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** ☐	**1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐
1.1. Access to and use of food and tools needed for meal preparation Comments:		**Independent** ☐
1.2. Preparation of food Comments:		**Independent** ☐

1.3. Table set-up Comments:	**Independent** ☐
1.4. Clean-up Comments:	**Independent** ☐
1.5. Other Comments:	

2. Meal preparation — lunch	**Independent** ☐	**1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐
2.1. Access to and use of food and tools needed for meal preparation Comments:		**Independent** ☐
2.2. Preparation of food Comments:		**Independent** ☐
2.3. Table set-up Comments:		**Independent** ☐
2.4. Clean-up Comments:		**Independent** ☐

2.5. Other

Comments:

3. Meal preparation — dinner	**Independent** ☐	**1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐
3.1. Access to and use of food and tools needed for meal preparation Comments:		**Independent** ☐
3.2. Preparation of food Comments:		**Independent** ☐
3.3. Table set-up Comments:		**Independent** ☐
3.4. Clean-up Comments:		**Independent** ☐

3.5. Other

Comments:

4. Light housekeeping	Independent ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐
4.1. Dusting Comments:		**Independent** ☐
4.2. Sweeping Comments:		**Independent** ☐
4.3. General tidying of house Comments:		**Independent** ☐
4.4. Other Comments:		

5. Heavy housekeeping	Independent ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐
5.1. Vacuuming Comments:		**Independent** ☐
5.2. Making the bed Comments:		**Independent** ☐
5.3. Washing floors Comments:		**Independent** ☐

5.4. Garbage disposal

Comments:

Independent ☐

5.5. Cleaning appliances/bathroom(s)

Comments:

Independent ☐

5.6. Other

Comments:

6. Laundry

Independent ☐

1 ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐

6.1. Access laundry area

Comments:

Independent ☐

6.2. Carry basket of clothes

Comments:

Independent ☐

6.3. Transfer of laundry

Comments:

Independent ☐

6.4. Ironing

Comments:

Independent ☐

6.5. Folding Comments:	**Independent** ☐
6.6. Other Comments:	

7. Yard work	**Independent** ☐	**1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐
7.1. Raking leaves Comments:		**Independent** ☐
7.2. Mowing lawn Comments:		**Independent** ☐
7.3. Cleaning eaves troughs Comments:		**Independent** ☐
7.4. Snow removal Comments:		**Independent** ☐
7.5. Other Comments:		

8. Shopping for personal needs	Independent ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐
8.1. Store access Comments:		**Independent** ☐
8.2. Carrying items Comments:		**Independent** ☐
8.3. Paying for items Comments:		**Independent** ☐
8.4. Other Comments:		

9. Using private or public transportation other than transfers	Independent ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐
9.1. Assistance required to complete activity Comments:		**Independent** ☐
9.2. Other Comments:		

10. Undertake community outings	Independent ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐
10.1. Specify what public services and neighborhood shopping, medical and personal care facilities the client makes use of Comments:		**Independent** ☐
10.2. Assistance required to complete activity Comments:		**Independent** ☐
10.3. Other Comments:		

11. Managing personal finances, or personal medication, or both	Independent ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐
11.1. Manage personal finances Comments:		**Independent** ☐
11.2. Manage personal medication Comments:		**Independent** ☐
11.3. Other Comments:		

Level 2 Activities — Mobility and self-care

12. Transferring to and from bed

Independent ☐

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐

12.1. Transfer in and out of bed

Comments:

Independent ☐

12.2. Other

Comments:

13. Adjusting or maintaining body position in bed

Independent ☐

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐

13.1. Adjust body position

Comments:

Independent ☐

13.2. Raise self in bed from lying to sitting

Comments:

Independent ☐

13.3. Other

Comments:

14. Transfers: Vehicle

Independent ☐

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐

14.1. Transfer in and out of vehicle

Comments:

Independent ☐

14.2. Storage of mobility aid

Comments:

Independent ☐

14.3. Use of seatbelt

Comments:

Independent ☐

14.4. State use of any specialized transportation service

Comments:

Independent ☐

14.5. Other

Comments:

15. Transfers: Two person or lift

Independent ☐

1 ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐

15.1. State type of lift used with client

Comments:

Independent ☐

15.2. Other

Comments:

16. Home access

Independent ☐

1 ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐

16.1. Use of equipment

Comments:

Independent ☐

16.2. General mobility

Comments:

Independent ☐

16.3. Ascend/descend outdoor stairs or a ramp into the home

Comments:

