following the instructions below (see #3).

If applying online, ask your health care professional if they can complete the online Health Status Report and Activities of Daily Living form. Health care professionals who have access to the Ministry of Health Specialized Authorization Digital Information Exchange may complete the form online.

- **If they can complete the forms online**, you can provide your completed Consent to the Release of Medical and Related Information form and Self-Report to your health care professional to submit digitally on your behalf.
- If you choose not to provide the Consent to the Release of Medical and Related Information and Self-Report Form to your health care professional, mail these forms following the instructions below (#3).
- **If they are unable to complete online** please apply using the paper DDP.

3. How and when to send in your package

- Return all completed forms by **16-06-2024**.
- If you need more time to complete your forms, you can ask the Disability Adjudication Unit for more time. The Disability Adjudication Unit will give more time to anyone who needs it.
- The Disability Adjudication Unit will only accept the original forms, so please do not send copies. If any of your forms get damaged or lost, you can ask for new ones from the Disability Adjudication Unit.
- Send your completed paper DDP in **one package** by mail to the Disability Adjudication Unit.

Important: If you are receiving Canada Pension Plan Disability **(CPP-D)** or Quebec Pension Plan Disability **(QPP-D)**, or you have been found eligible for adult developmental services and support from Developmental Services Ontario **(DSO)**, you do not need to complete this form.

You need to contact your local ODSP office.

4. How to contact the Disability Adjudication Unit

- By Telephone ▶

City/Town	Telephone Number	Teletypewriter (TTY)
Within the Greater Toronto Area	416-326-5079	416-326-3372
Outside the Greater Toronto Area	1-888-256-6758	1-866-780-6050

- By fax ▶ 416-326-3374
- By mail ▶ Ontario Disability Support Program
  Disability Adjudication Unit
  Box B18
  Toronto ON M7A 1R3

To ask for more time for your application, you can phone, fax, or mail your request to the Disability Adjudication Unit. If you write a letter, please include:

- your full name, and
- 9-digit member ID.

5. Which health care professionals can complete your forms

The Health Status Report and Activities of Daily Living must be filled out by a health care professional (see below). Your health care professional must be registered to practice in Ontario. If you have more than one health care provider, you should ask the person who has the best understanding of your medical situation. You may provide documents from your other health care professionals with your application.

The **Health Status Report (HSR)** may be completed by:

- nurse practitioner
- optometrist
- physician
- psychologist
- psychological associate
- registered nurse

The **Activities of Daily Living (ADL)** may be completed by:

- audiologist
- chiropractor
- nurse practitioner
- occupational therapist
- optometrist
- physician
- physiotherapist
- psychological associate
- psychologist
- registered nurse
- social worker
- speech language pathologist

6. Asking for supporting medical information

You do not have to include any extra medical information with your forms. But it can be very helpful for us to have this information when we make our decision about your application.

You may ask your health care professional to include paper copies of medical reports already on file that might help us better understand your medical conditions. Here are some examples:

- consultations
- functional assessments
- psychiatric assessments
- specialist reports
- test results
- x-ray reports

7. What will happen after you send us your forms

We will review your information to decide if you qualify for ODSP. We will do our best to make a decision in 90 **business** days from the day we receive your completed package.

We may need more time to make a decision if:

- your forms are incomplete, or
- we need more information about your medical conditions to make a decision.

If this happens, we will contact you.

Ontario

Ministry of Children, Community and Social Services

Ontario Disability Support Program

Ontario Disability Support Program Self Report

What This Form Is for

This form is your chance to tell us about how your disability affects your life.
You do not have to fill out this form – it is your choice.
We encourage you to fill it out so we can better understand your situation.
This form is **confidential** and we only use it to understand your disability.

How to Fill out This Form

1. Answer the questions that apply to you or that you want to answer. All questions are **optional**.
2. Return it with the rest of your forms to the Disability Adjudication Unit.
3. If you need help with the questions, you can ask someone to help you.
4. If you cannot answer the questions yourself, you can ask someone to complete the form for you.

   Here are some **examples** of people you might ask for help with this form:
   - Parents or other family member
   - friend
   - social worker
   - peer support worker
   - community mental health worker
   - adult protective service worker
   - counsellor or therapist
   - occupational therapist
   - nurse

* client may choose not to complete the self-report form, but they must sign page 6 of the form - see last page

Notice with Respect to the Collection of Personal Information

(Freedom of Information and Protection of Privacy Act)

This information is collected under the legal authority of the *Ontario Disability Support Program Act, 1997*, sections 5 and 10, for the purpose of administering the Ontario Disability Support Program (ODSP). For more information about the collection of personal information, contact the Client Service Advisor at the Ministry's Disability Adjudication unit:

By telephone (collect calls will be accepted)

City/Town	Telephone Number	Teletypewriter (TTY)
Within the Greater Toronto Area	416-326-5079	416-326-3372
Outside the Greater Toronto Area	1-866-256-6758	1-866-780-6050

By writing

Ontario Disability Support Program
Disability Adjudication Unit
Box B18
Toronto ON M7A 1R3

By fax: 416-326-3374

If you appeal the decision about your disability, all medical information provided to the Disability Adjudication Unit will be released to you, your legal representatives, and the Social Benefits Tribunal.

