FINANCIAL SERVICES COMMISSION OF ONTARIO

ATTENDANT CARE

DESIGNATED ASSESSMENT CENTRE

ASSESSMENT GUIDE

A Guide to Conducting Attendant Care Assessments

Les directives sont également disponibles en français

December 2000

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Part 1 Introduction

This Guide for conducting attendant care assessments is intended for use by Attendant Care Designated Assessment Centres (DACs) designated under the Statutory Accident Benefits Schedule--Accidents On Or After November 1, 1996 (SABS)[1], a regulation under the Insurance Act. In the event of a discrepancy between the Guide and the SABS, the SABS shall prevail.

It is the responsibility of the DAC to screen each referral to ensure the DAC has the appropriate authorization and capability to conduct the assessment. It is also the responsibility of each clinician involved in DAC assessments to use his/her own clinical judgment in planning the assessment and interpreting the assessment outcomes. This Guide has been developed with consultation and consensus reached by practice experts. Where the DAC deviates from the Guide, this should be noted in the report and an explanation given.

The Guide structures the approach to performing attendant care assessments. It is designed to achieve the following objectives:

- To be consistent with the SABS.
- To assist DACs in producing reports that are useful to the parties and help them to resolve their dispute.
- To ensure DACs follow a common assessment approach and meet standards.
- To develop a structured reporting format that is comprehensive and includes well supported conclusions.

1.1 Purpose of Attendant Care DAC Assessment

The purpose of the attendant care DAC assessment is to offer an opinion about the level and amount of attendant care required by the claimant as a direct result of an accident. The SABS specifies [Section 43(7)] that the Attendant Care DAC will complete a report that shall include:

> (a) a determination in accordance with Form 1[2] of the amount to be paid by the insurer for the **future** (emphasis added) provision of attendant care services; and

[1]This guide is written to direct assessments under Bill 59 only. Assessments required under Bill 164 should use the guidelines pertinent to Bill 164.

[2] A copy of Form 1 is included in Appendix C.

(b) recommendations on the future provision of attendant care services to the insured person.

The claimant may apply for an attendant care benefit to pay for reasonable and necessary expenses for services provided by an aide or attendant[3] or services provided by a long-term care facility. When the claimant and his/her insurer cannot agree on the need for and/or the amount of an attendant care benefit, the claimant is entitled to an assessment at a DAC.

The DAC must conduct an assessment to determine:

(i) Level of attendant care required.
(ii) Calculation of attendant care benefit payments.

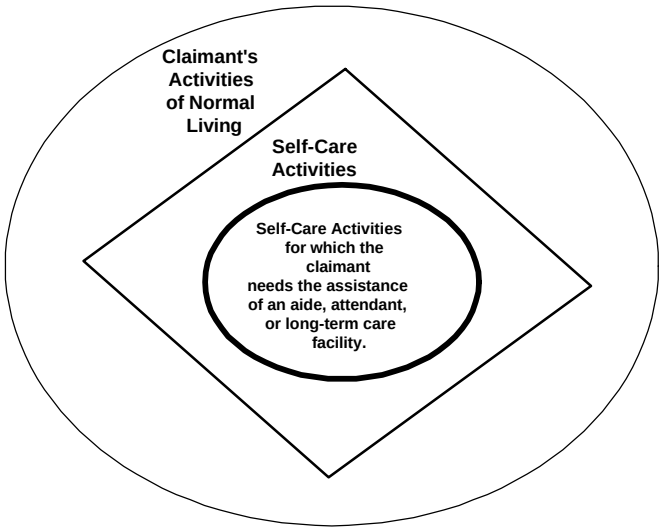

Figure 1

Attendant Care - Conceptual Model of Assessment Focus

This conceptual model demonstrates that a "sub-set" of the claimant's activities of normal living are self-care activities, and, a "sub-set" of self-care activities are activities for which the claimant needs assistance. The focus of the assessment is on this latter group of activities.

