

Instructions for Completing MEDICAL ASSESSMENT FORM For Students with Permanent Disabilities

Nova Scotia Student Assistance requires this form to be completed by a qualified medical assessor in order to verify the applicant's permanent disability and to determine eligibility for disability-related financial grants and disability training related goods and services, while attending post-secondary education. Individuals who meet the disability criteria become part of the Department of Labour and Advanced Education Labour Market Agreement for Persons with Disabilities (LMAPD) program administered through the Post-Secondary Disability Services Division.

"Permanent disability" means a functional limitation caused by a physical or mental impairment that restricts the ability of a person to perform the daily activities necessary to participate in studies at a post-secondary school level or the labour force and is expected to remain with the person for the person's expected life.

Note: Not all medical conditions are considered permanent disabilities for the purposes of these grants.

APPLICANT

- All applicants **must** complete the **Consent Form** on page 1, **Section A** and **Section B** on page 2.
- Have the sections relating to your disability completed by the appropriate qualified medical assessor. *For example, if you are visually impaired, your form should be completed by an Ophthalmologist or Optometrist. If you have a hearing impairment, your form should be completed by an Audiologist.* Your limitations and barriers to your program of study must be clearly identified.
- If you have a **Learning Disability**, you must attach a current Psycho-Educational Assessment, completed within the last 5 years by a Registered Psychologist and submit it with the signed **Consent Form** (page 1) and completed **Section A and B** (page 2). Any other supporting documentation in reference to your learning needs would also be helpful.
- If you have **ADD/ADHD**, the medical documentation must include a **comprehensive report** that includes the following information: diagnosis according to the DSM IV Criteria, year of diagnosis, in-depth background history, diagnostic tools used including information from collateral informants used for diagnostic purposes, evidence of impairment affecting various environments, medication used and recommendations for overcoming limitations/barriers. Any other supporting documentation in reference to your learning needs along with copies of any previous Psycho-Educational Assessments would be beneficial.
- If you previously did not meet the disability criteria either because your documentation was not current or there was insufficient information provided to support your application, you must provide additional or current information from your medical assessor that clearly outlines the limitations and barriers that your disability will present while participating in studies at a post-secondary institution. Any previous documentation sent to our office is on file.

MEDICAL ASSESSOR

This Medical Assessment Form will be used as one of the criteria to determine this student's eligibility to receive Federal and/or Provincial grant funding. Please ensure the diagnosis represents this student's permanent disability and identifies the disability-related educational barrier(s). Incomplete forms will result in denial and/or delays for your patient.

- Please complete the appropriate section(s) pertaining to the permanent disability diagnosis and return the form to the student.
- Medical assessors must complete all parts of **Section 9** on pages 6 and 7, clearly describing the disability-related educational barriers and recommended interventions.

Completed Forms are to be mailed to:

Nova Scotia Student Assistance
PO Box 2290, Halifax Central
Halifax, NS B3J 3C8
Telephone: 902-424-8420 Toll Free in Canada 1-800-565-8420

IMPORTANT INFORMATION

***Your student loan application will not be processed until all documentation has been received.
All information must be received no later than two months before your period of study ends. Funds cannot be released after your period of study end date.***

MEDICAL ASSESSMENT FORM

For Students with Permanent Disabilities

CONSENT FOR THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Your personal information is protected by *The Nova Scotia Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection of your personal information, including health information, please contact the Student Assistance Office of the Department of Labour and Advanced Education at 902-424-8420 or toll free in Canada at 1-800-565-8420.

