

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).

<b>Applicant Information</b>	Date of Birth (YYYYMMDD)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	*Telephone Number	Extension
	Last name	First name	***Middle name	
	Address			
	City	Province	Postal Code	

<b>Insurance Company Information</b>  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 <input type="checkbox"/> , OR	**Policy Holder Last Name	**Policy Holder First Name

<b>Attendant Care Assessment Information</b>	Date of this assessment (YYYYMMDD):	*Is this the first assessment of this applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date of Last Assessment (YYYYMMDD):	*Current Monthly Allowance:

<b>Assessor Information</b>	Name of Assessor	*Email Address
	Profession	College Registration Number

<b>Facility Information</b>	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
<b>Dress</b>	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)					
	<b>Subtotal</b>					
<b>Undress</b>	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)					
	<b>Subtotal</b>					
<b>Prosthetics</b>	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					
	<b>Subtotal</b>					
<b>Orthotics</b>	assists dressing applicant using prescribed orthotics (for example, burn garment(s), brace(s), support(s), splints, elastic stockings)					
<b>Subtotal</b>						
<b>Grooming</b>	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					
<b>Subtotal</b>						

Part 1 continued...

Number of Minutes X Times per week = Total minutes per week

<b>Feeding</b>	prepares applicant for meals (includes transfer to appropriate location)			
	provides assistance, either in whole or in part, in preparing serving and feeding meals			
	<b>Subtotal</b>			
<b>Mobility</b> (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)			
	<b>Subtotal</b>			
<b>Extra Laundering</b>	launders applicant's bedding and clothing as a result of incontinence/spillage			
	launders/cleans orthotic supplies that require special care			
	<b>Subtotal</b>			

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

<b>Hygiene</b>	<b>Bathroom</b>			
	cleans tub/shower/sink/toilet after applicant's use			
	<b>Bedroom</b>			
	changes applicant's bedding, makes bed, cleans bedroom, including Hoyer lifts, overhead bars, bedside tables			
	ensures comfort, safety and security in this environment			
	<b>Clothing Care</b>			
	assists in preparing daily wearing apparel			
	hangs clothes and sorts clothing to be laundered/cleaned			
	<b>Subtotal</b>			
<b>Basic Supervisory Care</b>	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			
	<b>Subtotal</b>			

Part 2 continued...

Number of Minutes X Times per week = Total minutes per week

<b>Co-ordination of Attendant Care</b>	applicant requires assistance in co-ordinating/scheduling attendant care (maximum 1 hour per week)			
	<b>Subtotal</b>			

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

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**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

<b>Genitourinary Tracts</b>	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			
	<b>Subtotal</b>			

<b>Bowel Care</b>	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			
<b>Subtotal</b>				

<b>Tracheostomy Care</b>	changes and cleans inner and outer cannulae as needed			
	changes tapes as required			
	performs suctioning as required			
	cleans and maintains suction equipment			
<b>Subtotal</b>				

<b>Ventilator Care</b>	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			
<b>Subtotal</b>				

Part 3 continued...

Number of Minutes X Times per week = Total minutes per week

<b>Exercise</b>	assists applicant with prescribed exercise/stretching program			
	assists applicant with walking activities using crutches, canes, braces and/or walker			
<b>Subtotal</b>				

<b>Skin Care</b> (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			
<b>Subtotal</b>				

<b>Medication</b>	<b>Oral</b>				
	administers prescribed medications				
	monitors medication intake and effect				
	maintains and controls medication supply				
	<b>Injections</b>				
	administers prescribed medications				
	monitors medication intake and effect				
	maintains and controls medication supply				
	<b>Inhalation/Oxygen Therapy</b>				
	administers prescribed dosage as required				
	maintains and controls inhalation supplies				
	cleans and maintains equipment				
	<b>Subtotal</b>				

<b>Bathing</b>	<b>Bathtub or Shower</b>				
	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				
	<b>Bed Bath</b>				
	prepares equipment				
	bathes and dries applicant				
	applies creams, lotions, pastes, ointments, powders as prescribed or required				
	cleans and maintains bed/bath equipment				
	<b>Oral Hygiene</b>				
	brushes and flosses				
	cleanses mouth as required				
	cleans dentures as required				
	<b>Subtotal</b>				

Part 3 continued...

Number of Minutes X Times per week = Total minutes per week

<b>Other Therapy</b>	<b>Transcutaneous Electrical Nerve Stimulation (TENS)</b>			
	prepares equipment			
	administers treatment as prescribed or required			
	<b>Dorsal Column Stimulation (DCS)</b>			
	monitors skin			
	maintains equipment			
<b>Subtotal</b>				
<b>Maintenance of Supplies and Equipment</b>	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			
<b>Subtotal</b>				
<b>Skilled Supervisory Care</b>	applicant requires skilled supervisory care for violent behaviour that may result in physical harm to themselves or others			
<b>Subtotal</b>				

**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	÷ 60 =	Total Weekly Hours	X 4.3 =	Total Monthly Hours	X	Hourly Rate	=	Monthly Care Benefit
Part 1						X	A*	=	\$
Part 2						X	B*	=	\$
Part 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

**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)