[3] Part 1 of the SABS, Definitions and Interpretation, section 2 (7) states: "*For the purpose of this Regulation, an aide or attendant for the person includes a family member or friend who acts as the person's aide or attendant, even if the family member or friend does not possess any special qualifications.*"

1.2 Attendant Care DAC Authorization

General Attendant Care DACs are authorized to see the majority of claimants with the exception of three groups of claimants:

- Claimants with identified brain impairments.
- Claimants with identified spinal cord impairments.
- Claimants who are less than 16 years of age at the time of the assessment (paediatric claimants).

Claimants from any of these three groups must be seen by an Attendant Care DAC with specified *extended authorization* to assess these groups.

Part 2 Human Resources

Attendant Care DACs are required to have a Core Team that will conduct the majority of assessments and an On-Call Team to access when specialized input is required. Members of both assessments team must have the following common qualifications:

- A member in good standing and holds a current certificate of registration with the appropriate Ontario regulatory college.
- Ensure, that for each claimant assessed, he/she has the necessary skills, knowledge, and ability to offer an opinion, considering the attendant care benefit under question, the claimant's individual circumstances, age, impairment and disability.
- Fully conversant with the relevant section of the SABS, and remains current with DAC guidelines and relevant arbitration decisions.
- Experienced in generating well-supported and comprehensive reports.
- Demonstrated ability to articulate assessment outcomes and rationale in a manner accessible to the average lay reader.

2.1 Core Assessment Team

General Attendant Care DACs must have a Core Team that consists of an occupational therapist (OT) or physiotherapist (PT) and a registered nurse (RN) (not every case will require two assessors). DACs with an extended authorization will need to meet the same expectations as the general Attendant Care DAC, plus have other specified assessor expertise as follows:

Attendant Care DAC--Core Team	• RN with a minimum of three years' experience assessing complex healthcare and hygiene function attendant care needs of individuals with trauma-induced impairment; and • OT or PT with a minimum of three years' experience assessing self-care functional ability; with experience in the application of readily available assistive devices and adaptations used to increase functional independence in self-care activities for individuals with trauma-induced impairment.

Attendant Care DAC--*Extended Authorization*-- Brain Injury	• OT or PT or RN with a minimum of three years' experience in determining the supervisory or custodial care needs of individuals with brain injury.
Attendant Care DAC--*Extended Authorization*-- Spinal Cord Injury	• OT or PT or RN with a minimum of three years' experience in determining the specific attendant care needs of individuals with a spinal cord injury.
Attendant Care DAC--*Extended Authorization*-- Paediatrics	• OT or PT or RN with a minimum of three years' experience in determining the specific attendant care needs of paediatric individuals.

It is sufficient for the extended authorization assessor to form part of the general Core Team, provided the qualifications are met.

From experience, it is the norm that only one assessor will be required in the majority of cases. If more than one assessor is required, the reasons for this requirement are to be explained in the DAC Report.

2.2 On-Call Assessment Team

From time to time the Core Team may require specialized input to assist in decision-making about the claimant's level of disability, or to ensure a link between the claimant's attendant care needs and impairments from the automobile accident. Although this will occur in a minority of cases, the DAC must ensure reasonable access to these specialists so that neither assessments nor reports are unreasonably delayed. Depending on the DAC's authorization, the On-Call Team may include (but not be limited to) the following health professionals:

- psychologist with skills in assessing claimants with cognitive impairments
- physician specialists (including but not limited to: physical medicine, neurology, psychiatry, rheumatology, gerontology, paediatrics)
- musculoskeletal practitioner (orthopaedic surgeon, physician, chiropractor, physiotherapist).

In determining the link between the impairment and the motor vehicle accident, a document review by an on-call assessor may be sufficient to achieve cost effectiveness. If the claimant is interviewed or examined by an on-call assessor, the reasons for this appointment should be explained in the narrative report.

2.3 Case Co-ordination

It is important that each "case" be co-ordinated to provide a smooth process. As well, someone within the DAC must assume ultimate responsibility for ensuring that the SABS and the DAC Guide have been followed.

