

Return this form to:

## Assessment of Attendant Care Needs (Form 1)

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

Policy No.:

Claim No.:

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
- the applicant's insurance company

**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's<br/>Name</b> | Applicant's Name                               | Date of Birth    |             |
|                             | Street Address                                 | Date of Accident |             |
|                             | City   | Province         | Postal Code |
|                             | Name of Policyholder (if different than above) | Policy No.       |             |

What is the date of this assessment?

Is this the first assessment of this applicant?

Yes  No

Date of Last Assessment

Current Monthly Allowance

|                 |                         |               |
|-----------------|-------------------------|---------------|
| <b>Assessor</b> | Name of Assessor        | Telephone No. |
|                 | Facility or Institution |               |
|                 | Street Address          |               |
|                 | City                    | Province      |

|                              |                      |               |             |
|------------------------------|----------------------|---------------|-------------|
| <b>Insurance<br/>Company</b> | Name                 | Telephone No. |             |
|                              | Street Address       |               |             |
|                              | City                 | Province      | Postal Code |
|                              | Name of Policyholder | Policy No.    |             |

**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> |   |  |  |  |

|                 |   |  |  |  |
|-----------------|---|--|--|--|
| <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> |   |  |  |  |

Part 1 continued...

|                                      |   | Number<br>of<br>Minutes | X | Times<br>per<br>week | = | Total<br>minutes<br>per week |
|--------------------------------------|---|-------------------------|---|----------------------|---|------------------------------|
| <b>Mobility</b><br>(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<br/>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 on Page 7**

**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<br>of<br>Minutes | X | Times<br>per<br>week | = | Total<br>minutes<br>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<br/>Supervisory<br/>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>  |  |                         |   |                      |   |                              |
| <b>Co-ordination of<br/>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 on Page 7**

**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<br>of<br>Minutes | X | Times<br>per<br>week | = | Total<br>minutes<br>per week |
|---------------------------------|---|-------------------------|---|----------------------|---|------------------------------|
| <b>Genitourinary<br/>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<br/>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>   |                         |   |                      |   |                              |
| <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>   |                         |   |                      |   |                              |

Part 3 continued...

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

|   |   | Number of Minutes | Times per week | Total minutes per week |
|---|---|-------------------|----------------|------------------------|
| <b>Skin Care</b><br>(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 |
|------------------------------|------------------------|--------|--------------------|---------|---------------------|---|-------------|---|----------------------|
| <b>Part 1</b><br>(from Pg.3) |                        |        |                    |         |                     | X | A*          |   | \$                   |
| <b>Part 2</b><br>(from Pg.3) |                        |        |                    |         |                     | X | B*          |   | \$                   |
| <b>Part 3</b><br>(from Pg.6) |                        |        |                    |         |                     | 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  |
|----------|--|--|
| <b>A</b> | \$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>B</b> | \$8.75   |  |
| <b>C</b> | \$17.98  |  |

**Part 5: Signature(s) of Assessor(s)**

|  |           |                             |  |
|--|-----------|-----------------------------|--|
| Name of Assessor   |           | Registration Number         |  |
| Facility Name (if applicable)  |           | AISI number (if applicable) |  |
| Address  |           |                             |  |
| City   | Province  | Postal Code                 |  |
| Telephone Number   | Extension | Fax Number                  |  |
| Email Address  |           |                             |  |
| 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)             |  |