Applicant's Information

Member ID | Referral ID | Date of Birth (dd-mm-yyyy)

Last Name | First Name | Middle Initial

* usually pre-populated with client info

Address

Unit Number | Street Number | Street Name

City/Town | Province | Postal Code

1. How Your Disability Affects Your Life

Please tell us about how your disability affects you. Here are some examples of things you might like to write about:

- how your disability and your symptoms affect your life
- any treatments or care you may be receiving
- issues with getting services where you live
- your ability to do physical activities like walking, getting around, sitting or reaching
- your ability to do mental activities like learn, focus, remember or think
- your physical health issues
- your mental health, such as your anxiety, depression, ability to cope or motivation
- your ability to take care of your personal needs, like getting dressed or bathing
- your ability to look after your home, like cooking and cleaning
- your ability to work or go to school
- your ability to take part in activities like shopping for food, banking, going to appointments
- your ability to take part in social activities, like meeting with friends, going to a community centre, going to a recreational facility or going to a place of worship

2. Services and Supports

Please tell us about any services, supports or aids that help you with your disability.

☐ I do **not need** any special services or supports

☐ I need special services or supports but I am **not using** them because:
Describe

☐ I use an assistive device like a cane, a wheelchair, hearing aid, visual and communication aids, etc.
Describe

☐ I use support services from an agency, such as developmental services, respite care, community mental health, counselling, caseworker, social work, personal support, home care, meal delivery, transportation, etc.
Describe

☐ I get help from another person like a family member or a friend. Describe in table below.

Relationship (e.g., family member, friend, neighbour, caseworker, social worker)	**What they help you with** (e.g., cleaning, shopping, travel, bathing)

☐ I use a service animal.
Describe how your service animal helps you

☐ I use another kind of aid or support.
Describe

3. Employment Activities

Important: You can work and still qualify for Ontario Disability Support Program (ODSP) income support. Also, ODSP employment supports can help you get ready for, find and keep a job.

How has your disability affected your job or ability to work?

Have you worked in the last five years?

☐ Yes ☐ No If **yes**, tell us more about your **current** and **past jobs** below. ▼

What is or was your job (the name of your job or what you did)?	**Employment Type**	**When did you start?**	**When did you stop?**	**Why did this job end** (e.g., seasonal, health reasons, laid off, got a new job etc.)?
	☐ Full time ☐ Part time ☐ Casual or seasonal			
	☐ Full time ☐ Part time ☐ Casual or seasonal			
	☐ Full time ☐ Part time ☐ Casual or seasonal			

Do you need support from an employer in order to work?

☐ Yes ☐ No If **yes**, describe (e.g., flexible work hours, equipment, etc.) ▼

Have you used any employment services (e.g., help finding work, a training program, job coaching)?

☐ Yes ☐ No If **yes**, describe ▼

4. Education and Training

Important: You can go to school or attend training and still qualify for ODSP income support.

What is your highest degree or level of school completed?

☐ Some elementary school up to grade 6
☐ Elementary school up to 8th grade
☐ Some high school, no diploma
☐ High school graduate, diploma or the equivalent (e.g., General Education Development or General Education Diploma (GED))
☐ Some post-secondary
☐ College or university
☐ Trade, technical or vocational training
☐ I don't know my highest level of education
☐ I never went to school

Have you ever been in a special education program or had your disability accommodated at school?

☐ Yes ☐ No If **yes**, describe ▼

Have you taken other classes or training (e.g., English as a Second Language (ESL))?

☐ Yes ☐ No If **yes**, describe ▼

How has your disability affected your education or training?

5. **Additional Reports**

You can attach reports related to your disability that are not with your health care provider

Here are some examples of reports you might want to share:

- psychological assessment
- education assessment
- Individual Educational Plan (IEP) or other related school reports
- vocational assessment

Are you attaching any reports?

☐ Yes ☐ No If **yes**, describe ▼

6. **Is There Anything Else We Should Know About You**

This is your chance to tell us any other information or about any other issues that affect how you live with a disability.

Here are some examples of what you might like to write about:

- language barriers
- your race or ethnicity
- Indigenous status
- experience of discrimination
- addiction or substance use
- poverty, needing a food bank
- your gender identity or gender expression
- your religion or your culture
- a history of homelessness
- a history of trauma or abuse
- experience with the justice system
- unsafe or unstable housing

7. Who Completed This Form

The form was completed by:

- [x] the person applying for ODSP
- [ ] someone else

If the **person applying did not complete the form,** would you like to tell us why?