The nature of these responsibilities can be viewed as either "administrative" or "clinical". This section details these responsibilities. The DAC can decide who will be responsible for the "administrative" role and the "clinical role" (an appropriate clinician may assume both roles; however, certain functions **must** be fulfilled by a clinician). Accordingly, the roles are broken into these two realms and described as ***Case Co-ordinator*** (administrative) and ***Primary Evaluator*** (clinical). The report should clearly identify which individual(s) fulfilled these separate but complementary roles in each case.

2.3.1 Case Co-ordinator

The case co-ordinator ensures efficient handling of the assessment. Specific functions include:

- Ensure the referral is complete, and identify any missing information.
- Screen the file for conflict of interest, and respond to any conflicts as outlined in the DAC General Guidelines and in Section 53 of the SABS.
- Screen for any claimant special needs and respond as appropriate.
- Review and organize all documentation on the file, and compile a document list (this list is used for reference by other team members and is included in the "Appointment Confirmation Letter" and the final report).
- Ensure that time-lines are adhered to, and that all assessors have completed their draft report within a week of assessing the claimant.
- Ensure the OCF-11A/59 form is completed.
- Ensure the relevant portion of Form 1 is completed (first page).
- Check for OCF-15/59. (In order to assess the need to continue paying attendant care benefits, insurance companies are entitled to ask claimants to provide a Certificate for Attendant Care (OCF-15/59) from their treating practitioner. The certificate will confirm what attendant services a claimant needs as a result of the automobile accident for which the benefits are being paid).

- Serve as contact person regarding any ongoing activity relative to that assessment.

- Respond to any complaints.

2.3.2 Primary Evaluator

The primary evaluator is the clinical co-ordinator for that case and is in charge of the assessment process. His/her role is to ensure smooth, efficient, and appropriate handling of the assessment from intake to the end of the reporting phase. The primary evaluator must be a health professional. Specific functions include:

- Review file, note, and respond as appropriate to any particular concerns that might put the claimant at risk in proceeding with the assessment.

- Ensure the referral is complete and determine if any additional information is required (see ***DAC General Guideline #4 - Ensuring Neutrality in the DAC System***).

- Prepare the assessment plan (if necessary, explain reasons why more than one assessor is required).

- Review (all) draft report(s), and determine there are no inconsistencies and that consensus has been reached--where necessary, co-ordinate a conference between all pertinent assessors.

- Create the narrative report.

- Complete the OCF-11B/59.

- Complete Form 1.

Part 3 Intake Process

The overall goal of the intake process is to decide on the appropriateness of proceeding to an assessment and, where required, select the relevant assessment team. The intake process is structured to ensure that comprehensive information is obtained and delays are minimized.

3.1 Objectives

The standard intake process employed by Attendant Care DACs is designed to ensure that:

- The claimant has been referred to the appropriate DAC type (i.e., Attendant Care DAC), and the DAC is authorized to assess the claimant (i.e., brain injury, spinal cord injury, or paediatric claimants may only be assessed by a DAC with an extended authorization to assess that impairment).
- The claimant understands the reason for the DAC assessment and the assessment process.
- All necessary forms are collected.
- All required information is collected for the assessor/assessment team.
- No conflict of interest is present, or if any is noted, it is appropriately responded to.
- Information is organized to maximize access for the assessor/assessment team.
- The appropriate assessor/assessment team is selected.
- The claimant and insurer have agreed to co-operate with the assessment.
- The claimant's special needs are noted, and a plan is in place to accommodate these needs.
- Both the claimant and the insurer have had an opportunity to contribute to the assessment information.
- If video surveillance material has been received from the insurance company, the claimant is advised of the existence of the surveillance video.[4]

[4] See use of surveillance material in ***DAC General Guideline #1 - Use of Surveillance in DAC Assessments***. The special nature of the attendant care DAC assessment (i.e., in the claimant's home) means that Attendant Care DACs should review surveillance videos (which have been judged to have a bearing on the assessment outcome) at an appropriate locale with the claimant; this should take place after the in-home assessment.

