



Personal Care Assistance Assessment Report

Return To ICBC
PO BOX 2121, STN TERMINAL
VANCOUVER BC V6B 0L6

Fax 1-877-686-4222



INVOICE INFORMATION			
CLAIM NUMBER	DATE OF ACCIDENT (dd/mmm/yyyy)	DATE OF REPORT (dd/mmm/yyyy)	VENDOR NUMBER
INVOICE/REFERENCE NUMBER	PAYEE NAME		
PAYEE ADDRESS			
PAYEE ADDRESS			

CLIENT INFORMATION			
FIRST NAME	LAST NAME	DATE OF BIRTH (dd/mmm/yyyy)	PERSONAL HEALTH NUMBER (PHN)

PRACTITIONER INFORMATION		
FIRST NAME	LAST NAME	PRACTITIONER NUMBER

Use the following legend when selecting a reason for 'Not applicable'

- 1 — No need to do this activity or the client derives no benefit from this activity
- 2 — Client did not normally perform this activity before the accident
- 3 — Activity not normally expected of a client of this age
- 4 — Need met by another agency/institution
- 5 — Needed assistance before the accident and no increase in need due to accident
- 6 — Need unrelated to the accident that appeared after the accident
- 7 — Other reason (specify)

Personal Care Assistance Assessment Report

Level 1 Activities — Home and community management	Check if applicable	Select reason if item is not applicable
1. Meal preparation — breakfast	Independent <input type="checkbox"/>	1 2 3 4 5 6 7 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
1.1. Access to and use of food and tools needed for meal preparation Comments:		Independent <input type="checkbox"/>
1.2. Preparation of food Comments:		Independent <input type="checkbox"/>

1.3. Table set-up Comments:		Independent <input type="checkbox"/>								
1.4. Clean-up Comments:		Independent <input type="checkbox"/>								
1.5. Other Comments:										
2. Meal preparation – lunch		Independent <input type="checkbox"/>		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
2.1. Access to and use of food and tools needed for meal preparation Comments:		Independent <input type="checkbox"/>								
2.2. Preparation of food Comments:		Independent <input type="checkbox"/>								
2.3. Table set-up Comments:		Independent <input type="checkbox"/>								
2.4. Clean-up Comments:		Independent <input type="checkbox"/>								

2.5. Other Comments:													
3. Meal preparation — dinner						Independent <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
3.1. Access to and use of food and tools needed for meal preparation Comments:								Independent <input type="checkbox"/>					
3.2. Preparation of food Comments:								Independent <input type="checkbox"/>					
3.3. Table set-up Comments:								Independent <input type="checkbox"/>					
3.4. Clean-up Comments:								Independent <input type="checkbox"/>					
3.5. Other Comments:													

4. Light housekeeping	Independent <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
4.1. Dusting Comments:	Independent <input type="checkbox"/>							
4.2. Sweeping Comments:	Independent <input type="checkbox"/>							
4.3. General tidying of house Comments:	Independent <input type="checkbox"/>							
4.4. Other Comments:								
5. Heavy housekeeping	Independent <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
5.1. Vacuuming Comments:	Independent <input type="checkbox"/>							
5.2. Making the bed Comments:	Independent <input type="checkbox"/>							
5.3. Washing floors Comments:	Independent <input type="checkbox"/>							

5.4. Garbage disposal Comments:		Independent <input type="checkbox"/>						
5.5. Cleaning appliances/bathroom(s) Comments:		Independent <input type="checkbox"/>						
5.6. Other Comments:								
6. Laundry		Independent <input type="checkbox"/>		1 2 3 4 5 6 7 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				
6.1. Access laundry area Comments:		Independent <input type="checkbox"/>						
6.2. Carry basket of clothes Comments:		Independent <input type="checkbox"/>						
6.3. Transfer of laundry Comments:		Independent <input type="checkbox"/>						
6.4. Ironing Comments:		Independent <input type="checkbox"/>						