I choose not to complete the self-report form

8. Signature

Please sign and date the form below. If you are unable to sign this form, it may be signed by your trustee or guardian.

By signing this form I agree that the statements in this document are true.

Signature	Date (dd-mm-yyyy)
Client Signature	Date

Ontario

Ministry of Children, Community and Social Services

Ontario Disability Support Program

Ontario Disability Support Program Information for Health Care Professional

The Ministry of Children, Community and Social Services is collecting information on your patient's medical condition to determine if they qualify for Ontario Disability Support Program (ODSP) income support.

Your patient requires your assistance to complete their application form.

What is ODSP?

ODSP provides financial assistance, benefits and employment supports to eligible people with disabilities.

To qualify for ODSP income support, a person must be:

- 18 years of age or older;
- a resident of Ontario;
- in financial need; and
- a person with a disability as defined by the Ontario Disability Support Program Act, or a member of a prescribed class.

Who is a person with a disability?

Under the *ODSP Act*, a person must have:

- a substantial physical or mental impairment, that is continuous or recurrent, expected to last a year or more, and
- the impairment must directly and cumulatively result in a substantial restriction in the person's ability to take care of themselves, function in the community or the workplace, and
- an approved health care professional has verified the impairments and their duration; and the restrictions.

What is a health care professional's role in completing the application form?

The information you provide helps the ministry decide if your patient qualifies for ODSP income support. Specially trained staff who work in the ministry will review the information you provide to make a decision.

Approved health care professionals who are registered in Ontario complete the form for their patients. The form gathers information about a person's medical situation and has two sections, the Health Status Report (HSR) and the Activities of Daily Living (ADL). The ministry will pay you to complete these forms. Information about payment is on page 2.

Who may complete the forms?

The **Health Status Report (HSR)** may be completed by:

- nurse practitioner
- optometrist
- physician
- psychologist
- psychological associate
- registered nurse

The **Activities of Daily Living (ADL)** may be completed by:

- audiologist
- chiropractor
- nurse practitioner
- occupational therapist
- optometrist
- physician
- physiotherapist
- psychological associate
- psychologist
- registered nurse
- social worker
- speech language pathologist

How to complete the paper forms

1. Please answer as completely as possible. If anything is missing, the ministry will need to follow up with you. This can cause a delay with your patient's application.
2. The HSR and the ADL can be completed by different health care professionals. If this happens, each health care professional needs to sign and date the section that they completed.
3. The ministry will only accept **originals** of forms. Please make a copy for your records.

4. You may attach copies of reports that are available as supporting medical information that may help the ministry understand your patient's medical situation.

Note: Please send only **copies** of reports. We will not return reports. Do not send an actual x-ray, pathology slides, or CD-ROMs. Here are some examples of supporting information:

- consultations
- functional assessments
- psychiatric assessments
- radiological reports
- specialist reports
- test results

How to complete the online forms

- Health Care Professionals who have access to the Ministry of Health's Special Authorization Digital Information Exchange (SADIE) may complete the HSR and the ADL online, and upload additional medical and supporting information (ontario.ca/SADIE).
- Health Care Professionals also have the option of submitting their patient's completed Consent to the Release of Medical and Related Information form and Self-Report form online with the patient's consent.

Who do I contact if I have any questions?

You can contact the Disability Adjudication Unit:

- By telephone ▶

City/Town	Telephone Number	Teletypewriter (TTY)
Within the Greater Toronto Area	416-326-5079	416-326-3372
Outside the Greater Toronto Area	1-888-256-6758	1-866-780-6050

- By fax ▶ 416-326-3374
- By mail ▶ Ontario Disability Support Program
  Disability Adjudication Unit
  Box B18
  Toronto ON M7A 1R3

How do I receive payment for completing these forms?

You will receive payment by billing the Ontario Health Insurance Plan (OHIP) or submitting an invoice to the ministry.

Description	Amount	OHIP Code
Both HSR and ADL	$103.55	K050
Only HSR	$ 82.85	K051
Only ADL	$ 20.70	K052

If you submit an invoice, please:

1. Create an invoice on letter size paper that includes:
   - your full name and profession, address and telephone number
   - your patient's full name, date of birth and member ID (this is on each page of the form)
   - the name of the section you completed (i.e., HSR and/or ADL)
2. Mail your invoice to ▶ Ontario Disability Support Program
   Disability Adjudication Unit
   Box B18
   Toronto ON M7A 1R3

How much time does my patient have to complete their Disability Determination Package?

Your patient was given 90 days to complete and return their forms. The ministry is aware that medical appointments can take time to schedule, so the ministry will give more time if your patient needs it. If more time is not requested and the

ministry does not receive the forms by the due date, then your patient's file will be closed and they will be required to reapply.

