Indian and Northern Affairs Canada | Affaires indiennes et du Nord Canada

MEDICAL REPORT
(FOR PERSONS WITH PERSISTENT MULTIPLE BARRIERS)

The personal information requested on this form is collected and will be used for the purpose of administering social assistance in accordance with the INAC *Social Development Program Policy and Procedures Manual, BC Region.* The collection, use and disclosure of personal information is subject to the provisions of the *federal Privacy Act and the Personal Information Protection and Electronic Documents Act.* If you have any questions about the collection, use or disclosure of this information, please contact your local Administering Authority office.

A - PERSONAL IDENTIFICATION

Last Name	First Name	Middle Name

Date of Birth (Year Month Day)	Personal Health Number	Social Insurance Number (Optional)

B - AUTHORITY TO RELEASE INFORMATION (Completed by Client)

I authorize the medical practitioner indicated below to complete this assessment and to disclose medical information concerning myself to the Administering Authority, and DIAND.

Signature of Client	Date Signed (Year Month Day)	Signature of Witness

C - MEDICAL ASSESSMENT - To be completed by a Medical Practitioner (Please Print)

1. Medical Condition: Date of Onset (Year Month Day)
   a. Primary medical condition: ______________________ ______________
   b. Secondary medical condition : ______________________ ______________
   c. Severity of medical condition : ☐ Mild ☐ Moderate ☐ Severe
   d. Has this condition existed for at least 1 year ☐ Yes ☐ No

2. Prognosis:
   a. Expected duration of medical condition: ☐ less than 2 years ☐ more than 2 years ☐ additional comments: ______________
   b. Medical condition is episodic in nature ☐ Yes ☐ No
      i) How frequently have the episodes occurred? ______________
      ii) How frequently are they likely to recur? ______________
   c. Please describe the nature and reasons for any restrictions in employment, specific to the above medical conditions.
   d. Please describe any steps that can be taken to overcome/reduce restrictions to employment. (e.g. change from physical labour to desk work).
   e. Please describe any workplace supports recommended to assist in employment (e.g. flexible work hours).

3. Certification of Examining Medical Practitioner

I, ______________________ (print name)
am a licensed medical practitioner specializing in
______________________ . G.P. or specialty
I have examined the patient and this report contains my findings and considered opinion at this time. I have been the patient's medical practitioner for:
☐ 6 months or less ☐ over 6 months
If under 6 months ☐ I have examined previous medical records
☐ I have not examined previous medical records

Address including postal code (stamp or print)

Telephone

Signature of Medical Practitioner	Date (Year Month Day)

Please Refer to the Back of this Form for Billing Information

PHYSICIAN'S INVOICE - Please return this invoice to the client. The Band Administering Authority listed at the bottom of this page will pay the fee upon receipt of the invoice from the client.

PPMB

Invoice Date (Year Month Day) | Invoice Number

Applicant Name | Applicant Date Of Birth | Personal Health Number

Completion of PPMB Medical Report ....$ 25.00

Date of Service | Description of Service

Make cheque payable to:

Physician's or Supplier Name | Physician's Signature

Address | City | Postal Code | Telephone

Billing Information

Only Medical Reports bearing the original signature of the Band Social Development Worker in the *Band Administering Authority Office Use Only* section below will be accepted for payment.

Once the *Medical Report* is complete the invoice must be filled out, given to the client who will return it to the Administering Authority for process. DO NOT bill against the provincial Medical Service Plan (MSP).

The Band Administering Authority will pay the Physician fee upon receipt of the above invoice.

Note to Physicians: you may wish to keep a copy of this invoice for your records

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Band Administering Authority Office Use Only

This form is provided to the person identified in Section A (Page 1) in order to collect the person's medical information for the purposes of determining the person's eligibility for the Persons with Persistent Multiple Barriers category in accordance with Indian and Northern Affairs Canada's *Social Development Program Policy and Procedure Manual, BC Region*.

Band Administering Authority Address Stamp

Band Social Development Worker (Print Name)

Signature – Band Social Development Worker

Band Administering Authority Number: ___________

Indian and Northern Affairs Canada — Affaires indiennes et du Nord Canada

PERSONS WITH PERSISTENT MULTIPLE BARRIERS CHECKLIST & DECISION FORM

The personal information requested on this form is collected and will be used for the purpose of administering social assistance in accordance with the INAC *Social Development Program Policy and Procedures Manual, BC Region.* The collection, use and disclosure of personal information is subject to the provisions of the *federal Privacy Act and the Personal Information Protection and Electronic Documents Act.* If you have any questions about the collection, use or disclosure of this information, please contact your local Administering Authority office.

