Canada-New Brunswick Integrated Student Financial Assistance Program

Medical Assessment Form

Purpose of this form

This form is used to collect information about your disability, including documentation from a qualified medical assessor (physician or other regulated health care professional). This information is used to verify your status as a person with a permanent disability for student financial assistance purposes.

If approved, you may receive additional disability-related funding through the Canada Student Grant for Students with Permanent Disabilities. You may also qualify for other funding through the Canada Student Grant for Services and Equipment for Students with Permanent Disabilities. This program, which requires a separate application, helps students with the costs of their disability-related educational services and equipment, such as note-takers, tutors, or technical aids. A copy of the application is available at studentaid.gnb.ca.

*A **permanent disability**, for the purpose of student financial assistance, is a functional limitation caused by a physical or mental impairment that restricts the ability of a person to perform the daily activities necessary to participate in studies at a post-secondary school level or the labour force and is expected to remain with the person for the person's expected life.*

Note: Not all medical conditions are considered permanent disabilities for the purpose of permanent disability program funding.

How to complete this form

There are two parts to this form: Section A and Section B.

- Fill out Section A, including the declaration and consent that you must sign and date; and
- Have Section B completed by a qualified medical assessor. The appropriate, qualified health care professional for each type of disability is specified in Section B.

Normally, you are only required to have this form completed once. Fees that you may be charged to have this form completed are your responsibility and will not be reimbursed by Student Financial Services.

Students with Learning Disabilities

Students applying for permanent disability grant funding on the basis of a learning disability must have a psychoeducational assessment completed by a registered psychologist. For the purpose of this application, your psychoeducational assessment must have been completed within five years of the date of your application or at the age of 18 or older. You are not required to have Section B of this form completed by a medical assessor. You will need to complete Section A of this form and attach a copy of the psychoeducational assessment.

Deadline to Submit this Form

The completed form and all supporting documentation should be submitted as early as possible; however, it must be received by Student Financial Services no later than six weeks before the end of your study period as funds cannot be released after your period of study end date.

Your student financial assistance application will not be processed until all documentation has been received. You must have your educational institution complete a separate Request for Program Information form if you are applying for full time studies as a student with a permanent disability.

If you are experiencing difficulties in obtaining the required documentation, please contact Student Financial Services at 1-800-667-5626.

Completed forms and supporting documentation can be submitted electronically by visiting studentaid.gnb.ca and selecting *Upload a Document*. All forms and documentation can also be sent by fax or mailed to Student Financial Services.

Contact Information

STUDENT FINANCIAL SERVICES

Mailing Address:	Student Financial Services Post-Secondary Education, Training and Labour Beaverbrook Building, P.O. Box 6000 Fredericton, New Brunswick E3B 5H1
Fax:	506-444-4333
Telephone:	1-800-667-5626 506-453-2577
Hours:	8:00 a.m. to 7:30 p.m. Monday to Friday 9:00 a.m. to 1:00 p.m. Saturday
Website:	studentaid.gnb.ca

SECTION A – TO BE COMPLETED BY ALL APPLICANTS

Part 1: Applicant Information

Social Insurance Number (SIN): _____

Date of Birth (yyyy/mm/dd): _____

_____

Legal First Name Legal Last Name Middle Initial

Mailing Address

_____

Street Address/P.O. Box Apartment No. City/Town

_____

Province/Territory Country (other than Canada) Postal Code

Area Code and Telephone No.: _____

Program Information

Name of Post-Secondary Educational Institution: _____

Name of Program: _____

Program Start Date (yyyy-mm): _____

Please check the appropriate box:

☐ This is my first time applying as a student with a permanent disability.

☐ I was denied on a previous application and am now providing additional information or my situation has changed.

Part 2: Applicant's Statement of Limitations and Restrictions

Please explain how you will be restricted and/or experience a barrier in your ability to perform the daily activities to participate in studies at the post-secondary level. Please print clearly if completing by hand.

Part 3: Applicant's Declaration and Consent

To be completed by all applicants.

I understand that this form is part of my application for student financial assistance and as such includes all the terms and conditions as stated in the full time or part-time student financial assistance application.

In addition to the terms and conditions stated in the full time or part time student financial assistance application, I also understand that:

I certify that the information provided on this form is accurate and complete, to the best of my knowledge. I understand that it is an offence to make a false or misleading statement.