For more information

- about ODSP: visit https://www.ontario.ca/page/social-assistance

Ontario

Ministry of Children, Community and Social Services
Ontario Disability Support Program

Health Status Report and Activities of Daily Living

Instructions

This form gathers information about a person's disability as part of their application for income support from the Ontario Disability Support Program (ODSP).

The form has two sections:

- the **Health Status Report (HSR)**, and
- the **Activities of Daily Living (ADL)**.

The ministry will pay you to complete these forms.

Important: Applicants who do not require disability adjudication (prescribed class)

Applicants who are members of a "prescribed class" do not require disability adjudication. For example, the following persons are members of a prescribed class:

- those receiving disability benefits from the Canada Pension Plan (CPP) or the Quebec Pension Plan (QPP); and
- those with a letter from a Developmental Services Ontario (DSO) office confirming that they are eligible for adult developmental services and supports.

You do not need to complete this form if the applicant is a member of a prescribed class. The applicant or their family needs to contact their local ODSP office.

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By telephone (collect calls will be accepted)

City/Town	Telephone Number	Teletypewriter (TTY)
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By fax: 416-326-3374

By writing

Ontario Disability Support Program
Disability Adjudication Unit
Box B18
Toronto ON M7A 1R3

If the applicant appeals the decision, this and all supplementary medical information provided will be released to the applicant, their legal representatives, and the Social Benefits Tribunal.

Applicant's Information

Member ID	Referral ID	Date of Birth (dd-mm-yyyy)

Last Name	First Name	Middle Initial

Current Address Unit Number	Street Number	Street Name

* usually pre-populated with client info

City/Town Toronto	Province	Postal Code

Health Status Report (HSR)

1. Medical Conditions that Contribute to the Applicant's Current Status

Please provide information below.

Medical Condition	Refers to illness, disease, injury (e.g., physiological, mental health, psychological, developmental).
Impairment	Refers to any loss or deviation in psychological, physiological or anatomical structure or function.
Duration	Refers to how long the impairment, either continuous or recurrent, is expected to last from the date the disability determination form is completed.
Restriction	Refers to a limitation in activities of daily living caused directly by the impairment.

Medical Condition **Example 1**

Chronic Back Pain

Prognosis - condition is likely to:

☐ improve ☐ remain same

☒ deteriorate ☐ unknown

Impairment(s)

Pain in low back, hips and thighs

Duration of Impairment(s)
(**MANDATORY** - complete both columns)

Expected to last:	And is:
☐ less than 1 year	☐ recurrent/episodic
☒ 1 year or more	☒ continuous

Restriction(s)

Difficulty with sitting and standing for lengthy periods (longer than 30 minutes). Difficulty with mobility in the home and in the community.

Medical Condition **Example 2**

Major Depression

Prognosis - condition is likely to:

☐ improve ☐ remain same

☐ deteriorate ☒ unknown

Impairment(s)

Depressed mood; anhedonia; poor concentration

Duration of Impairment(s)
(**MANDATORY** - complete both columns)

Expected to last:	And is:
☐ less than 1 year	☒ recurrent/episodic
☒ 1 year or more	☐ continuous

Restriction(s)

Difficulty attending to and completing daily tasks such as self-care, paying bills and keeping appointments. Problems with social interactions.

Medical Condition **Example 3**

Learning Disability

Prognosis - condition is likely to:

☐ improve ☒ remain same

☐ deteriorate ☐ unknown

Impairment(s)

Difficulty learning and retaining information

Poor comprehension skills; poor planning and time management

Duration of Impairment(s)
(**MANDATORY** - complete both columns)

Expected to last:	And is:
☐ less than 1 year	☐ recurrent/episodic
☒ 1 year or more	☒ continuous

Restriction(s)

Low academic achievement; problems learning job tasks and following instructions.

1. **Medical Condition**

Human Immunodeficiency Virus (HIV)

Prognosis - condition is likely to:

☐ improve ☒ remain same

☐ deteriorate ☐ unknown

Impairment(s)

none at this time

Duration of Impairment(s)
(**MANDATORY** - complete both columns)

Expected to last:	And is:
☐ less than 1 year	☐ recurrent/episodic
☒ 1 year or more	☒ continuous

Restriction(s)

none at this time

---

2. **Medical Condition**

Prognosis - condition is likely to:

☐ improve ☐ remain same

☐ deteriorate ☐ unknown

Impairment(s)

Duration of Impairment(s)
(**MANDATORY** - complete both columns)

Expected to last:	And is:
☐ less than 1 year	☐ recurrent/episodic
☐ 1 year or more	☐ continuous

Restriction(s)

---

3. **Medical Condition**

Prognosis - condition is likely to:

☐ improve ☐ remain same

☐ deteriorate ☐ unknown

Impairment(s)

Duration of Impairment(s)
(**MANDATORY** - complete both columns)

