CONTRACT REFERENCE GUIDE FOR REPORT FORM C1258
(PERSONAL CARE ALLOWANCE and HOME EQUIPMENT ASSESSMENT)

Service Description

The Personal Care Allowance Assessment is used to determine a Worker's functional ability, personal care, and adaptive equipment needs relative to their **work-related Injury accepted under this claim**. This information, along with other relevant medical data, may be used to determine an allowance the WCB may pay to cover the cost of in-home care for an injured Worker. The allowance is called a Personal Care Allowance, and is designed to provide an alternative to institutional care for severely injured Workers by providing funding for care in the home.

The Home Equipment Assessment is to determine if the Worker is able to maintain their independence in their home environment. Assessment recommendations should be directly related to the compensable work injury accepted on the claim.

The service provider shall not render an opinion directly to the Worker with respect to the extent of injury, compensation, personal care, treatment or equipment needs without prior WCB Claim Owner authorization. The service provider shall direct the Worker back to the attending Claim Owner to address these issues.

Reporting/Service Guidelines

1. The service provider will commence the assessment within five (5) working days from the date of referral.

2. The service provider will provide the completed Personal Care Allowance Assessment Report to the WCB within five (5) working days from the date of assessment.

3. The report will address the criteria as outlined below, as well as specific issues and questions identified by the claim owner. The service provider should have a clear understanding of the Worker's medical history and **compensable** injury prior to initiating the assessment.

4. The report shall be **typewritten**.

5. To assist the WCB in determining personal care needs, the following items should be addressed.
    a. Please indicate whether the Worker is able to complete the task independently, with the assistance of a device or a caregiver, is totally dependent, or not applicable (n/a).
    b. Indicate the length of time it would take to complete the task, how often assistance is required (e.g., once per day, twice per day, etc.), and who provides the assistance.
    c. Accuracy and details are required.
    d. Information reported by the Worker should be validated by observations when possible.

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Report Field:
WCB Claim Number

Content Expectations:

This is the seven-digit number used by the WCB to identify a Worker's claim for a specific condition (e.g. 439-8625).

Report Field:
Worker Names

Content Expectations:

The full name of the Worker using the following specific format:
a. Surname in mixed case (e.g. Canuck)
b. First name and middle initial (if any) in mixed case (e.g. Joseph S)

Report Field:
Personal Health Number

Content Expectations:

The Worker's nine (9) digit health care number in the following format (e.g. 12345-6789)

Report Field:
Date of Birth

Content Expectations:

The Worker's date of birth (*yyyy/mm/dd* format)

Report Field:
Referral Date

Content Expectations:

The date that the referral is received by the provider (*yyyy/mm/dd* format)

Report Field:
Assessment Date

Content Expectations:

The date of the assessment (*yyyy/mm/dd* format)

Report Field:
Date of Accident

Content Expectations:

The date that the accident took place (*yyyy/mm/dd* format)

Report Field:
Provider's Contact Name

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The name of the provider who completed the assessment

Report Field:
Telephone Number

Content Expectations:

The provider's ten (10) digit phone number (e.g. 403-725-4432)

Report Field:
Provider Reference Number

Content Expectations:

The provider's internal file number

Report Field:
Compensable Conditions (based on referral form)

Content Expectations:

1. What is the work related injury accepted under this claim?

2. Does the Worker have medical restrictions related to this claim

Report Field:
Non Compensable Conditions (based on referral form)

Content Expectations:

1. Are there conditions or injuries that are not accepted under this claim that will impact the Worker's ability to perform home maintenance activities?
    a. Other WCB claims
    b. Other conditions or diseases unrelated to a WCB claim

Report Field:
Employer's Name

Content Expectations:

The name of the Worker's date of accident employer (company name)

Report Field:
Employer's Contact Name

Content Expectations:

The contact name of the Worker's date of accident employer

Report Field:
Telephone Number

Content Expectations:

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The employer's ten (10) digit phone number (e.g. 403-725-4432)

Report Field:
Occupation

Content Expectations:

The Worker's date of accident occupation

Report Field:
NOC Number

Content Expectations:

The four (4) digit National Occupation Classification number

Report Field:
Job Attached

Content Expectations:

Check the most appropriate box

Report Field:
General

Content Expectations:

1. Referral questions
    a. What is the purpose of the referral?
    b. What information is the claim owner hoping to obtain?

2. Brief history
    a. Describe the events/accident that resulted in the work injury.
    b. What treatment is provided to date?
    c. Current functional abilities/restrictions if known.

3. Claimants anthropometric measurements
    a. Height in inches
    b. Weight in pounds

4. Physical and functional assessment
    a. Comment on physical limitations which would affect task performance:
        i. Muscle strength (0-5)
        ii. Range of motion (in degrees)
        iii. Sensation
        iv. Vision
        v. Hearing
        vi. Communication
        vii. Balance (sit, stand)
        viii. Tone
        ix. Respiration
        x. Circulation
        xi. Others, as applicable

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b. Comment of functional limitations
    i. This should be based on observation of the Worker performing activities of daily living and not on Worker subjective reports only.

Report Field:
Living Situation

Content Expectations:

1. Type of residence – check the most appropriate box

2. Ownership - check the most appropriate box

3. Living Arrangement - check the most appropriate box

4. Support
    a. Does the Worker receive assistance from his/her family or friends? (Yes/No)
        i. Describe the assistance he/she receives.
    b. Did they receive this level of assistance prior to the injury? (Yes/No)
        i. If no, give details of what has changed.

5. Family situation
    a. Do they have children? (Yes/No)
        i. If yes, how many children are there and what are the ages and of each child?
    b. Are the children dependent or independent?
        i. If the children are dependent who provides the daily child-care?

Report Field:
Mobility

Content Expectations:

	Independent	Requires Assistance	Dependent
Stairs	☐	☐	☐
Inside the home	☐	☐	☐
Outside the home	☐	☐	☐
In/out of bed	☐	☐	☐
In/out of chair/wheelchair	☐	☐	☐
Wheelchair to toilet	☐	☐	☐
Into shower or bathtub	☐	☐	☐
In/out of vehicle	☐	☐	☐

1. Check the most appropriate boxes according to the Worker's level of independence with each mobility/transfer task.

2. If the Worker requires assistance or is dependent for any of the above tasks, describe the assistance required.
    a. How much time is required?
    b. How often is assistance required?

3. Does the Worker currently use mobility aids? – check the most appropriate box

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Report Field:
Bowel Routine

Content Expectations:

	Independent	Requires Assistance	Dependent
Bowel toileting	☐	☐	☐
Continence ☐ All of the time ☐ Some of the time	☐	☐	☐

1. Check the most appropriate boxes according to the Worker's level of independence with each task.
    a. Check the most appropriate box regarding the Worker's continence (all of the time, some of the time)

2. Incontinence
    a. Check the most appropriate boxes related to the Worker's incontinence (reason and bowel care/routine)
    b. Describe the Worker's bowel routine
        i. When and how often
        ii. Does the Worker require assistance or not?

3. Equipment used – check the most appropriate box

4. Other information on bowel routine
    a. Provide any additional information not covered above pertaining to the Worker's bowel routine.

Report Field:
Bladder Routine

Content Expectations:

	Independent	Requires Assistance	Dependent
Bladder toileting	☐	☐	☐
Continence ☐ All of the time ☐ Some of the time	☐	☐	☐

1. Check the most appropriate boxes according to the Worker's level of independence with each task.
    a. Check the most appropriate box regarding the Worker's continence (all of the time, some of the time)

2. Incontinence
    a. Check the most appropriate boxes related to the Worker's incontinence (reason, frequency, occurrence, bladder routine).
    b. Describe the type and frequency of catherization.

3. Other information on bladder routine
    a. Provide any additional information not covered above pertaining to the Worker's bladder routine.

	Independent	Requires Assistance	Dependent	Not Applicable
Menstrual care	☐	☐	☐	☐

4. Check the most appropriate boxes according to the Worker's level of independence with each task.

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5. If assistance is required, specify the frequency and time required.

Report Field:
Hygiene/Grooming and Skin Care:

Content Expectations:

	Independent	Requires Assistance	Dependent
Bathing	☐	☐	☐

1. Check the most appropriate boxes according to the Worker's level of independence with this task.
2. Primary form of bathing – check the most appropriate box
3. If assistance is required, specify the frequency and time required.
4. Equipment used - check the most appropriate box(es).
5. Equipment recommended (based on the work-related injury) - check the most appropriate box(es).

	Independent	Requires Assistance	Dependent
Brushing teeth	☐	☐	☐
Brushing/combing hair	☐	☐	☐
Shampooing	☐	☐	☐
Shaving	☐	☐	☐
Applying make-up	☐	☐	☐
Applying deodorant	☐	☐	☐
Applying cologne/perfume	☐	☐	☐
Other *(Specify)*:	☐	☐	☐

6. Check the most appropriate boxes according to the Worker's level of independence with each grooming task.
7. If assistance is required, specify the frequency and time required.