6.5. Folding Comments:		Independent <input type="checkbox"/>							
6.6. Other Comments:									
7. Yard work		Independent <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
7.1. Raking leaves Comments:		Independent <input type="checkbox"/>							
7.2. Mowing lawn Comments:		Independent <input type="checkbox"/>							
7.3. Cleaning eaves troughs Comments:		Independent <input type="checkbox"/>							
7.4. Snow removal Comments:		Independent <input type="checkbox"/>							
7.5. Other Comments:									

8. Shopping for personal needs	Independent <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
8.1. Store access Comments:		Independent <input type="checkbox"/>						
8.2. Carrying items Comments:		Independent <input type="checkbox"/>						
8.3. Paying for items Comments:		Independent <input type="checkbox"/>						
8.4. Other Comments:								
9. Using private or public transportation other than transfers	Independent <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
9.1. Assistance required to complete activity Comments:		Independent <input type="checkbox"/>						
9.2. Other Comments:								

10. Undertake community outings	Independent <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
10.1. Specify what public services and neighborhood shopping, medical and personal care facilities the client makes use of Comments:	Independent <input type="checkbox"/>							
10.2. Assistance required to complete activity Comments:	Independent <input type="checkbox"/>							
10.3. Other Comments:								
11. Managing personal finances, or personal medication, or both	Independent <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
11.1. Manage personal finances Comments:	Independent <input type="checkbox"/>							
11.2. Manage personal medication Comments:	Independent <input type="checkbox"/>							
11.3. Other Comments:								

Level 2 Activities — Mobility and self-care														
12. Transferring to and from bed						Independent <input type="checkbox"/>		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
12.1. Transfer in and out of bed Comments:						Independent <input type="checkbox"/>								
12.2. Other Comments:														
13. Adjusting or maintaining body position in bed						Independent <input type="checkbox"/>		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
13.1. Adjust body position Comments:						Independent <input type="checkbox"/>								
13.2. Raise self in bed from lying to sitting Comments:						Independent <input type="checkbox"/>								
13.3. Other Comments:														
14. Transfers: Vehicle						Independent <input type="checkbox"/>		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
14.1. Transfer in and out of vehicle Comments:						Independent <input type="checkbox"/>								

14.2. Storage of mobility aid Comments:		Independent <input type="checkbox"/>							
14.3. Use of seatbelt Comments:		Independent <input type="checkbox"/>							
14.4. State use of any specialized transportation service Comments:		Independent <input type="checkbox"/>							
14.5. Other Comments:									
15. Transfers: Two person or lift		Independent <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
15.1. State type of lift used with client Comments:		Independent <input type="checkbox"/>							
15.2. Other Comments:									
16. Home access		Independent <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
16.1. Use of equipment Comments:		Independent <input type="checkbox"/>							

16.2. General mobility Comments:		Independent <input type="checkbox"/>						
16.3. Ascend/descend outdoor stairs or a ramp into the home Comments:		Independent <input type="checkbox"/>						
16.4. Other Comments:								
17. Stair use		Independent <input type="checkbox"/>		1 2 3 4 5 6 7 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				
17.1. Ascend/descend indoor stairs in the client's home Comments:		Independent <input type="checkbox"/>						
17.2. Other Comments:								
18. Eating/drinking		Independent <input type="checkbox"/>		1 2 3 4 5 6 7 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				
18.1. Use of utensils Comments:		Independent <input type="checkbox"/>						
18.2. Drink to mouth Comments:		Independent <input type="checkbox"/>						

18.3. Special equipment Comments:		Independent <input type="checkbox"/>							
18.4. Other Comments:									
19. Grooming/hygiene		Independent <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
19.1. Oral care Comments:		Independent <input type="checkbox"/>							
19.2. Shaving Comments:		Independent <input type="checkbox"/>							
19.3. Hair grooming Comments:		Independent <input type="checkbox"/>							
19.4. Nail (finger/toe) care Comments:		Independent <input type="checkbox"/>							
19.5. Washing hands/face Comments:		Independent <input type="checkbox"/>							