Expected to last:	And is:
☐ less than 1 year	☐ recurrent/episodic
☐ 1 year or more	☐ continuous

Restriction(s)

---

4. **Medical Condition**

Prognosis - condition is likely to:

☐ improve ☐ remain same

☐ deteriorate ☐ unknown

Impairment(s)

Duration of Impairment(s)
(**MANDATORY** - complete both columns)

Expected to last:	And is:
☐ less than 1 year	☐ recurrent/episodic
☐ 1 year or more	☐ continuous

Restriction(s)

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* if relevant, please complete and attach reports

2. Additional Information

2.1 Are any of the medical conditions reported in section 1 listed below?

Mental health condition . . . . . ☐ Yes ☒ No

Substance-related or addictive disorder . . . . . ☐ Yes ☒ No

Neurodevelopmental disorder (e.g., intellectual disability, autism spectrum disorder, developmental delay, specific learning disability, attention-deficit/hyperactivity disorder, Fetal Alcohol Spectrum Disorder . . . . . ☐ Yes ☒ No

Other medical condition presenting with a mental or cognitive impairment (e.g., traumatic brain injury, stroke, seizure disorder) . . . . . ☐ Yes ☒ No

If you answered **"Yes"** to any of the above, and there is additional information that might be useful in understanding the applicant's mental or cognitive impairments please **describe or attach copies of available reports** (e.g., psychology, psychiatry, educational assessment, individual education plan, neuropsychological assessment, other mental health consult).

Relevant additional information may include: History, interventions, access to treatment, services, housing, homelessness, etc. that might be useful to understand the presenting impairments and their impact.

Note: You **do not** have to repeat the information already provided in Section 1.

☐ See attached reports

* only complete if condition from 2.1 was selected; otherwise leave blank

2.2. Intellectual and Emotional Wellness Scale (IEWS)

The checklist below consists of some features or symptoms that might be seen in mental health, substance use, neurocognitive and related conditions that can impact daily functioning

Rate the symptoms in the context of the applicant's presenting conditions and impairments. For episodic symptoms, please describe how fluctuations in the severity level affect the patient.

Rating scale

DK = Don't know | **0 =** Not present / Not at all | **1 =** Mild / Just a little | **2 =** Moderate / Quite a bit | **3 =** Severe / Very Much

Symptoms	DK	0	1	2	3
1. Amotivation	☐	☐	☐	☐	☐
2. Anxiety	☐	☐	☐	☐	☐
3. Appetite Change: ☐ Increase ☐ Decrease	☐	☐	☐	☐	☐
4. Attention deficit	☐	☐	☐	☐	☐
5. Comprehension deficit	☐	☐	☐	☐	☐
6. Concentration deficit	☐	☐	☐	☐	☐
7. Delusions	☐	☐	☐	☐	☐
8. Depressive mood	☐	☐	☐	☐	☐
9. Disinhibition	☐	☐	☐	☐	☐
10. Disorientation (person, place or time)	☐	☐	☐	☐	☐
11. Dissociative symptoms	☐	☐	☐	☐	☐
12. Emotional dysregulation	☐	☐	☐	☐	☐
13. Energy Change: ☐ Increase ☐ Decrease	☐	☐	☐	☐	☐
14. Euphoria/Elation (elevated mood)	☐	☐	☐	☐	☐
15. Executive function deficits (e.g., self-regulation, planning and organization)	☐	☐	☐	☐	☐
16. Grandiosity	☐	☐	☐	☐	☐
17. Hallucination	☐	☐	☐	☐	☐
18. Impulse control deficit	☐	☐	☐	☐	☐
19. Insight deficit	☐	☐	☐	☐	☐
20. Judgement deficit	☐	☐	☐	☐	☐
21. Learning deficits (specify) ▶	☐	☐	☐	☐	☐
22. Memory deficit: ☐ Long term memory ☐ Short term memory ☐ Working Memory	☐	☐	☐	☐	☐
23. Psychomotor retardation: ☐ Agitation ☐ Retardation	☐	☐	☐	☐	☐
24. Sleep dysfunction: ☐ Difficulty sleeping ☐ Excessive Sleeping	☐	☐	☐	☐	☐
25. Speech deficit (not due to language barrier) (specify) ▶	☐	☐	☐	☐	☐
26. Suicidality: ☐ Ideation/Thoughts ☐ Plans ☐ Attempts	☐	☐	☐	☐	☐
27. Thought disorganization	☐	☐	☐	☐	☐
28. Withdrawn	☐	☐	☐	☐	☐

For episodic symptoms describe how fluctuations in **severity level affect** the patient

3. Available Medical and Other Information Related to Section 1

Note: You **do not** have to repeat the information already provided in previous sections.