	Independent	Requires Assistance	Dependent
Checking skin	☐	☐	☐
Applying lotions/powder	☐	☐	☐

8. Check the most appropriate box according to the Worker's level of independence with each skin care task.
9. Comment on tissue and skin integrity issues.

Report Field:
Dressing

Content Expectations:

	Independent	Requires Assistance	Dependent
Underwear	☐	☐	☐
Shirt	☐	☐	☐
Pants	☐	☐	☐

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Socks	☐	☐	☐
Dresses *(if applicable)*	☐	☐	☐
Coats	☐	☐	☐
Shoes/boots	☐	☐	☐
Zippers	☐	☐	☐
Buttons	☐	☐	☐
Putting clothes away	☐	☐	☐
Putting on/removing glasses	☐	☐	☐
Putting on/removing earrings	☐	☐	☐
Putting on/removing hearing aids	☐	☐	☐

1. Check the most appropriate box according to the Worker's level of independence with each dressing task.
2. Equipment used - check the most appropriate box(es)
3. Equipment recommended (based on the work-related injury) - check the most appropriate box(es)
4. If assistance is required, specify the frequency and time required.

Report Field:
Nutrition:

Content Expectations:

	Independent	Requires Assistance	Dependent
Preparation of simple meals	☐	☐	☐
Preparation of main meals	☐	☐	☐
Eating	☐	☐	☐
Drinking	☐	☐	☐
Meal clean-up	☐	☐	☐

1. Check the most appropriate box according to the Worker's level of independence with each nutrition task.
2. Equipment used – check the most appropriate box(es).
3. Equipment recommended (based on the work-related injury) - check the most appropriate box(es).
4. Describe any assistance and/or assistive devices that are required.
5. For nutritional consideration, indicate what the Worker has eaten in the last 24 hours.

Report Field:
Homemaking Services

Content Expectations:

	Independent	Requires Assistance	Dependent
Washing clothes	☐	☐	☐
Ironing clothes	☐	☐	☐
Changing or making beds	☐	☐	☐

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Light household cleaning	☐	☐	☐
Heavier household cleaning	☐	☐	☐
Home maintenance tasks	☐	☐	☐
Cleaning wheelchair or other devices	☐	☐	☐
Shopping	☐	☐	☐
Grocery shopping	☐	☐	☐
Putting groceries away	☐	☐	☐

1. Check the most appropriate box according to the Worker's level of independence with each homemaking task.

2. If assistance is required, specify the time and frequency required.

3. Are there any assistive devices that could be used to enhance independence and reduce assistance requirements?
   If yes, describe

Report Field:
Medical or Para-Medical Requirements

Content Expectations:

	Independent	Requires Assistance	Dependent
Dressing changes	☐	☐	☐
Medication regime	☐	☐	☐
Exercises	☐	☐	☐
Orthotics	☐	☐	☐
Ordering supplies/equipment	☐	☐	☐
Maintain supplies/equipment	☐	☐	☐

1. Check the most appropriate box according to the Worker's level of independence with each task.

2. If assistance is required, specify the time and frequency required.

Report Field:
Supervision

Content Expectations:

1. If the Worker requires monitoring, specify why and how often and how long monitoring will be required and by whom.

Report Field:
Mental Status (Psychological/Cognitive)

Content Expectations:

1. Behaviors noted or reported - check the most appropriate box(es)

2. Specify any safety concerns

3. Cognitive
   a. Check the most appropriate box according to the Worker's orientation (person, place and time)

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	Independent	Requires Assistance	Dependent
Planning and organizing	☐	☐	☐
Comprehension	☐	☐	☐
Ability to initiate	☐	☐	☐
Insight	☐	☐	☐
Problem solving	☐	☐	☐
Decision making	☐	☐	☐
Attention/Concentration	☐	☐	☐

b. Check the most appropriate box according to the Worker's level of independence with each cognitive task.
c. Document any observations or findings that support the Worker's level of cognitive independence or dependence.

4. Communication

	Independent	Requires Assistance	Dependent
Speech	☐	☐	☐
Word finding	☐	☐	☐
Written	☐	☐	☐
Other *(Specify)*:	☐	☐	☐

a. Check the most appropriate box according to the Worker's level of independence with each communication task.
b. Document any observations or findings on the Worker's communication ability.

