



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. How and when to send in your package
3. How to contact the Disability Adjudication Unit
4. Which health care professionals can complete your forms
5. Asking for supporting medical information
6. 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. How and when to send in your package

- Return all completed forms by **24-06-2021**.
- 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 forms 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.

## 3. 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.

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#### 4. 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
- psychologist
- optometrist
- psychological associate
- physician
- registered nurse

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

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

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#### 5. 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

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#### 6. 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.



## 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

## 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 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 111222333	Referral ID 111111111111	Date of Birth (dd-mm-yyyy) 05-11-1975	
Last Name Lastname	First Name Firstname	Middle Initial E	
<b>Address</b>			
Unit Number	Street Number 204466	Street Name Dora St E	
City/Town Windsor	Province ON	Postal Code N8X 2K7	

### 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

Multiple horizontal lines for writing, overlaid with a large 'SAMPLE' watermark.

## 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.)?
	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Casual or seasonal			
	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Casual or seasonal			
	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> 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:

- the person applying for ODSP
- someone else

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

**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)

SAMPLE





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.

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## 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.

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## 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.

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## 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.

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## Who may complete the forms?

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

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

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

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

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## How to complete the 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

### 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
<b>Both</b> HSR and ADL	\$103.55	K050
<b>Only</b> HSR	\$ 82.85	K051
<b>Only</b> 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 the "[About social assistance in Ontario](#)" on the Ministry of Children, Community and Social Services website.
- on how to complete the forms: follow the [Ontario Disability Support Program Health Care Professional's Guide](#).



## 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.

### Notice with Respect to the Collection of Personal Information

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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 111222333	Referral ID 11111111111	Date of Birth (dd-mm-yyyy) 05-11-1975	
Last Name Lastname	First Name Firstname	Middle Initial E	
<b>Current Address</b>			
Unit Number	Street Number 204466	Street Name Dora St E	
City/Town Windsor	Province ON	Postal Code N8X 2K7	

**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.

<b>Medical Condition</b> Chronic Back Pain	<b>Example 1</b>	Prognosis - condition is likely to:	
		<input type="checkbox"/> improve	<input type="checkbox"/> remain same
		<input checked="" type="checkbox"/> deteriorate	<input type="checkbox"/> unknown
<b>Impairment(s)</b> Pain in low back, hips and thighs		Prognosis - condition is likely to: (mandatory - complete both columns)	
		Expected to last:	And is:
		<input type="checkbox"/> less than 1 year	<input type="checkbox"/> recurrent/episodic
		<input checked="" type="checkbox"/> 1 year or more	<input checked="" type="checkbox"/> continuous
<b>Restriction(s)</b> Difficulty with sitting and standing for lengthy periods (longer than 30 minutes). Difficulty with mobility in the home and in the community.			

<b>Medical Condition</b> Major Depression	<b>Example 2</b>	Prognosis - condition is likely to:	
		<input type="checkbox"/> improve	<input type="checkbox"/> remain same
		<input type="checkbox"/> deteriorate	<input checked="" type="checkbox"/> unknown
<b>Impairment(s)</b> Depressed mood; anhedonia; poor concentration		Prognosis - condition is likely to: (mandatory - complete both columns)	
		Expected to last:	And is:
		<input type="checkbox"/> less than 1 year	<input checked="" type="checkbox"/> recurrent/episodic
		<input checked="" type="checkbox"/> 1 year or more	<input type="checkbox"/> continuous
<b>Restriction(s)</b> Difficulty attending to and completing daily tasks such as self-care, paying bills and keeping appointments. Problems with social interactions.			

<b>Medical Condition</b> Learning Disability	<b>Example 3</b>	Prognosis - condition is likely to:	
		<input type="checkbox"/> improve	<input checked="" type="checkbox"/> remain same
		<input type="checkbox"/> deteriorate	<input type="checkbox"/> unknown
<b>Impairment(s)</b> Difficulty learning and retaining information Poor comprehension skills; poor planning and time management		Prognosis - condition is likely to: (mandatory - complete both columns)	
		Expected to last:	And is:
		<input type="checkbox"/> less than 1 year	<input type="checkbox"/> recurrent/episodic
		<input checked="" type="checkbox"/> 1 year or more	<input checked="" type="checkbox"/> continuous
<b>Restriction(s)</b> Low academic achievement; problems learning job tasks and following instructions.			

1. 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:  |
| <input type="checkbox"/> less than 1 year | <input checked="" type="checkbox"/> recurrent/episodic |
| <input type="checkbox"/> 1 year or more   | <input type="checkbox"/> continuous                    |

Restriction(s)

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:                                     |
| <input type="checkbox"/> less than 1 year | <input type="checkbox"/> recurrent/episodic |
| <input type="checkbox"/> 1 year or more   | <input type="checkbox"/> 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:                                     |
| <input type="checkbox"/> less than 1 year | <input type="checkbox"/> recurrent/episodic |
| <input type="checkbox"/> 1 year or more   | <input type="checkbox"/> 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:                                     |
| <input type="checkbox"/> less than 1 year | <input type="checkbox"/> recurrent/episodic |
| <input type="checkbox"/> 1 year or more   | <input type="checkbox"/> continuous         |

Restriction(s)

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

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

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?

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

3.3 Please describe available information, if applicable.

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

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.

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



**4. Visual**

**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**

**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.				<input type="checkbox"/>
2.				<input type="checkbox"/>
3.				<input type="checkbox"/>
4.				<input type="checkbox"/>

Pharmacotherapy	Dosage	Frequency	Start Date (dd-mm-yyyy)	List Conditions or Impairments Being Treated
1.				
2.				
3.				

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				<input type="checkbox"/>
2. Chemotherapy				<input type="checkbox"/>
3. Cognitive Behavioural Therapy (CBT)				<input type="checkbox"/>
4. Counselling				<input type="checkbox"/>
5. Occupational therapy				<input type="checkbox"/>
6. Physiotherapy				<input type="checkbox"/>
7. Psychotherapy				<input type="checkbox"/>
8. Radiation				<input type="checkbox"/>
9. Vocational rehabilitation				<input type="checkbox"/>
10. Other rehabilitation (specify) ▼				<input type="checkbox"/>
11. Other (e.g., Indigenous Healer) ▼				<input type="checkbox"/>

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)

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

**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  
 am a legally qualified \_\_\_\_\_ in the Province of Ontario;  
 Profession  
 and registered with \_\_\_\_\_  
 Professional Regulatory College  
 My registration number is \_\_\_\_\_  
 Registration Number

Address		<b>or</b> Stamp Address	
Unit/Suite Number	Street Number and Name		
City/Town			
Province		Postal Code	
ON			
Telephone Number	Fax Number	Office Email (optional)	
ext.			

**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)

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.



### 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
- occupational therapist
- physiotherapist
- registered nurse
- chiropractor
- optometrist
- psychological associate
- social worker
- nurse practitioner
- physician
- psychologist
- 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 writing

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

**By Fax:** 416-326-3374

**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 111222333	Referral ID 111111111111	Date of Birth (dd-mm-yyyy) 05-11-1975	
Last Name Lastname	First Name Firstname	Middle Initial E	

#### Current Address

Unit Number	Street Number 204466	Street Name Dora St E
City/Town Windsor	Province ON	Postal Code N8X 2K7

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

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

am a legally qualified \_\_\_\_\_ in the Province of Ontario;  
Profession

and registered with \_\_\_\_\_  
Professional Regulatory College

My registration number is \_\_\_\_\_  
Registration Number

Office Address		or	Stamp Address
Unit/Suite Number	Street Number and Name		
City/Town			
Province		Postal Code	
ON			

Telephone Number	Fax Number	Office Email (optional)
ext.		

**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)

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.



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 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.**

### Please Complete This Section

My name is \_\_\_\_\_ 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

#### Address of My Health Care Professional

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)
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