3.1 How long have you known the applicant?

e.g. 1 month

3.2 How often do you see the applicant for the conditions and/or impairments listed in Section 1?

e.g. twice monthly

3.3 Please describe available information, if applicable. * okay to leave blank if not applicable (e.g. no weight loss)

If **relevant** to any of the conditions or impairments listed in section 1, state the applicant's

Height	Weight	Body Mass Index (BMI)	Other (i.e., blood pressure)

Examination findings

For recurrent or episodic impairments listed, describe how fluctuations in **severity level** affect the patient

3.4 Have any consultations or assessments been completed by another health care professional? . . . . . ☒ Yes ☐ No

If **Yes**, select type. ▼

☒ Diagnostic test or investigation (e.g., laboratory, biopsy, sleep study, ultrasound, imaging, stress test)
Describe

HIV laboratory results - see attached

☐ Specialist consults (e.g., cardiology, neurology, oncology, psychiatry, psychology, rheumatology)
Describe

☐ Other assessments or reports (e.g., vocational assessment, occupational therapy report)
Describe

Describe relevant findings **or** ☒ attach copies of the available report

Note: Do not send actual x-rays or an original report. The cost of photocopying has been included in the fee.

* remember to attach HIV serology or HIV viral load

If **no**, comment (e.g., pending or waiting list, not available)

4. Visual

* okay to leave blank if not applicable, or no assessment available

Note: Complete only if a visual condition or impairment is identified in section 1.

Date of Diagnosis (if known) (dd-mm-yyyy)	Most Recent Assessment Date (dd-mm-yyyy) ☐ See attached report

4.1 Snellen Visual Acuity Chart

	Uncorrected		Corrected	
	Near	**Distance**	**Near**	**Distance**
Right Eye				
Left Eye				
Both Eyes				

4.2 Is there a visual field defect component in the visual impairment? . . . . . ☐ Yes ☐ No

If **yes**, describe ▼ **or** ☐ attach report

4.3 Is there a change in ocular mobility (e.g., diplopia, strabismus) or deformities of the orbit that alter function? . . . . . ☐ Yes ☐ No

If **yes**, describe ▼ **or** ☐ attach report

5. Auditory

* okay to leave blank if not applicable, or no assessment available

Note: Complete only if an auditory condition or impairment is identified in section 1.

Date of Diagnosis (if known) (dd-mm-yyyy)	Most Recent Assessment Date (dd-mm-yyyy) ☐ See attached report

5.1 What type is the hearing loss? . . . . . ☐ Unilateral ☐ Bilateral

5.2 Has there been any change in hearing loss over the last 5 years? . . . . . ☐ Yes ☐ No

If **yes**, describe

5.3 Does the applicant have difficulty understanding speech in a quiet environment? . . . . . ☐ Yes ☐ No

If **yes**, describe

5.4 Does the applicant have difficulty understanding conversational speech in the presence of background noise? . . . . . ☐ Yes ☐ No

If **yes**, describe

5.5 Are there safety concerns related to hearing (e.g., unable to localize sound of approaching vehicles)? ☐ Yes ☐ No

If **yes**, describe

5.6 Does the applicant have a constant/annoying ringing (tinnitus) in ears? . . . . . ☐ Yes ☐ No

If **yes**, describe

5.7 Does the applicant wear hearing aids? . . . . . ☐ Yes ☐ No

If **yes**, describe

5.8 With the hearing aid(s), could or can the applicant function within normal limits? . . . . . ☐ Yes ☐ No

If **no**, describe

6. Intervention and Treatment

6.1 Is the applicant receiving any intervention and treatment for conditions and impairments listed in section 1? . . . . . ☐ Yes ☐ No

If **yes**, complete relevant sections below and comment on progress

Admission, Emergency Room Visit, Surgery	Date of Visit (dd-mm-yyyy)	Duration	Describe Purpose or Attach Admission/ Discharge Report ▶	Attach Report
1. * if hospital visit relevant, please complete				☐
2.				☐
3.				☐
4.				☐

Pharmacotherapy	Dosage	Frequency	Start Date (dd-mm-yyyy)	List Conditions or Impairments Being Treated
1. e.g. Biktarvy	1 pill	once daily	01-01-2022	HIV infection
2.		OR		
3. will initiate ART as soon as possible				HIV infection

Pharmacotherapy	Dosage	Frequency	Start Date (dd-mm-yyyy)	List Conditions or Impairments Being Treated
4.				