I authorize the physician or other regulated health care professional who has completed Section B of this form to provide the requested personal health information to the Department of Post-Secondary Education, Training and Labour (the Department) and, if required by the Department, to provide additional personal health information relating to my disability or disability-related needs.

I authorize the Department to contact the physician or other regulated health care professional if the personal health information provided by him or her is not clear or is illegible. This authorization is limited and does not extend to allow the Department to gather any personal health information from my physician or other regulated health care professional that is not related to this form or any related documentation that I have submitted.

I understand that information I provide, including the personal health information provided by my physician or other regulated health care professional, may be verified and audited.

INFORMATION CONSENT

Personal information is collected and used for the administration of the Canada Student Financial Assistance Program under the authority of the *Canada Student Financial Assistance Act* (CSFAA) and the *Canada Student Loans Act* (CSLA). Information about you under the control of Canada will be administered in accordance with the *Privacy Act* (Canada).

Under the authority of the *Post-Secondary Student Financial Assistance Act*, 2007, c.P-9.315, the Department collects, accesses, uses, discloses and protects information provided by you in accordance with section 46(1) of the *Right to Information and Protection of Privacy Act*, SNB 2009, c. R-10.6 (RTIPPA); section 37(1) of the Personal Health Information Protection and Access Act, SNB 2009, c. P-7.05 (PHIPAA); and the Department's *Document and Record Management Policy* for the purposes of administrating programs and services.

THIS IS A TWO PAGE DECLARATION AND CONSENT
PLEASE INITIAL TO ACKNOWLEDGE THAT YOU HAVE READ THIS FIRST PAGE _____

I consent to the Department collecting only as much personal information as is reasonably necessary and using my information for the following purposes:

- processing my application for student financial assistance;
- determining and verifying my eligibility for student financial assistance;
- administering any student financial assistance provided to me, including the repayment and collection thereof;
- conducting research and evaluation of the Student Financial Assistance Program(s);
- carrying out their powers and duties in accordance with the *Post-Secondary Student Financial Assistance Act* and the regulations thereunder;
- the administration and enforcement of the *Post-Secondary Student Financial Assistance Act* and the regulations thereunder;
- confirming the accuracy of my identification in the context of my application for federal and provincial student financial assistance.

I understand that in order to accomplish these purposes, my information may need to be shared. I hereby consent to the Department exchanging any personal information about me collected in relation to my application for financial assistance, with any department of the Province of New Brunswick, the government of any other province or territory of Canada, the Government of Canada, service provider(s), educational institution(s), financial institution(s), and other agencies and persons.

I understand that I can cancel my consent in writing at any time and in doing so I understand that I will no longer be able to participate in the program because of its administrative requirements and the requirements established by the *Canada-New Brunswick Student Loan Program Integration Agreement* and in accordance with the RTIPPA.

If you have any questions regarding how your personal information is collected or used, you may contact the Program Liaison and Quality Assurance Manager at 506-453-2713.

I have read the above information in its entirety. I acknowledge that this authorization is valid for the duration of the program(s) or service(s) and the monitoring associated with it.

X _____ _____

Signature of Applicant | Date

Are you applying as a student with a **Learning Disability ONLY**? ☐ Yes ☐ No

If Yes:
- complete and submit only **Section A of this form; and**
- submit confirmation of your learning disability in the form of a copy of your psychoeducational assessment (completed within 5 years of your application for financial assistance or at the age of 18 or older) that confirms a learning disability and lists barriers.

If No:
- have a qualified medical assessor complete Section B.

SECTION B – VERIFICATION OF PERMANENT DISABILITY

To be completed by the qualified medical assessor as specified.

This form will be used to determine your patient's eligibility for student financial assistance for students with permanent disabilities. Eligibility for funding is based on the permanence of the patient's disability and the daily functional impact(s) of the disability on their ability to participate in a post-secondary educational environment.

Please print clearly and fully answer all questions below with information about your patient's functional limitations. Forms that are incomplete or do not provide enough information will result in denial or delays in funding. If you require extra space, please attach a letter with the additional information. Note that the patient is responsible for any fees incurred to complete this form.