- An assessment plan is sent to the insurer and claimant.
- Necessary appointment times are scheduled to begin the assessment after insurer and claimant agree to proceed.

3.2 Intake Steps

The intake process is described as a logical series of steps with appropriate "decision points".

The first column of the chart names the intake step, the second column elaborates on the procedures involved in that step, and the third column indicates *"who"* must complete the step *when there is a requirement that a clinician or particular member of the DAC team complete that step*.

Intake Step	Procedure and Explanation	Who
1. Date referral received	Record this date on the DAC Activity Tracking Form (this form must be completed even if the referral is declined). This establishes the point in time when the DAC begins to handle the file. The time lapse between this date and the date when the referral is complete allows for a tracking of the average time spent in completing referral information.	At the DAC's discretion
2. Claimant is referred to the appropriate DAC	Occasionally referrals are received that are intended for another DAC type, i.e., not requesting an attendant care assessment, or the DAC does not have the extended authorization (brain injury, spinal cord injury or paediatrics) to assess the claimant. Such referrals should be returned to the insurer with an explanation.	At the DAC's discretion
3. Nearest DAC	The SABS requires that claimants be assessed at the DAC that is nearest to their home and is *authorized to assess their impairment.* If the insurer has not selected the nearest DAC, the insurer must note this on the referral form (OCF-11A/59) and provide an explanation. If the insurer has indicated that your DAC is not the nearest, and no explanation is provided, the form must be returned to the insurer for completion. The DAC report must also note the reason provided by the insurer regarding why the nearest DAC was not selected.[5] See General Guideline # 5 for further information.	At the DAC's discretion

[5] Selecting the DAC nearest the claimant's home is a mechanism to ensure impartiality in the selection of the DAC. If the DAC nearest the claimant's home is unable to provide the service, the referral must be made to the next nearest DAC to the claimant's home.

4.	Verify forms are completed	Forms that must be completed, and appropriately signed, include: • Form 1 with the relevant portion of page 1 completed. • OCF 14/59 Permission to Disclose Health Information to the Designated Assessment Centre (a signed, faxed copy is acceptable--see General Guideline #3). • OCF-11A/59 Designated Assessment Referral and Summary Report. • OCF-15/59 (if it was requested by the insurer).	At the DAC's discretion
5.	Initiate conflict of interest screen	Each DAC should maintain its own roster of assessors who provide service to the DAC. This should include, for each assessor, his/her affiliations (where he/she works, what relevant ownerships/partnerships he/she and related persons have). As referral material is assembled and reviewed, the screening for conflict continues. The General Guidelines should be consulted for detailed instructions regarding conflict screening and the DAC's responsibilities when a conflict is discovered.	At the DAC's discretion
6.	Organize referral material	Create a claimant file with information organized in tabbed sections to facilitate the assessment team's access. Compile a document list (this list is used for reference by other team members, and is included in the "Appointment Confirmation Letter" and the final report).	At the DAC's discretion
7.	Claimant special needs	Where claimant special needs (physical accessibility, language, sensory impairments) are noted, this should be flagged for the team, and a plan for accommodating these needs made.	At the DAC's discretion

Decision Point

The assessment may be terminated at this point when:

- The insurer or claimant fails to provide the necessary forms/records to allow an informed assessment to proceed.
- The claimant has been referred to the wrong DAC; i.e., not an Attendant Care DAC referral, or the DAC is not authorized to assess the claimant's impairment type.
- A conflict of interest cannot be resolved.
- The insurer or claimant indicates that he/she is unable or unwilling to proceed with the assessment.

If the referral is not to proceed for these or any other reasons, this must be documented and sent to the insurer and claimant.