Interventions and Services	Start Date (dd-mm-yyyy)	End Date (dd-mm-yyyy)	Describe Response to Treatment or ▶	Attach Report
1. Addiction services				☐
2. Chemotherapy				☐
3. Cognitive Behavioural Therapy (CBT)				☐
4. Counselling				☐
5. Occupational therapy				☐
6. Physiotherapy				☐
7. Psychotherapy				☐
8. Radiation				☐
9. Vocational rehabilitation				☐
10. Other rehabilitation (specify) ▼				☐
11. Other (e.g., Indigenous Healer) ▼				☐

If **no**, comment (e.g., pending, side effects, no definitive diagnosis, not available, poor insight)

6.2 Describe any relevant past treatment and reason for discontinuation (e.g., remission, failed treatment, change in treatment, side effects)

* okay to leave blank if not applicable

6.3 Provide any other information that might be useful in understanding the applicant's current situation

* okay to leave blank if not applicable

* okay to leave this page blank if completing **both** sections of *Health Status Report* **and** *Activities of Daily Living*

7. Certificate of Approved Health Care Professional

Note: You must sign and date this section. If you are also completing the Activities of Daily Living, you can sign and date Section 9 instead.

I, Last Name, First Name
Last Name, First Name

am a legally qualified e.g. Registered Nurse in the Province of Ontario;
Profession

and registered with e.g. College of Nurses of Ontario
Professional Regulatory College

My registration number is 1234567
Registration Number

Address * provide workplace contact information **or** Stamp Address

Unit/Suite Number	Street Number and Name
City/Town	
Province ON	Postal Code
Telephone Number ext.	Fax Number
Office Email (optional)	

I confirm that the information I have provided is true in my professional opinion.

Signature (By hand, do not use stamp here)	Date (dd-mm-yyyy)
Health Care Provider Signature	Date

The *Criminal Code of Canada* s.s 380 (1) states that everyone who by deceit, falsehood or other fraudulent means defrauds the public of any property, money or valuable security, is guilty of an offence. The *Ontario Disability Support Program Act*, 1997, section 59, states that a person who knowingly aid or abets another person to obtain or receive assistance to which the other person is not entitled to under the Act and the regulations is guilty of an offence.

Ontario

Ministry of Children, Community and Social Services

Ontario Disability Support Program

Health Status Report and Activities of Daily Living

Activities of Daily Living (ADL) (mandatory section)

The Activities of Daily Living (ADL) is comprised of a group of routine activities that people tend to do everyday.

The ADL section may be completed by an Ontario registered:

- audiologist
- chiropractor
- nurse practitioner
- occupational therapist
- optometrist
- physician
- physiotherapist
- psychological associate
- psychologist
- registered nurse
- social worker
- speech language pathologist

Notice with Respect to the Collection of Personal Information

(Freedom of Information and Protection of Privacy Act)

This information is collected under the legal authority of the *Ontario Disability Support Program Act, 1997*, sections 5 and 10, for the purpose of administering the Ontario Disability Support Program (ODSP). For more information about the collection of personal information, contact the Client Service Advisor at the Ministry's Disability Adjudication unit:

By telephone (collect calls will be accepted)

City/Town	Telephone Number	Teletypewriter (TTY)
Within the Greater Toronto Area	416-326-5079	416-326-3372
Outside the Greater Toronto Area	1-866-256-6758	1-866-780-6050

By Fax: 416-326-3374

By writing

Ontario Disability Support Program
Disability Adjudication Unit
Box B18
Toronto ON M7A 1R3

If the applicant appeals the decision, this and all supplementary medical information provided will be released to the applicant, their legal representatives, and the Social Benefits Tribunal.

Applicant's Information

Member ID	Referral ID	Date of Birth (dd-mm-yyyy)

Last Name	First Name	Middle Initial

Current Address Unit Number	Street Number	Street Name

* usually pre-populated with client info

City/Town	Province	Postal Code

Is the ADL section being completed by the same health care professional who completed the HSR?

☒ Yes ☐ No

Additional Comments/Information (optional)

8. Activities of Daily Living Index (ADLI)

This section consists of a list of activities that seeks to understand the impact of the presenting impairments on the applicant's restrictions.

8.1 This information helps the ministry understand the direct impact of the impairments and restrictions listed in Section 1 on the applicant's current ability to perform and carry out each activity.

Rating scale

DK = Don't know	**0 = No limitation** (e.g., can carry out task completely without assistance)	**1 = Mild** (e.g., can complete task with minor assistance or extra time)	**2 = Moderate** (e.g., needs support in order to complete task; some supervision needed to get task done)	**3 = Severe** (e.g., completely unable to do task; task is done by someone else; does not understand the concept)

Please rate the limitation for each activity.