Patient's Full Name: _____

Patient's Date of Birth (yyyy/mm/dd): _____

A ***permanent disability***, for the purpose of student financial assistance, is a functional limitation caused by a physical or mental impairment that restricts the ability of a person to perform the daily activities necessary to participate in studies at a post-secondary school level or the labour force and is expected to remain with the person for the person's expected life.

How long has this person been in your care for this disability? _____

Is the disability permanent, as defined above? ☐ Yes ☐ No

Date of onset of disability (if known): _____

Severity and Prognosis

Explain the severity and prognosis of the medical diagnosis:

Severity
Prognosis

Type of Disability (check all that apply)

☐ **Mobility/Agility Impairment**

Form to be completed by a Physician or Nurse Practitioner.

☐ **Visual Impairment**

Form to be completed by an Ophthalmologist or Optometrist.

- ☐ A visual acuity of 6/21 (20/70) or less in the better eye after correction
- ☐ A visual field or 20 degrees or less
- ☐ Any progressive eye disease with a prognosis of becoming one of the above in the next two years
- ☐ Near point vision for print reading of _____

☐ **Hearing Impairment**

Form to be completed by a Certified Audiologist.

Level of hearing loss in the better ear (Check the appropriate boxes)

☐ Mild ☐ Moderate ☐ Severe ☐ Profound

- ☐ Hearing loss interferes with patient's learning
- ☐ Uses hearing aids
- ☐ Would benefit from amplification devices in an educational/vocational setting

☐ **Speech Impairment**

Form to be completed by a Speech Language Pathologist.

☐ **Attention Deficit Disorder (ADD) / Attention Deficit Hyperactivity Disorder (ADHD)**

Form to be completed by a Psychologist, Physician or Nurse Practitioner.

☐ **Pervasive Developmental Disorder** (Autism)

Form to be completed by a Physician, Nurse Practitioner or Psychologist.

☐ **Psychiatric or Psychological**

Form to be completed by a Clinical Psychologist, Psychiatrist, Physician or Nurse Practitioner.

☐ **Cognitive Impairment** (ex: Acquired Brain Injury)

Form to be completed by a Physician or Nurse Practitioner.

☐ **Other Permanent Disability** (specify)

Disability Impacts on Daily Functioning (as it relates to an educational setting)

☐ **Physical Impacts** (Check all that apply)

- ☐ Standing
- ☐ Sitting
- ☐ Ambulation (cane, wheelchair, walker, crutches)
- ☐ Fatigue
- ☐ Stair Climbing
- ☐ Lifting/Carrying/Reaching
- ☐ Handwriting
- ☐ Keyboarding
- ☐ Grasping/Gripping/Dexterity
- ☐ Other (specify) _____

Description of daily activities needed for post-secondary studies that are restricted as a result of the patient's disability. Indicate limitations, frequency and level of severity.

☐ **Cognitive and/or Behavioural Impacts** (Check all that apply)

- ☐ Attention and Concentration
- ☐ Information Processing (verbal and written)
- ☐ Stress Management
- ☐ Organization and Time Management
- ☐ Memory
- ☐ Social Interactions
- ☐ Fatigue
- ☐ Communication
- ☐ Other (specify) _____

Description of daily activities needed for post-secondary studies that are restricted as a result of the patient's disability. Indicate limitations, frequency and level of severity.

Suggested Supports (must be related to permanent disability in an educational setting)

☐ This person would benefit from taking a reduced course load.

☐ Services: The person would benefit from specialized services such as tutoring, note-taking, sign language interpreting, oral interpreting, classroom captioning, alternate formats in order to fully participate in post-secondary studies. **Please specify**:

☐ Equipment: The person would benefit from assistive technology or equipment such as a computer or laptop, digital recorder, FM system, braille reader, specialized software in order to fully participate in post-secondary studies. **Please specify**:

Medical Assessor Information

Name of Qualified Medical Assessor: _____

Specialty of Qualified Medical Assessor: _____

Address: _____

Telephone Number: _____

Registration I.D.: _____

Practitioner Stamp:

I certify that the information provided is, to the best of my knowledge, accurate and complete and I understand that this information will be used to determine if my patient is eligible for student financial assistance programs for students with permanent disabilities.

X _____ _____

Signature of Medical Assessor Date (yyyy/mm/dd)