Surname	First Name	Middle Name

Date of Birth (Year Month Day).	Personal Health Number	Social Insurance Number (Optional)

1. Has the client been on assistance with INAC, BC Region or the BC Ministry of Human Resources 12 of the last 15 months? OR Is client a previous PPMB client (of INAC BC Region or BC Ministry of Human Resources) re-applying within 12 months after their file was closed?

☐ Yes ☐ No

2. The Medical Practitioner has confirmed a medical condition that has continued for at least one year and is likely to continue for at least two years or has occurred frequently over the past year and is likely to continue on that basis for at least the next two years, as per the *Medical Report* (SA 116)

☐ Yes ☐ No

3. The Medical Practitioner has confirmed that the medical condition results in restrictions in employment.

☐ Yes ☐ No

4. Do these conditions seriously restrict the client's ability to search for, accept or continue employment?

☐ Yes ☐ No

5. Does the client qualify as a Person with Persistent Multiple Barriers (PPMB)?

☐ **Yes - PPMB Expiry Date** (Year Month Day): ______________________ **(Maximum 2 years)**

☐ **No**

If no, reason for denial:

Signature of Band Social Development Worker: ______________________ Date: ______________

Print Name: ______________________ Administrating Authority Number: ______________

I acknowledge that I have received a copy of this form.

Signature of Client: ______________________ Date: ______________

 DISTRIBUTION: ORIGINAL - CLIENT FILE COPY - CLIENT

Indian and Northern Affairs Canada | Affaires indiennes et du Nord Canada

Protected B (when completed)

NUTRITIONAL SUPPLEMENT REQUEST & AUTHORIZATION

PRIVACY ACT STATEMENT
Information collected on, and disclosed pursuant to, this document is collected pursuant to the Indian and Northern Affairs Canada (INAC) *Social Development Policy and Procedures Manual, BC Region* for the purpose of determining eligibility for assistance and will be maintained pursuant to the *Privacy Act* and described in the personal information bank INA-PPU-240. The accuracy of the information in this document may be checked by comparing it against information held by any federal or provincial department or agency or any private agency.

Please complete in full. Please print clearly.

Administering Authority:	Number:

SECTION A: CLIENT INFORMATION – TO BE COMPLETED BY BAND SOCIAL DEVELOPMENT WORKER

Client's Last Name	Client's First Name	(√) ONE of the following: ☐ Infant Formula ☐ Short- Term Supplement ☐ Tube Feed Supplement Timeframe:
Personal Health Number	Telephone Number	
Indian Registry Number	Date of Birth	Type of income assistance being collected? (i.e., PWD, PPMB, etc.)

SECTION B: SERVICE INFORMATION – TO BE COMPLETED BY PRACTITIONER (DENTAL/OPTICAL/PHARMACIST/OTHER)

Note: Authorization may not be converted to cash or transferred to another person. It must be presented for goods/services by the person authorized to purchase. (NO SUBSTITUTIONS OR CASH REFUNDS ARE ALLOWED)

Please describe the services or supplies you are recommending, with the estimated cost:

Date	Qty.	FeeCode	Description of Goods/Services	Estimated Amount

If these goods/services have previously been provided, list dates and amounts (e.g., Boost or Infant Formula - March 2010 - $189.00):

Supplier Name	Supplier Phone ( )	Supplier Fax Number ( )
Supplier Signature	Supplier Mailing Address	Postal Code

Please contact the Band Social Development Worker if you have any billing enquires or questions.

SECTION C: AUTHORIZATION FOR GOODS OR SERVICE – TO BE COMPLETED BY BAND SOCIAL DEVELOPMENT WORKER

I have examined the written request and supporting documentation carefully as per Chapter 11, Other Benefits policy for the specific benefit and:

☐ Approve the request until ______________________________,
20______ for the amount of $______________________.

☐ Deny the request based on the following reasons:

I have examined the written request and supporting documentation carefully as per Chapter 11, Other Benefits policy for the specific benefit and:

☐ Approve the request until ______________________________,
20______ for the amount of $______________________.

☐ Deny the request based on the following reasons: