Return this form to:

Assessment of Attendant Care Needs
(Form 1)

Use this form for accidents that occur on or after March 31, 2008

****Claim Number:**	
****Policy Number:**	
Date of Accident: (YYYYMMDD)	

Use this form to report the future needs for attendant care required by the applicant as a result of an automobile accident. This form must be completed by an occupational therapist or a registered nurse (in this form referred to as the Assessor). This form has five parts:

Part 1: Level 1 Attendant Care
Part 2: Level 2 Attendant Care
Part 3: Level 3 Attendant Care
Part 4: Calculation of Attendant Care Costs
Part 5: Signature of Assessor(s)

Please complete all relevant parts. You will have to make copies and give one to: ▪ the applicant ▪ the applicant's health practitioner	**All fields must be completed subject to the following exceptions:** * required if known ** at least one field in this section *** optional

Please note: Users of Form 1 should also review other accident benefits available under the Statutory Accident Benefits Schedule (SABS) for possible reimbursement of other losses and expenses (such as housekeeping and home maintenance, transportation, home modifications and other medical and rehabilitation expenses).

Applicant Information

Date of Birth (YYYYMMDD)	Gender ☐ Male ☐ Female	*Telephone Number Extension
Last name	First name	***Middle name
Address		
City	Province	Postal Code

Insurance Company Information

To be provided by the applicant

Insurance Company Name		
City or Town of Branch Office (if applicable)		*Telephone Number
**Name of Policy Holder same as Applicant ☐, OR	**Policy Holder Last Name	**Policy Holder First Name

Attendant Care Assessment Information

Date of this assessment (YYYYMMDD):	*Is this the first assessment of this applicant? ☐ Yes ☐ No
Date of Last Assessment (YYYYMMDD):	*Current Monthly Allowance:

Assessor Information

Name of Assessor	*Email Address
Profession	College Registration Number

PRINT RESET SAVE

Facility Information

Facility Name		
HCAI Facility Registry Number	*FSCO Licence Number (if applicable)	
Service Address		
City	Province	Postal Code
Telephone Number *Extension	*Fax	*Email Address

Part 1: Level 1 Attendant Care

Level 1 attendant care is for routine personal care. Please assess the care requirements of the applicant for each activity listed. Estimate the time it takes to perform each activity, and the number of times each week it should be performed. Multiply the number of minutes by the number of times each week the activity should be performed to get the total number of minutes per week for each activity.

		Number of Minutes	X	Times per week	=	Total minutes per week
Dress	Upper Body (for example, underwear, shirt/blouse, sweater, tie, jacket, gloves, jewelry)					
	Lower Body (for example, underwear, disposable briefs, skirt/pants, socks, panty hose, slippers shoes)					
				Subtotal		
Undress	Upper Body (for example, underwear, shirt/blouse, sweater, tie, jacket, gloves, jewelry)					
	Lower Body (for example, underwear, disposable briefs, skirt/pants, socks, panty hose, slippers shoes)					
				Subtotal		
Prosthetics	applies to upper/lower limb prosthesis and stump sock(s)					
	exchanges terminal devices and adjusts prosthesis as required					
	ensures prosthesis is properly maintained and in good working condition					
				Subtotal		
Orthotics	assists dressing applicant using prescribed orthotics (for example, burn garment(s), brace(s), support(s), splints, elastic stockings)					
				Subtotal		
Grooming	Face: wash, rinse, dry, morning and evening					
	Hands: wash, rinse, dry, morning and evening, before and after meals, and after elimination					
	Shaving: shaves applicant using electric/safety razor					
	Cosmetics: applies makeup as desired or required					
	Hair:					
	brushes/combs as required					
	shampoos, blow/towel dries					
	performs styling, set and comb-out					
	Fingernails: cleans and manicures as required					
	Toenails: cleans and trims as required					
				Subtotal		

PRINT RESET SAVE

Part 1 continued…

		Number of Minutes	X	Times per week	=	Total minutes per week
Feeding	prepares applicant for meals (includes transfer to appropriate location)					
	provides assistance, either in whole or in part, in preparing serving and feeding meals					
				Subtotal		
Mobility (location change)	assists applicant from sitting position (for example, wheelchair, chair, sofa)					
	supervises/assists in walking					
	performs transfer needs as required (for example, bed to wheelchair, wheelchair to bed)					
				Subtotal		
Extra Laundering	launders applicant's bedding and clothing as a result of incontinence/spillage					
	launders/cleans orthotic supplies that require special care					
				Subtotal		

Part 1 Total – Add all Part 1 Subtotals. Fill in total here and in Part 4

Part 2: Level 2 Attendant Care

Level 2 Attendant Care is for basic supervisory functions. Please assess the care requirements of the applicant for each activity listed. Estimate the time it takes to perform each activity, and the number of times each week it should be performed. Multiply the number of minutes by the number of times each week the activity should be performed to get the total number of minutes per week for each activity.

		Number of Minutes	X	Times per week	=	Total minutes per week
Hygiene	**Bathroom**					
	cleans tub/shower/sink/toilet after applicant's use					
	Bedroom					
	changes applicant's bedding, makes bed, cleans bedroom, including Hoyer lifts, overhead bars, bedside tables					
	ensures comfort, safety and security in this environment					
	Clothing Care					
	assists in preparing daily wearing apparel					
	hangs clothes and sorts clothing to be laundered/cleaned					
				Subtotal		
Basic Supervisory Care	applicant lacks the capacity to reattach tubing if it becomes detached from trachea					
	applicant requires assistance to transfer from wheelchair, periodic turning, genitourinary care					
	applicant lacks the ability to independently get in and out of a wheelchair or to be self-sufficient in an emergency					
	applicant lacks the ability to respond to an emergency or needs custodial care due to changes in behaviour					
				Subtotal		

PRINT RESET SAVE

Part 2 continued…

		Number of Minutes	X	Times per week	=	Total minutes per week
Co-ordination of Attendant Care	applicant requires assistance in co-ordinating/scheduling attendant care (maximum 1 hour per week)					
	Subtotal					

Part 2 Total – Add all Part 2 Subtotals. Fill in total here and in Part 4

Part 3: Level 3 Attendant Care

Level 3 attendant care is for complex health/care and hygiene functions. Please assess the care requirements of the applicant for each activity listed. Estimate the time it takes to perform each activity, and the number of times each week it should be performed. Multiply the number of minutes by the number of times each week the activity should be performed to get the total number of minutes per week for each activity.

		Number of Minutes	X	Times per week	=	Total minutes per week
Genitourinary Tracts	performs catheterizations					
	positions, empties and cleans drainage systems					
	cleans applicant and equipment after procedure/incontinence					
	uses disposable briefs as required					
	attends to menstrual cycle needs as required					
	monitors residuals					
	Subtotal					
Bowel Care	administers enemas or suppositories and performs stimulation or disimpaction					
	performs colostomy and/or ileostomy care					
	positions, empties and cleans drainage systems, including ilio-conduits					
	uses disposable briefs as required					
	cleans applicant and equipment after procedure/evacuation					
	Subtotal					
Tracheostomy Care	changes and cleans inner and outer cannulae as needed					
	changes tapes as required					
	performs suctioning as required					
	cleans and maintains suction equipment					
	Subtotal					
Ventilator Care	ensures volume rate and pressure are maintained as prescribed					
	maintains humidification as specified					
	changes and cleans tubing and filters as required					
	cleans humidification system as required					
	adjusts settings according to client needs (for example, colds, congestion)					
	reattaches tubing if it becomes detached					
	Subtotal					