8.	Clinical record is reviewed	• Review all documentation on the file. • During the documentation review, complete a secondary screen for conflict of interest and claimant special needs. • Note and respond to any particular concerns that might put the claimant at risk in proceeding with the assessment. • Ensure the referral is complete, and determine if any additional information is required. • Formulate a summary of the documentation.	Primary evaluator
9.	Pursuing missing material	Material missing from the record is identified and pursued as appropriate (see ***DAC General Guideline #4***).	Primary evaluator
		Decision Point The assessment may be terminated at this point when: • The insurer or claimant fails to provide the necessary forms/records to allow an informed assessment to proceed. • The claimant's impairment/disability does not fall within the authorization of the DAC. • A conflict of interest cannot be resolved. • The record raises concerns about the safety of proceeding to an assessment. **If the referral is not to proceed for these or any other reasons, this must be documented and sent to the insurer and claimant.**	
10.	Assessment plan generated and sent to insurer and claimant	The plan includes: • A description of the proposed assessment (includes purpose of the assessment). • A projection of the length of time required to complete the assessment. • An estimate of cost, including reasons for more than one assessor.	Primary evaluator & case co-ordinator

Decision Point

The assessment may be terminated at this point when:

- The insurer declines to proceed with the assessment.
- The claimant declines to proceed with the assessment.

*It is essential for DACs to note that insurers and claimants must either accept or reject the entire proposed assessment plan. They **may not** "negotiate" to have the plan altered in any way, nor may they alter the assessment team proposed.*

If the referral is not to proceed for these or any other reasons, this must be documented and sent to the insurer and claimant.

11. Telephone claimant	The claimant is contacted by telephone to confirm his/her appointment date, review the assessment process and purpose. ***(Note: The assessment must commence within 14 days after the referral information is complete.)***[6]	At the DAC's discretion
12. Correspondence	The Standard Appointment Confirmation Letter (copied to the insurer)[7] is sent. This letter includes the approved assessment plan. Copying this to the insurance company ensures that the claimant and insurer receive the same information. A list of documents sent by the insurance company is included, and the claimant is invited to provide any additional documents he/she believes are necessary for the DAC to review. A "DAC Assessor Practice Summary" for each assessor on the team should be included.	At the DAC's discretion

[6] SABS Part XI, Section 53(7).

[7] Appendix "B"

Part 4 Attendant Care DAC Assessment Process

4.1 Location of Assessment

The assessment takes place in the location where the claimant requires the attendant care. In most cases this will be the claimant's place of residence; however, in some cases the assessment may need to be conducted in other venues **where the claimant requires attendant care**. The decision regarding the need to access other venues is left to the DAC and the reasons for this decision are to be reflected in the DAC Report.

From time to time it may be necessary to require the claimant to attend the DAC facility for further assessment by a specialist. An example of this would be when the Core Team assessment has raised concern about a brain-injured claimant's ability to exercise appropriate judgment without supervision and an appropriate specialist such as a psychologist, neurologist or psychiatrist is asked to provide further input to the assessment decision.

4.2 Scope of Assessment

The determination of the scope of the assessment--*i.e., range of self-care activities assessed*--should be guided by the following principles:

- It is determined after reviewing the claimant's file and with input from the claimant.

- Attendant care needs may not be completed "retrospectively" as the SABS specifies that the report will address "future provision of attendant care services" [section 43(7)].

- It should only focus on functions for which the claimant reports needing attendant care. A screen with the claimant should ensure that the claimant has not overlooked any crucial area. (In the case of claimants who lack the insight to appropriately identify the areas with which they require assistance--e.g., a claimant with brain injury--the DAC assessor may solicit this information from another appropriate person, perhaps the aide or attendant.)

- It may include the need for attendant care during transportation, *with the exception of* transportation of the insured person to and from treatment/ counselling/ training/ assessment/ examination sessions (which is covered elsewhere in the SABS).

The SABS does not provide a definition of self-care activities. Since the claimant's individual characteristics and circumstances are pivotal to the question of "self-care", the DAC assessor must, guided by the details in Form 1, use his/her own judgment to determine which activities should be considered for the individual claimant.