19.6. Applying make-up Comments:		Independent <input type="checkbox"/>								
19.7. Other Comments:										
20. Dressing/undressing		Independent <input type="checkbox"/>		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
20.1. Set-up Comments:		Independent <input type="checkbox"/>								
20.2. Lower body Comments:		Independent <input type="checkbox"/>								
20.3. Upper body Comments:		Independent <input type="checkbox"/>								
20.4. Fasteners, buttons, zippers Comments:		Independent <input type="checkbox"/>								
20.5. Other Comments:										

21. Orthosis/prosthesis	Independent <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
21.1. State type of orthosis/prosthesis devices Comments:		Independent <input type="checkbox"/>						
21.2. Other Comments:								
22. Bathing/showering	Independent <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
22.1. Set-up Comments:		Independent <input type="checkbox"/>						
22.2. Transfer in/out of tub or shower Comments:		Independent <input type="checkbox"/>						
22.3. Washing and rinsing Comments:		Independent <input type="checkbox"/>						
22.4. Drying Comments:		Independent <input type="checkbox"/>						
22.5. Other Comments:								

23. Toileting		Independent <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
23.1. Transfer on/off toilet Comments:			Independent <input type="checkbox"/>						
23.2. Genital/perineal hygiene Comments:			Independent <input type="checkbox"/>						
23.3. Use of special devices Comments:			Independent <input type="checkbox"/>						
23.4. Other Comments:									
Level 3 Activities – Bowel and bladder care									
24. Incontinence garment, catheter, disimpaction									
a. Does the client require an incontinence garment? If yes, is the client independent?			<input type="checkbox"/> Yes <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> No				
b. Does the client require a catheter? If yes, is the client independent?			<input type="checkbox"/> Yes <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> No				
c. Does the client require bowel disimpaction? If yes, is the client independent?			<input type="checkbox"/> Yes <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> No				
25. Supervision		Independent <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
25.1. Supervision Comments:			Independent <input type="checkbox"/>						

Personal Care Assistance Assessment Report – Scoring Sheet

Section 1 – Personal Care Activities	Personal Care Activities Scoring Sheet					
Level 1 Activities – Home and community management	N/A	Class 1	Class 2	Class 3	Class 4	Enter Score
1. Meal preparation – breakfast	0	1	2	3	4	
2. Meal preparation – lunch	0	1.5	3	4.5	6	
3. Meal preparation – dinner	0	2	4	6	8	
4. Light housekeeping	0	3			6	
5. Heavy housekeeping	0	0			3	
6. Laundry	0	1			2	
7. Yard work	0	0			3	
8. Shopping for personal needs	0	0			1	
9. Using private or public transportation other than transfers	0	0			1	
10. Undertake community outings	0	0			1	
11. Managing personal finances, or personal medication, or both	0	0			1	
	Total Score for Level 1 (Line 101)					
Section 1 – Personal Care Activities	Personal Care Activities Scoring Sheet					
Level 2 Activities – Mobility and self-care	N/A	Class 1	Class 2	Class 3	Class 4	Enter Score
12. Transferring to and from bed	0	1.5			3	
13. Adjusting and maintaining position in bed	0	1.5			3	
14. Transfers – Vehicle	0	2			4	
15. Transfers – Two person or lift	0	0			6	
16. Home access	0	4			7	
17. Stair use	0	1.5			3	
18. Eating/drinking	0	4			16	
19. Grooming/hygiene	0	2			3	
20. Dressing/undressing	0	1.5	3	4.5	6	
21. Orthosis/prosthesis	0	2			3	
22. Bathing/showering	0	2	4	6	8	
23. Toileting	0	6			12	
	Total Score for Level 2 (Line 102)					
Level 3 Activities – Bowel and bladder care	N/A	Class 1	Class 2	Class 3	Class 4	Enter Score
24. Incontinence garment, catheter, disimpaction	0	8			16	

Section 2 – Supervision Requirements	Score	Enter Score
25. Supervision	Average number of hours per day ____ x 12 =	
	Total Score for Supervision (Line 104)	