I understand and agree that my personal information will be used to determine and verify my eligibility for Federal and Provincial post-secondary disability programs, to administer these programs, to enforce both the Canada Student Loans Program and the Nova Scotia Student Assistance Program (and related legislation), and to conduct program evaluation of disability based financial grants, goods and services. I further understand that:

1. The contents of my medical report which I submit to the Department of Labour and Advanced Education, Student Assistance Division will be used by the Federal and Provincial governments to determine my eligibility for disability grants, goods and/or services and repayment assistance provided to students with disabilities.
2. The Department of Labour and Advanced Education Student Assistance Division and/or the Post-Secondary Disability Services Division may contact the medical assessor who has completed my medical and request additional information or clarification in reference to my disability.
3. The contents of the submitted medical documentation may be shared, as necessary, with the post-secondary institution's disability services facilitator at the campus I will be attending. The disability services facilitator may contact me to ensure that I am aware of all programs, goods and/or services that are funded through the Federal and Provincial governments.
4. For Federal/Provincial program evaluation requirements, my personal information may be shared, as necessary, with the Federal and Provincial governments and/or third parties contracted to do program evaluations.
5. Once disability eligibility has been established the Federal and Provincial government may use my information for program administration and evaluation purposes. I may be contacted by Post-Secondary Disability Services or a third party contractor, for the purposes of program evaluation. Such contact may occur while I am attending post-secondary training and/or after I have graduated or withdrawn from post-secondary training.
6. This entire form and associated information may be shared with an appeal board, if an appeal is launched regarding my eligibility.

Applicant's Name (*Please Print*): _____

SIN: _____
Social Insurance Number

Applicant's Signature: _____

Date: _____

MEDICAL ASSESSMENT FORM For Students with Permanent Disabilities

VERIFICATION OF PERMANENT DISABILITY

Student First Name:	Student Last Name:
----------------------------	---------------------------

IMPORTANT INFORMATION FOR MEDICAL ASSESSORS

Nova Scotia Student Assistance will use this *Medical Assessment Form for Students with Permanent Disabilities* as one of the criteria to determine this student's eligibility to receive federal grant funding and/or provision of disability training related goods and services. Please ensure that the **information thoroughly represents this student's permanent disability and details of the impact that will affect the student's ability to meet the typical demands of a Post-Secondary environment.** Incomplete forms will result in denial and/or delays for your patient. Where applicable, indicate if the student's disability necessitates a reduced course load (less than 60% of a full course load), even with the recommended supports.

"Permanent disability" means a functional limitation caused by a physical or mental impairment that restricts the ability of a person to perform the daily activities necessary to participate in studies at a post-secondary school level or the labour force and is expected to remain with the person for the person's expected life.

Not all medical conditions are considered permanent disabilities for the purposes of these grants.

**PLEASE COMPLETE THE APPROPRIATE SECTION(S) THAT PERTAINS TO THE STUDENT'S DISABILITY.
Section 9 on pages 6 & 7 must be completed by the medical assessor for all applicants.**

Section 1: Physical Disability *(to be completed by a Physician)*

Examples: Spinal Cord Injury, Spina Bifida, Back Injury, Arthritis etc.

Primary Diagnosis: _____ **Year of Diagnosis/Onset:** _____

Current symptoms and levels of impairment presently experienced by the student:

Current treatment, medication and side effects: *(if applicable)*

Expected prognosis and is the condition considered permanent, chronic or temporary:

Please Complete Section 9 on Pages 6 & 7

Section 2: Hearing Impairment *(to be completed by a Certified Audiologist)*

I certify this client to be hearing impaired according to the following criteria. *(Indicate appropriate description):*

**** Level of hearing loss in the better ear *(indicate appropriate descriptions):***

Part A: Mild Moderate Profound Severe

Part B: Hearing loss interferes with student's learning
 Uses hearing aids
 Would benefit from amplification devices in an educational / vocational setting.

****A copy of a recent Audiogram must be submitted.** *Please Complete Section 9 on Pages 6 & 7*

Section 3: Visual Impairment (to be completed by an Ophthalmologist or Optometrist)

I certify this client to be visually impaired according to the following criteria. *(Indicate appropriate description):*

- A visual acuity of 6/21 (20/70), or less in the better eye after correction.
- A visual field of 20 degrees or less.
- Any progressive eye disease with a prognosis of becoming one of the above, in the next two years.
- An uncorrectable visual problem or reduced visual stamina such that the applicant functions throughout the day as if his/her visual acuity is limited to 6/21 or less in the better eye.