Activities	DK	0	1	2	3	Describe limitation, if needed
1. Bladder control	☐	☒	☐	☐	☐	
2. Bowel control	☐	☒	☐	☐	☐	
3. Bathing and self-cleaning	☐	☒	☐	☐	☐	
4. Grooming (hair, face teeth, hands and nails)	☐	☒	☐	☐	☐	
5. Dressing (including buttons, clasps, zips, shoe laces)	☐	☒	☐	☐	☐	
6. Select clothes for weather and situation	☐	☒	☐	☐	☐	
7. Meal Preparation	☐	☒	☐	☐	☐	
8. Eating: using utensils	☐	☒	☐	☐	☐	
9. Shopping for groceries	☐	☒	☐	☐	☐	
10. Housekeeping	☐	☒	☐	☐	☐	
11 Laundry	☐	☒	☐	☐	☐	* complete as per individual client assessment
12. Physical activity: ability to participate in sustained activities and physical strength commensurate with person's age	☐	☒	☐	☐	☐	* "DK" and "0" are acceptable responses
13 Mobility: walking, getting around	☐	☒	☐	☐	☐	
14. Sitting	☐	☒	☐	☐	☐	
15 Standing	☐	☒	☐	☐	☐	
16. Stair climbing	☐	☒	☐	☐	☐	
17. Transferring: in and out of bed; on and off toilet	☐	☒	☐	☐	☐	
18. Transportation: ability to use available means of transportation	☐	☒	☐	☐	☐	
19. Attending medical appointments	☐	☒	☐	☐	☐	
20. Managing finances: ability to manage own money	☐	☒	☐	☐	☐	
21. Managing medication (if applicable)	☐	☒	☐	☐	☐	
22. Communication using phone, text, email etc.	☐	☒	☐	☐	☐	
23. Cognitive based activities (i.e., reading, writing, understand or following simple instructions)	☐	☒	☐	☐	☐	
24. Safety: ability to maintain personal safety	☐	☒	☐	☐	☐	
25. Social interactions (get along with others, maintains social boundaries)	☐	☒	☐	☐	☐	
26. Hobbies/taking part in activities for relaxation or pleasure	☐	☒	☐	☐	☐	

8.2 Does the applicant require any of the services or help listed below?

☐ Assistive Device or Equipment (e.g., cane, wheelchair, continuous positive airway pressure (CPAP))
Describe

☐ Support Service or Resource (e.g., case management, developmental services, personal support worker)
Describe

☐ Service or guide animal
Describe

8.3 Is there any additional comments/information about activities of daily living?

☐ Yes ☒ No

If **yes**, describe.

9. Certificate of Approved Health Care Professional

Note: You must sign and date this section.

I, Last Name, First Name
Last Name, First Name

am a legally qualified e.g. Registered Nurse in the Province of Ontario;
Profession

and registered with e.g. College of Nurses of Ontario .
Professional Regulatory College

My registration number is 1234567 .
Registration Number

Office Address * provide workplace contact information *or* Stamp Address

Unit/Suite Number	Street Number and Name
City/Town	
Province ON	Postal Code

Telephone Number ext.	Fax Number	Office Email (optional)

I confirm that the information I have provided is true in my professional opinion.

Signature (By hand, do not use stamp here)	Date (dd-mm-yyyy)
Health Care Professional Signature	Date

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Ontario

Ministry of Children, Community and Social Services

Ontario Disability Support Program

Consent to the Release of Medical and Related Information

Why We Need Your Consent

To complete your application, the Disability Adjudication Unit may need to contact your health care professional to collect more medical and related information. This can happen if:

- your health care professional did not complete all required parts of your application forms, or
- the Disability Adjudication Unit needs more information about your medical conditions to make a decision.

Notice with Respect to the Collection of Personal Information

(Freedom of Information and Protection of Privacy Act)

This information is collected under the legal authority of the *Ontario Disability Support Program Act, 1997*, sections 5 and 10, for the purpose of administering the Ontario Disability Support Program (ODSP) (for further details, please see "Why we need your consent above"). For more information about the collection of personal information, contact the Client Service Advisor at the Ministry's Disability Adjudication unit:

By telephone (collect calls will be accepted)

City/Town	Telephone Number	Teletypewriter (TTY)
Within the Greater Toronto Area	416-326-5079	416-326-3372
Outside the Greater Toronto Area	1-866-256-6758	1-866-780-6050

By fax: 416-326-3374

By writing

Ontario Disability Support Program
Disability Adjudication Unit
Box B18
Toronto ON M7A 1R3

If you appeal the decision about your disability, all medical information provided to the Disability Adjudication Unit will be released to you, your legal representatives, and the Social Benefits Tribunal.

Please Complete This Section

My name is Client Last Name, Client First Name and I understand that

(Print) Last Name, First Name

this information will be used by the Disability Adjudication Unit to determine my eligibility for ODSP. I consent to:

- my health care professional releasing information about my present medical conditions to the Disability Adjudication Unit, and
- the Disability Adjudication Unit receiving this information directly from my health care professional.

Name of My Health Care Professional

Health Care Professional Name

Address of My Health Care Professional * workplace contact information

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone Number

ext.

I give my consent voluntarily. I understand that I can refuse to give my consent but this may affect my eligibility for ODSP.

Signature of Applicant or Legally Authorized Representative	Witness	Date (dd-mm-yyyy)
Client Signature	Witness Signature	Date