Independent ☐

16.4. Other

Comments:

17. Stair use

Independent ☐

1 ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐

17.1. Ascend/descend indoor stairs in the client's home

Comments:

Independent ☐

17.2. Other

Comments:

18. Eating/drinking

Independent ☐

1 ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐

18.1. Use of utensils

Comments:

Independent ☐

18.2. Drink to mouth

Comments:

Independent ☐

18.3. Special equipment

Comments:

Independent ☐

18.4. Other

Comments:

19. Grooming/hygiene	**Independent** ☐	**1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐

19.1. Oral care

Comments:

Independent ☐

19.2. Shaving

Comments:

Independent ☐

19.3. Hair grooming

Comments:

Independent ☐

19.4. Nail (finger/toe) care

Comments:

Independent ☐

19.5. Washing hands/face

Comments:

Independent ☐

19.6. Applying make-up Comments:	**Independent** ☐
19.7. Other Comments:	

20. Dressing/undressing	**Independent** ☐	**1 2 3 4 5 6 7** ☐ ☐ ☐ ☐ ☐ ☐ ☐
20.1. Set-up Comments:		**Independent** ☐
20.2. Lower body Comments:		**Independent** ☐
20.3. Upper body Comments:		**Independent** ☐
20.4. Fasteners, buttons, zippers Comments:		**Independent** ☐
20.5. Other Comments:		

21. Orthosis/prosthesis	Independent ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐
21.1. State type of orthosis/prosthesis devices Comments:		**Independent** ☐
21.2. Other Comments:		

22. Bathing/showering	Independent ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐
22.1. Set-up Comments:		**Independent** ☐
22.2. Transfer in/out of tub or shower Comments:		**Independent** ☐
22.3. Washing and rinsing Comments:		**Independent** ☐
22.4. Drying Comments:		**Independent** ☐
22.5. Other Comments:		

23. Toileting	Independent ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐
23.1. Transfer on/off toilet Comments:		**Independent** ☐
23.2. Genital/perineal hygiene Comments:		**Independent** ☐
23.3. Use of special devices Comments:		**Independent** ☐
23.4. Other Comments:		

Level 3 Activities — Bowel and bladder care

24. Incontinence garment, catheter, disimpaction

a. Does the client require an incontinence garment?	☐ Yes	☐ No
If yes, is the client independent?	☐ Yes	☐ No
b. Does the client require a catheter?	☐ Yes	☐ No
If yes, is the client independent?	☐ Yes	☐ No
c. Does the client require bowel disimpaction?	☐ Yes	☐ No
If yes, is the client independent?	☐ Yes	☐ No

25. Supervision	Independent ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐
25.1. Supervision Comments:		**Independent** ☐

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)*	**0.0**

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)*	**0.0**

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	
						0

Section 2 – Supervision Requirements	Score	Enter Score
25. Supervision	Average number of hours per day ___ x 12 =	
	Total Score for Supervision *(Line 104)*	**0**

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* **0.0**	**x 1.00 =**	*Line 106* **0.00**
Section 1 — Level 2 Activities — Self-care and mobility	*Line 102* **0.0**	**x 1.05 =**	*Line 107* **0.00**
Section 1 — Level 3 Activities — Bowel and bladder care	*Line 103* **0**	**x 2.54 =**	*Line 108* **0.00**
Section 2 — Supervision requirements	*Line 104* **0**	**x 1.00 =**	*Line 109* **0.00**
Calculate and enter the **Total Score** *(Line 101 + Line 102 + Line 103 + Line 104)*	*Line 105* **0.0**		
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

- ☐ Meal preparation
- ☐ Light housekeeping
- ☐ Heavy housekeeping
- ☐ Laundry
- ☐ Yard work
- ☐ Shopping for personal needs
- ☐ Using private or public transportation (excluding transfers)
- ☐ Undertaking community outings
- ☐ Managing personal finances, or personal medication, or both

Level 2 Activities — Mobility and self-care

- ☐ Transferring to and from bed
- ☐ Adjusting and maintaining position in bed
- ☐ Vehicle transfers
- ☐ Two person transfers
- ☐ Home access
- ☐ Stair use
- ☐ Eating/drinking
- ☐ Grooming/hygiene
- ☐ Dressing/undressing
- ☐ Donning/doffing orthosis/prosthesis
- ☐ Bathing/showering
- ☐ Toileting

Level 3 Activities — Bowel and bladder care

- ☐ 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):