Year of Diagnosis/Onset:

Attach a copy of your most recent visual acuity report. *Please Complete Section 9 on Pages 6 & 7*

Section 4: Neurological Disability (to be completed by a Neurologist, Psychiatrist or Physician)

Examples: epilepsy, multiple sclerosis, brain tumor, stroke, traumatic brain injury, etc.

Primary Diagnosis: **Year of Diagnosis/Onset:**

Current symptoms and levels of impairment presently experienced by the student:

Current treatment, medication and side effects: *(if applicable)*

Expected prognosis and is the condition considered permanent, chronic or temporary:

Please Complete Section 9 on Pages 6 & 7

Section 5: ADD / ADHD (to be completed by a qualified Psychiatrist, Psychologist or Physician)

I certify this client to be ADD / ADHD according to the following criteria. *(Indicate appropriate description):*

Diagnosis according to DSM criteria is:

ADHD Inattentive Type ADHD Impulsive -Hyperactive Type ADHD Combined Type

Year of diagnosis:

Please submit a comprehensive report that provides detailed information in reference to the diagnosis and the DSM criteria:

This **must** include an in depth account of background history, year of diagnosis, diagnostic tools used including information from collateral informants used for diagnostic purposes, evidence of impairment affecting both social/labour force and educational environments, medication used and recommendations for overcoming limitations/barriers. This could be documentation on file at time of original diagnosis or reassessment.

Please advise client to submit current supporting documentation in reference to their learning needs along with copies of any previous Psycho-Educational Assessments if available.

Please Complete Section 9 on Pages 6 & 7

Section 6: Psychiatric Disability (to be completed by a Clinical Psychologist, Psychiatrist or Physician)

Example: Mental Health Consumer
<p>Primary Diagnosis according to DSM criteria (include DSM Code):</p> <p>Year of Diagnosis/Onset:</p> <p>Description of the symptoms that formed the basis of the diagnosis:</p> <p>Current symptoms and levels of impairment presently experienced by the student:</p> <p>Current treatment, medication and side effects:</p> <p>Expected prognosis and is the condition considered permanent, chronic or temporary:</p>
<p><i>(Attach separate sheet if necessary)</i> <i>Please Complete Section 9 on Pages 6 & 7</i></p>

Section 7: Developmental Disabilities (to be completed by the appropriate medical assessor)

Example: Autism Spectrum Disorder, Intellectual, FAS, etc.
<p>Primary Diagnosis: Year of Diagnosis:</p> <p>Diagnosis based on the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Psycho-Educational Assessment <i>(Please include a copy)</i> <input type="checkbox"/> Medical Assessment <i>(Behavioral Evaluations - include report)</i> <p>Include copies of evaluations completed at time of diagnosis and current supporting documentation of educational adaptations/accommodations.</p>
<p style="text-align: right;"><i>Please Complete Section 9 on Pages 6 & 7</i></p>

Section 8: Other Chronic Illnesses/Syndromes - the illness/syndrome must have been persistent for a minimum of three years and is likely to last and become permanent. (to be completed by the appropriate medical assessor)

Examples: fibromyalgia, crohn's, lupus, etc.
<p>Primary Diagnosis: Year of Diagnosis/Onset:</p> <p>Current symptoms and levels of impairment presently experienced by the student:</p> <p>Current treatment, medication, and side effects:</p> <p>Expected prognosis and is the condition considered permanent, chronic or temporary:</p>
<p style="text-align: right;"><i>Please Complete Section 9 on Pages 6 & 7</i></p>

Section 9: (continued)

Part C: Medical Assessor Information	
I certify that the information provided on this form is accurate and the student identified in this assessment experiences the disability-related educational barriers indicated.	
Name of certifying Medical Assessor: (Please Print) _____	
Mailing Address: _____	
City/Town: _____	Province: _____ Postal Code: _____
Telephone: _____	
Signature: <i>(must be signed in ink)</i>	Date: _____ <i>Day / Month / Year</i>

Please return this form to the student or forward all pages of this form to the address below. It would also be beneficial for the applicant to have a copy of the completed form for their records.

Nova Scotia Student Assistance
PO Box 2290, Halifax Central
Halifax, NS B3J 3C8

Telephone: 902-424-8420 Toll Free in Canada 1-800-565-8420