Ministry of Social Development and Poverty Reduction

# APPLICATION
# PERSONS WITH PERSISTENT MULTIPLE BARRIERS

The personal information requested on this form is collected and used by the Ministry of Social Development and Poverty Reduction pursuant to sections 26(c) and 32(b) of the *Freedom of Information and Protection of Privacy Act* for the purpose of administering the *Employment and Assistance Act*. If you have any questions about the collection or use of this information, please contact the Ministry of Social Development and Poverty Reduction at 1-866-866-0800.

## Section 1

### Part A - Personal Information

| Last Name | First Name | Middle Name |
|---|---|---|
| | | |
| **Case Number** | **Personal Health Number** | |
| | | |

### Part B - Authority to Release Information (To be signed by Applicant)

I consent to the health professional indicated below disclosing health and other personal information about me, as requested in this form, to the Ministry of Social Development and Poverty Reduction for the purposes of assisting the ministry to determine if I qualify as a person who has persistent multiple barriers to employment.

| Signature of Applicant | Date Signed (YYYY MMM DD) | Signature of Witness |
|---|---|---|
| | | |

### Part C - Health Assessment - to be completed by a registered/licensed Health Professional (Please Print)

All questions must be answered completely for the Ministry of Social Development and Poverty Reduction to determine how the applicant's health condition(s) may seriously impede their ability to search for, accept or continue in employment. Incomplete information may result in the applicant not being adjudicated for the appropriate client category.

The contents of this report are confidential, but are subject to the following conditions:

- the report will be shared with the Applicant;
- the report will be shared with the Employment and Assistance Appeal Tribunal if an appeal is initiated; and
- the report may be reviewed by a ministry medical consultant.

One of the following health professionals can complete the health assessment;

- Medical Practitioner
- Nurse Practitioner
- Registered Nurse
- Registered Psychiatric Nurse
- Chiropractor
- Occupational Therapist
- Physical Therapist
- Registered Social Worker
- Registered Psychologist
- School Psychologist
- Registered Clinical Counsellor

**1. Health Condition(s):**

| | ICD9 or DSM Code (optional) | Date of Onset (YYYY MMM DD) |
|---|---|---|
| List health condition(s): | | |
| | | |
| | | |

How long has this condition(s) existed? _____ Years _____ Months

**2. Duration:**

a. Expected continuation of health condition(s): ☐ Less than 2 years ☐ 2 years or more

b. Indicate if the health condition(s) is episodic in nature? ☐ Yes ☐ No

i) How frequently have the episodes occurred in the past year? _____

ii) How frequently are they likely to recur? _____

Additional comments: _____

**3. Restrictions:**

Please describe the nature (including the severity) of any physical or mental restrictions that result from the health condition(s) described above.



**4. Enclosures:**

Please enclose copies of any documentation that confirms or verifies the existence and severity of the restrictions described above (e.g. laboratory or diagnostic reports, psychological reports, etc.).

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## 5. Certification - Health Professional

I, _____

am a _____

practicing in British Columbia.

I am registered with a professional regulatory body: ☐ Yes ☐ No

Name of regulatory body: _____

My registration number is: _____

I am employed by:

☐ Self Employed; private practice ☐ Health Authority

☐ Other employer (please specify): _____

Address including postal code (stamp or print)

This report contains my findings and considered opinion at this time.

| Signature | Date (YYYY MMM DD) |
|---|---|
| | |

| Telephone Number | Fax Number | Email address |
|---|---|---|
| | | |

A $50.00 fee may be paid to a Health Professional provided that the Health Professional has fully completed Section 1 of the Application.

Fees for physicians completing Section 1 of this form should be billed through the Medical Services Plan under Fee Item 96503. Other Health Professionals completing Section 1 may bill the ministry by submitting the attached completed invoice in the amount of $50.00: via fax at 1-866-399-9350 or by mail to SDD Accounts Payable PO Box 5051 Stn Main Vancouver, BC V6B 4A9.

Please keep a copy of the fully completed Section 1 of this form until you receive payment for your fee. Health Professionals having questions regarding this application may contact the Health Assistance, Ministry of Social Development and Poverty Reduction at 1-888-221-7711.

## Health Professional's Invoice

| Invoice No. | Invoice Date |
|---|---|
| | |

| Applicant Name | Applicant Date of Birth | Personal Health Number |
|---|---|---|
| | | |

| Date of Service | Description of Service |
|---|---|
| | Completion of Health Professional's Report Section 1.....$50.00 |

Make cheque payable to:

| Supplier Name | | |
|---|---|---|
| | | |

| Address | Postal Code | Telephone |
|---|---|---|
| | | |

| Supplier Signature | Registration Number |
|---|---|
| | |

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## Section 2

### Part A - Personal Information

| Last Name | First Name | Middle Name |
|---|---|---|
| | | |

| Case Number | Personal Health Number |
|---|---|
| | |

### Part B - Barriers to Employment (To be completed and signed by Applicant)

**1. Restrictions:**

Please indicate which of the following barriers you have that seriously impede your ability to search for, accept or continue in employment:

- ☐ Homelessness

  Currently experiencing homelessness or have experienced homelessness in the past 12 months

- ☐ Domestic violence

  Currently experiencing domestic violence or having experienced domestic violence in the past 6 months

- ☐ In need of English language skills training
- ☐ Not having basic skills for employment
- ☐ Criminal Record
- ☐ Less than Grade 12 education
- ☐ Have accessed emergency health, mental health or addiction service multiple times in the past 12 months
- ☐ Recent Convention refugee (within the past 24 months) or currently a refugee claimant
- ☐ Former Child in Care

  A former child in care of the BC Ministry of Children and Family Development or an equivalent government agency in another jurisdiction in Canada.

- ☐ Other severe barrier(s) to employment _____

_____

Please provide information or documentation to support any other severe barrier(s) you have identified. Additional pages may be attached.

_____

_____

### Declaration and Notification

I, _____, wish to be qualified as a Person with Persistent Multiple Barriers to Employment status as set out in the Employment and Assistance Regulation and I declare that the information provided in this form and any supporting documents provided is true and complete. I understand the BC government may verify the information and supporting documents provided in this application as necessary to determine and confirm my eligibility.

| Applicant's Signature | Date Signed (YYYY-MMM-DD) |
|---|---|
| | |