Manitoba

Family Services and Consumer Affairs
Employment and Income Assistance (EIA)

To the Applicant

How to fill out your application for the disability category of Employment and Income Assistance (EIA)

The application package includes this cover sheet and four forms described below.

Keep the self-report form (#4) and give the other forms to your doctor. You may also give the forms to a specialized nurse called a "nurse practitioner" to complete.

1. To the Physician

This instruction sheet tells your doctor and nurse practitioner what to do with the reports you are giving them.

2. Assessment Report

Ask your doctor to fill this out and either return it to you or mail it to your EIA case co-ordinator at the address on the statement of account.

3. Statement of Account

Ask your doctor to fill this out and return it directly to your EIA case co-ordinator. We need this form to pay doctors for their services.

4. Self-Report

This form gives you a chance to tell the EIA program more about your disability or medical condition. You can ask someone to help you fill out the form if you would like help.

Tell your EIA case co-ordinator if you are going to fill out this form and when you are able to return it. This will keep your application for income assistance under the disability category from being held up.

Why is EIA collecting personal health information about me?

The information is required under *The Employment and Income Assistance Act*. By signing the EIA application for financial assistance, you are giving EIA permission to collect the medical, educational, financial and employment information we need to make sure you are eligible for income assistance in the disability category.

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To the Physician*

To help determine if your patient is eligible for the disability category of the Employment and Income Assistance (EIA) program, please complete the attached disability assessment report. Please type or write legibly. You may substitute this report with a letter.

Income Assistance may be provided under another category if the patient is not eligible for the disability category and is financially eligible.

It is the responsibility of EIA to make the final decision about the person's eligibility.

Definition of Disability

Under *The Employment and Income Assistance Act* (disability category), assistance may be granted if, by reason of age or by reason of physical or mental ill health, or physical or mental incapacity or disorder likely to continue for more than 90 days, a person is:

i) unable to earn sufficient money for basic needs for themselves or any dependents
ii) unable to care for themselves

Access to Personal Health Information

Under *The Personal and Health Information Act*, EIA must, when asked in writing or in person, provide applicants with any information or records, including medical reports, contained in their files. A copy of the completed disability assessment report should be given to the patient, if requested.

Return of Disability Assessment Report

You may return the completed disability assessment report directly to your patient or mail it to the EIA office at the address on the statement of account. Please advise your patient if you are mailing the report.

Payment

EIA will pay the physician $45 in addition to the examination fee (as determined by Manitoba Health - Insured Benefits Branch) for completing the disability assessment report. To receive payment, please return the completed statement of account to the EIA office indicated.

Thank you for your help.

* A registered nurse (Extended Practice designation) is also authorized to complete this report

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DISABILITY ASSESSMENT REPORT

The patient is applying for income assistance, or requesting an extension, under the Employment and Income Assistance (EIA) disability category. To help EIA staff determine whether this person is eligible or continues to be eligible under the disability category, please complete the report below.
You may choose to photocopy this report for your files.

PATIENT INFORMATION

First name	Initial	Last name			
Address (No., Street, Apt., or RR)		City	Date of birth (day/month/year)		
How long has the patient been in your care? ______ months ______ years (specify)	Date of last visit (day/month/year)	Height	Weight	Blood pressure	

PRIMARY DIAGNOSIS CAUSING PHYSICAL, PSYCHOLOGICAL, OR INTELLECTUAL IMPAIRMENT

Original date of diagnosis (month/year)	Diagnosis	Duration	Prognosis	Objective findings supporting this diagnosis
		❒ Expected to last less than 90 days OR ❒ Estimate of duration ____ months ____ years (specify)	Is likely to: ❒ improve ❒ deteriorate ❒ remain same ❒ unknown	

SECONDARY DIAGNOSIS (ES)

Original date of diagnosis (month/year)	Diagnosis	Duration	Prognosis	Objective findings supporting this diagnosis
		❒ Expected to last less than 90 days OR ❒ Estimate of duration ____ months ____ years (specify)	Is likely to: ❒ improve ❒ deteriorate ❒ remain same ❒ unknown	
		❒ Expected to last less than 90 days OR ❒ Estimate of duration ____ months ____ years (specify)	Is likely to: ❒ improve ❒ deteriorate ❒ remain same ❒ unknown	
		❒ Expected to last less than 90 days OR ❒ Estimate of duration ____ months ____ years (specify)	Is likely to: ❒ improve ❒ deteriorate ❒ remain same ❒ unknown	

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ADDITIONAL COMMENTS REGARDING DIAGNOSIS (ES)

OTHER MEDICAL INVESTIGATIONS

Results of recent relevant laboratory examinations, including dates of tests. For example: X-rays, CT scans, MRIs, etc.

Has the patient been referred to any medical specialists?

❒ Yes (If yes, identify medical condition, name of specialist, date referred or if pending. Please include results of consultation, if available.)

❒ No

MEDICATIONS

List the current medications prescribed to the patient for any of the medical conditions noted.

Medical condition	Name of drug	Dosage/frequency	Duration (months)	Compliance (yes/no/unknown)

HOSPITALIZATION

Has the patient been, or will the patient be, admitted to a hospital for any of the medical conditions noted?

❒ Yes (If yes, please identify the medical condition, the reason, admission date, and duration)

❒ No

REFERRALS

Please identify the applicable referrals to allied health professionals made for the patient.

Health care professional/ community clinic/program (circle)	Date referred (month/year)	Expected duration (months)	Status
Dietician			
Chiropractor			
Occupational therapist			
Physiotherapist (hospital or community-based)			
Psychologist			
Chemical withdrawal unit			
Pain clinic			
Psychiatric day clinic / program			
Podiatrist /chiropodist			
Other (specify)			

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WORK ACTIVITY

Based upon your assessment of this patient's physical/mental functioning, please indicate which of the following activities would be appropriate at this time:

❒ Able to work with:
- ❒ no restrictions
- ❒ temporary limitation of functions (please explain below)
- ❒ permanent limitation of functions (please explain below)

❒ Not able to work
i) Estimated time frame to return to work:
❒ Less than 90 days ❒ 3-6 months ❒ 7-12 months ❒ 13-18 months
❒ 19-24 months ❒ Other ____________________

ii) Please explain what is functionally stopping the patient from working at this time:

SIGNATURE

Physician's or nurse practitioner's full name (please print or use stamp)		Signature	
Office address	Date (day/month/year)	Telephone number	Best time to contact (if clarification required)

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