The DAC's conclusions should be well-explained in a narrative report that accompanies the Form 1.

4.3 Direct Assessment versus Self-Report

In some instances, the DAC will rely on the claimant or attendant's self-report regarding the level and amount of time needed for an activity, and in other instances, the DAC will complete an observation of the activity. The decision regarding the need for direct observational assessment versus self-report is left to the discretion of the DAC. The narrative report should explain the assessment method used.

4.4 Assistive Devices and Adaptations

It is not in the scope of the Attendant Care DAC to recommend the need for additional assistive device(s)/adaptation(s) in their DAC report. [8]

When determining the level of the attendant care required, the Attendant Care DAC should only consider the assistive device(s) and adaptation(s) currently available to the claimant and base the calculation on those existing assistive device(s) or adaptation(s).

The Attendant Care DAC may discuss in the narrative portion of the individual assessor's report that the provision of additional suitable assistive device(s)/adaptation(s) may alter the current attendant care needs for those specific activities.

4.5 Recommendations on the Future Provision of Attendant Care Services

An Attendant Care DAC is required according to the SABS, Part X Section 43(7)(b) to include in their report **. . recommendations on the future provision of attendant care services to the insured person."**

The DAC should consider the impact of upcoming surgery and/or the incorporation of additional assistive device(s)/adaptation(s) that have already been approved by the insurer which could change the level of future attendant care needs.

[8] In some cases, the health professional involved in the assessment may discover issues or make findings that have an impact on the claimant's health and/or safety but are beyond the scope of the assessment. In situations like this, these issues/findings and any associated recommendations must not be raised in the report. These issues/finding should be raised with or reported to the claimant and/or the treating practitioner under a separate cover.

4.6 Standard Report Format

Attendant Care DACs must use the common report format detailed in this section. The report is structured as follows:

- **Cover Sheet** (see Appendix B)

  Following the completed OCF-11A and B, the report begins with the standard cover sheet (refer to Appendix A).

- **Completed OCF 11B/59**

- **Completed Form 1**

- **Narrative Report**

The narrative report must be addressed to both parties to reflect the DAC's neutrality and unbiased assessment.

If there was more than one assessor on the assessment team, the narrative report should be written as the combined discussion and opinion of the assessment team. In addition, any recommendations on the future provision of attendant care services are stated. The DAC's opinion must be substantiated with clear reasons for the findings.

It is not necessary for the narrative report to begin with statements about the writer's qualifications, as this (these) is (are) contained in the practice summary(ies) that both parties have.

The narrative report must follow a consistent format as follows:

1. Header or Footer — A header or footer must be included on **every page,** identifying the DAC name and 4-digit identification number. The header or footer must include the name of the claimant and the date of the claimant's motor vehicle accident.

2. Introduction — States the purpose of the assessment and a description of the assessment.

   Identification of assessor(s) and the date(s) and place each examined the claimant.

List of documents reviewed (include any surveillance material reviewed).

If the nearest DAC was not selected, the reason for this should be noted**.**

3. Claimant's History and Presenting Complaints

4. Accident-Related Impairments

5. Assessment Findings and Analysis of Needs

Use Level 1, Level 2 and Level 3 as subheadings, and explain observations and reasons for findings.

6. Collateral Issues — Summarize any recommendations for future provision of care, including any assistive devices and/or adaptations.

7. Closing — Include a statement that if either party has questions concerning the report, he/she is directed to contact the DAC in writing and provide a copy of his/her correspondence to the other party.

Appendix A

Standard Report Cover Sheet

Designated Assessment Centre--Attendant Care Assessment Report

DAC Name _____
Address _____
_____
_____

4-digit ID Code _ _ _ _

Report Date _____

Parties:

Claimant: **Mr./Ms. XXX**
Address

Insurer: **The ABC Insurance Co.**
Insurer contact person
Address

Claimant's Practitioner: **Dr. XX**
Address

Claimant's Representative: **(as directed by the claimant)**

DAC File #[9] _____ **Insurer Claim #** _____

Date of Loss _____

DAC Assessors:

Assessor Name	Discipline/Speciality	Date of Assessment

[9] Note: DACs must use a unique identifier for each case.