Personal Care Assistance Activity	Enter the Total Score for each Section	Multiply by Weighting Factor	Calculate and enter each Weighted Score
Section 1 — Level 1 Activities — Home and community management	Line 101	x 1.00 =	Line 106
Section 1 — Level 2 Activities — Self-care and mobility	Line 102	x 1.05 =	Line 107
Section 1 — Level 3 Activities — Bowel and bladder care	Line 103	x 2.54 =	Line 108
Section 2 — Supervision requirements	Line 104	x 1.00 =	Line 109
Calculate and enter the Total Score (Line 101 + Line 102 + Line 103 + Line 104)	Line 105		
If the Total Score (Line 105) is below 9 then client does not qualify and no further calculation is required			
If the Total Score (Line 105) is 9 or above then continue with the calculations below			
Calculate and enter the Total Weighted Score (Line 106 + Line 107 + Line 108 + Line 109)			Line 110

I certify that: (click box)

- ☐ When submitting a medical report, all information is accurate and complete based on all available information, treatments, and assessments performed.
Providing false or misleading information may result in the cancellation of your vendor number, and ICBC may seek financial restitution and/or take legal action.

Select one of the following:

- ☐ I have obtained consent from the client to share all information related to the history, examination, assessment and management of the injury related to the motor vehicle accident with ICBC.
- ☐ This report is being provided pursuant to a request by ICBC under Section 28 or Section 28.1 of the *Insurance (Vehicle) Act*.

HEALTHCARE PROVIDER SIGNATURE

DATE

Please send a copy of this completed form to my attention at your earliest convenience. Thank you for your anticipated cooperation regarding this matter.

Personal information on this form is being collected under Section 26 of the *Freedom of Information and Protection of Privacy Act* (BC) and section 28 or 28.1 of the *Insurance Vehicle Act* (BC) for the purpose of obtaining a health care report in order to manage the claim. Questions about the collection of this information may be directed to the claim representative, or call 604-661-2800 or contact the Privacy & Freedom of Information department at 151 Esplanade, North Vancouver, BC V7M 3H9.



Personal Care Assistance Assessment Report — Addendum

This addendum form must be completed in addition to the Personal Care Assistance Assessment Report.

Personal Care Assistance Services Recommendations

Service item	Recommend hours (Note: Recommended hours are subject to ICBC funding authorization and should not be communicated to the client prior to such authorization)		
Total Homemaking	visits/week	hours/visit	weeks
Total Attendant Care	visits/week	hours/visit	weeks
Services required (select all that apply)			
Level 1 Activities — Home and community management			
<input type="checkbox"/> Meal preparation			
<input type="checkbox"/> Shopping for personal needs			
<input type="checkbox"/> Light housekeeping			
<input type="checkbox"/> Using private or public transportation (excluding transfers)			
<input type="checkbox"/> Heavy housekeeping			
<input type="checkbox"/> Undertaking community outings			
<input type="checkbox"/> Laundry			
<input type="checkbox"/> Managing personal finances, or personal medication, or both			
<input type="checkbox"/> Yard work			
Level 2 Activities — Mobility and self-care			
<input type="checkbox"/> Transferring to and from bed			
<input type="checkbox"/> Eating/drinking			
<input type="checkbox"/> Adjusting and maintaining position in bed			
<input type="checkbox"/> Grooming/hygiene			
<input type="checkbox"/> Vehicle transfers			
<input type="checkbox"/> Dressing/undressing			
<input type="checkbox"/> Two person transfers			
<input type="checkbox"/> Donning/doffing orthosis/prosthesis			
<input type="checkbox"/> Home access			
<input type="checkbox"/> Bathing/showering			
<input type="checkbox"/> Stair use			
<input type="checkbox"/> Toileting			
Level 3 Activities — Bowel and bladder care			
<input type="checkbox"/> Incontinence garment, catheter, disimpaction			

Additional Comments/Recommendations (Optional)

Additional comments or recommendations for personal care assistance services, as applicable (e.g. Does the customer require nursing services)

Communication Request (Optional)

Do you wish to have a phone consult with the claim file handler?

☐ Yes ☐ No

Note: for urgent customer needs impacting customer safety, please contact the claim file handler directly.

If Yes, specify purpose of phone consult (contingent on the nature of the discussion, this communication may be billable; refer to the Occupational Therapy Performance Standards. Note that communication for the purpose of administrative correspondence is not funded):