PRINT RESET SAVE

Part 3 continued…

		Number of Minutes	X	Times per week	=	Total minutes per week
Exercise	assists applicant with prescribed exercise/stretching program					
	assists applicant with walking activities using crutches, canes, braces and/or walker					
				Subtotal		
Skin Care (excluding bathing)	attends to skin care needs – wounds, sores, eruptions, (amputees, severe burns, spinal cord injuries, etc.)					
	applies medication and prescribed dressings					
	applies creams, lotions, pastes, ointments, powders as prescribed or required					
	checks body area(s) for evidence of pressure sores, skin breakdown or eruptions					
	periodic turning to prevent or minimize pressure sores and skin breakdown/shearing					
				Subtotal		
Medication	**Oral**					
	administers prescribed medications					
	monitors medication intake and effect					
	maintains and controls medication supply					
	Injections					
	administers prescribed medications					
	monitors medication intake and effect					
	maintains and controls medication supply					
	Inhalation/Oxygen Therapy					
	administers prescribed dosage as required					
	maintains and controls inhalation supplies					
	cleans and maintains equipment					
				Subtotal		
Bathing	**Bathtub or Shower**					
	transfers applicant to and from bed, wheelchair or Hoyer lifts to bathtub or shower					
	bathes and dries client					
	applies creams, lotions, pastes, ointments, powders as prescribed or required					
	Bed Bath					
	prepares equipment					
	bathes and dries applicant					
	applies creams, lotions, pastes, ointments, powders as prescribed or required					
	cleans and maintains bed/bath equipment					
	Oral Hygiene					
	brushes and flosses					
	cleanses mouth as required					
	cleans dentures as required					
				Subtotal		

Part 3 continued…

		Number of Minutes	X	Times per week	=	Total minutes per week
Other Therapy	**Transcutaneous Electrical Nerve Stimulation (TENS)**					
	prepares equipment					
	administers treatment as prescribed or required					
	Dorsal Column Stimulation (DCS)					
	monitors skin					
	maintains equipment					
				Subtotal		
Maintenance of Supplies and Equipment	monitors, orders and maintains required supplies/equipment					
	ensures wheelchairs, prosthetic devices, Hoyer lifts, shower commodes and other specialized medical equipment and assistive devices are safe and secure					
				Subtotal		
Skilled Supervisory Care	applicant requires skilled supervisory care for violent behaviour that may result in physical harm to themselves or others					
				Subtotal		

Part 3 Total – Add all Part 3 Subtotals. Fill in total here and below

Part 4: Calculation of Attendant Care Costs

This part must be completed by the Assessor. Calculate the monthly attendant care allowance for Part 1, 2 and 3. The sum of all three parts will be the Total Assessed Monthly Attendant Care Benefit.

	Total Minutes per Week		Total Weekly Hours		Total Monthly Hours		Hourly Rate		Monthly Care Benefit
Part 1		÷ 60 =		X 4.3 =		X	A*	=	$
Part 2		÷ 60 =		X 4.3 =		X	B*	=	$
Part 3		÷ 60 =		X 4.3 =		X	C*	=	$

Total Assessed Monthly Attendant Care Benefit
(This amount is subject to the limits allowed under the Statutory Accident Benefits Schedule)

$

***For amounts to be used in the above table, please refer to the following chart:**

	Accidents occurring between March 31, 2008 and August 31, 2010	Accidents occurring on or after September 1, 2010
A	$11.23	Please refer to the hourly rates as set out in the Superintendent's Guideline issued under s. 19 (2) (a) of the SABS
B	$8.75	
C	$17.98	

Are there any attachments? ☐ **Yes** ☐ **No**

If Yes, how many? _____

Send any attachments directly to the insurer

PRINT **RESET** **SAVE**

Part 5: Signature(s) of Assessor(s)	I confirm that, to the best of my knowledge, the information in this form is accurate. I have obtained the appropriate consent from the applicant for the collection, use and disclosure of the information submitted.	
	Signature of Assessor	Date (YYYYMMDD)

For Insurer's use only	
I have reviewed this Assessment of Attendant Care Needs form and based upon information provided, I: ☐ Approve ☐ Partially Approve ☐ Do not approve	
Name of Adjuster (please print)	Date (YYYYMMDD)

PRINT RESET SAVE