Appendix B

Standard Appointment Confirmation Letter

Re: Attendant Care DAC Assessment

Dear

As we have already discussed by telephone, your assessment by (*DAC name*) will take place at your home on (*assessment date*). This letter is intended to provide you with more information about the assessment and an explanation of the other materials you will find enclosed.

What is a Designated Assessment Centre?

"Designated Assessment Centres" (DACs) are independent clinics with many kinds of medical and rehabilitation professionals on staff. Please note these clinics are not run by insurance companies nor by the government. Like other nurses, physiotherapists, occuptional therapists, and other health-care professionals, most DAC staff are regulated by professional colleges. Each DAC must be approved by the Minister's Committee on the DAC System.

DACs conduct assessments for automobile accident claimants when claimants and their insurance company cannot agree and need an unbiased opinion. This means the assessment must be fair to both you and your insurance company and give an opinion that is based on an appropriate and thorough assessment.

Once we have completed our assessment, a copy of our report will be sent to you, your insurance company, and (*practitioner's name*). If you disagree with the assessment, you may dispute the findings by applying for mediation with the Financial Services Commission of Ontario (FSCO). You can get an application form from your insurance company. For further information or assistance, call FSCO at: 1-800-668-0128.

What will the assessment involve?

We have already given you some idea of what to expect during our telephone conversation and in our written assessment plan. The assessment follows the legislation in the Insurance Act of Ontario, which defines attendant care necessary as a result of an accident. The purpose of the assessment is to consider this definition and offer our opinion about the extent of reasonable and necessary attendant care services required as a result of an accident.

We have already reviewed documents sent to us by your insurance company. You will find a list of these documents enclosed with this letter. If you have other information you believe is relevant to our assessment, you should phone us to let us know (our number is at the top of this letter) and arrange for this information to be sent to us as soon as possible.

The other document you will find enclosed is our “Assessment Plan”. This is a written outline of how we intend to proceed with your assessment and an estimate of how much it will cost. Your insurance company is required by law to pay for the assessment, and you are expected to co-operate with the assessment process.

You will also find enclosed the Practice Summary(ies) for the assessor(s) involved in your assessment. Practice Summaries provide you with an overview of the qualifications and experience of the health-care professional(s) who will be part of the assessment team. If you note that you have been previously assessed by or treated by this individual (one of these individuals), you should call us with this information. Your assessment will involve a home site visit, and possibly other locations where you require attendant care.

The assessor(s) will interview you and explain the part of the assessment being completing, and give you an opportunity for input or to ask any questions. You may also wish to have your attendant or a family member present, one who is familiar with your impairments and the care you require.

Please note your appointment(s) on your calendar and let us know at once if you will have a problem keeping the appointment(s).

What is expected of me?

The Statutory Accident Benefits Schedule says that you must co-operate with this assessment and make any necessary information available to the assessment team if you want to receive further benefits. This means that you should make the assessment a priority, do not miss your appointment(s), and assist the assessment team by co-operating with the assessment. Co-operating with the assessment will mean giving the assessors information they need to understand your situation and abilities, and performing the assessment activities to the best of your ability. Since the assessment is based on your ability to perform activity, you will find that the assessment will require you to carry out activities which are like your usual activities. If you do not cooperate with the DAC or do not show up for your appointments, your benefits may be terminated.

Who can I contact if I have questions?

If you have questions about the assessment or any problems that you think will interfere with your ability to attend the assessment, please contact: (*DAC should identify a contact person who is able to respond to a range of questions*) at *(DAC phone number)*. If you have questions for your insurance company, the person who referred you to us is *(insurer contact name as per referral form)* and can be contacted at: *(insurer contact phone number).*

cc: Insurer

Appendix C

Assessment of Attendant Care Needs (Form 1)