Report Field:
Transportation

Content Expectations:

1. Form of transportation - check the most appropriate box
    a. Is the Worker independent in taking public transportation? (Yes/No)
        i. If no, describe the reasons why and if it is related to the work-related injury

2. Transportation needs - check the most appropriate box
    a. Has the Worker's transportation changed since the work-related injury? (Yes/No)
        i. If yes, describe the changes

Report Field:
Vehicle

Content Expectations:

1. Does the Worker own their own vehicle? (Yes/No)
    a. If yes, describe the year, make and model of the vehicle

2. Are there modifications to the vehicle because of the work-related injury? (Yes/No)
    a. If yes, describe the modifications

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Report Field:
Banking/Legal Affairs

Content Expectations:

	Independent	Requires Assistance	Dependent
Banking	☐	☐	☐
Using an ATM	☐	☐	☐
Money management	☐	☐	☐
Writing cheques and managing accounts	☐	☐	☐
Legal affairs	☐	☐	☐

1. Check the most appropriate box according to the Worker's level of independence with each banking/legal affairs task.

2. If the Worker is dependent in any of the above areas, is this due to their work-related injury? (Yes/No)
    a. If yes, describe how this is related to their work-related injury.

Report Field:
Self-Managed Care

Content Expectations:

1. In your opinion, does the Worker have the skills and abilities (physical/cognitive/emotional) to participate in a self-managed care program? (Yes/No)

2. Describe any additional training or community support that would be required for the Worker to participate in a self-managed care program?

3. Do you believe the Worker needs to be monitored on a self-managed care program? (Yes/No)
    a. If yes, specify reasons for your concerns and how often the Worker should be monitored.

Report Field:
Vocational

Content Expectations:

1. Is the Worker employed? (Yes/No)

2. Is the Worker engaged in productive behavior (e.g. school volunteer, etc.)? (Yes/No)
    a. If yes, describe the activities they are involved in.

3. Is the Worker interested in expanding their vocational options? (Yes/No)

4. Is the Worker attending classes? (Yes/No)
    a. If yes, describe the class/program

	Independent	Requires Assistance	Dependent
Level of dependency	☐	☐	☐

5. Check the most appropriate box according to if the Worker is able to attend classes independently or if assistance is required.

6. Does the Worker own a computer? (Yes/No)

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7. Does the Worker own a smartphone? (Yes/No)

	Independent	Requires Assistance	Dependent
Computer use	☐	☐	☐
Smartphone use	☐	☐	☐

8. Check the most appropriate box according to the Worker's level of independency operating a computer and smartphone.

9. How many hours per day does the Worker use the computer/smartphone?

Report Field:
Recreation

Content Expectations:

1. Describe the Worker's leisure interests/pursuits.

	Independent	Requires Assistance	Dependent
Leisure activities	☐	☐	☐

2. Check the most appropriate box according to the Worker's level of independence with leisure activities.

3. Describe how the Worker occupies his/her day.

Report Field:
Aid and Equipment

Content Expectations:

1. With regards to their work-related injury, does the Worker currently use assistive devices not described in the above sections? (Yes/No)
    a. If yes, describe the devices used by the Worker (include the make, model, year provided and condition of equipment for larger items).

2. Would the Worker's functional abilities improve (independence) if equipment was supplied to compensate for the work-related injury and the subsequent function impairment? (Yes/No)

3. Specify what equipment is recommended and how it will impact their ability to function.

4. Is a follow up assessment required for aids/equipment, etc.? (Yes/No)

Report Field:
Additional Information

Content Expectations:

1. Does the Worker have a care-giver? (Yes/No)

2. Are there any specific issues with regards to the care-giver's ability to provide the necessary service(s) – physical/emotional health, availability, etc.?

3. Is the Worker's level of functioning consistent with what could be expected from the injury or disability?
    a. If no, explain what you would expect

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Report Field:
General Recommendations

Content Expectations:

When making recommendations please ensure the recommendations are directly related to the work injury accepted under this claim. Please discuss the recommendations with the claim owner prior to finalizing the recommendations and report.

1. Recommendations should be based on objective findings rather than based on the Worker's wants.

2. Case conference date
    a. The date of the case conference (yyyy/mm/dd format)

3. Re-assessment recommended? (Yes/No)

4. Rationale for re-assessment
    a. Provide a brief description of why a re-assessment is required.

Report Field:
Photos (if applicable)

Content Expectations:

1. If applicable, insert photos related to the home equipment assessment and/or recommendations.