This page is for information. Do not submit.

AISH Application - Part B
Medical Report

Information for Physicians

Your patient (the applicant) is applying for the Assured Income for the Severely Handicapped (AISH) program. AISH provides financial and health benefits to eligible adult Albertans with a permanent medical condition that prevents them from earning a living.

AISH has sole responsibility for determining whether an applicant meets medical, financial, age, and residency eligibility criteria for the program. We consider the information you and the applicant provide to understand how their medical condition impacts their ability to earn a living.

As a physician registered to practice in Alberta, your role is to complete the AISH Application Part B - Medical Report and provide supporting documentation to give a thorough and accurate picture of the applicant's:

- medical condition
- level of physical, mental, and cognitive functioning
- limitations on capacity to function
- prognosis.

Use the checklist and reference information on the next page to complete the AISH Application - Part B Medical Report.

Getting Consent

When completing the AISH Application - Part B Medical Report, you as a custodian under the *Health Information Act* (HIA), are responsible for obtaining your patient's consent to disclose their health information in accordance with the HIA.

For information about how to obtain a valid consent, please contact the HIA Help Desk using the contact information provided at: www.alberta.ca/health-information-act.aspx

The AISH Application Part B - Medical Report and supporting medical information you provide will be used by the Government of Alberta to administer AISH program eligibility and benefits, as well as other government benefits. The AISH Application Part B - Medical Report may be shared, in accordance with the *Freedom of Information and Protection of Privacy Act*, with:

- the applicant
- a medical consultant or psychological consultant on contract with the ministry of Community and Social Services
- the Canada Pension Plan Disability program, to help determine the applicant's medical eligibility for that program
- an AISH Appeal Panel in any appeal regarding the applicant's medical eligibility.

Receiving Payment

The applicant is responsible for paying you to complete the AISH Application - Part B Medical Report. The fee for service consists of the equivalent to the Alberta Health Schedule of Medical Benefits, Code 03.04A (or equivalent specialty code) for the examination, plus a fee agreed to by the Alberta Medical Association for report completion.

The Government of Alberta may cover costs to for you to complete and provide copies of the Part B - Medical Report for applicants who are receiving Income Support. When the Alberta government agrees to assume this cost, you will receive an expense approval letter directly from the Income Support program or the applicant will give it to you.

If the applicant needs more information, they can call the Alberta Supports Contact Centre at 1-877-644-9992, from 7:30 a.m. to 8:00 p.m. every Monday to Friday, except statutory holidays.

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Checklist for completing the AISH Application Part B - Medical Report

- ☐ Follow the step-by-step instructions in the Physicians' Guide to Completing the AISH Application (Physicians' Guide) available at www.alberta.ca/aish-how-to-apply.aspx, or refer to the Physicians' Guide quick reference below.
- ☐ Complete the AISH Application Part B - Medical Report yourself or with assistance from nurse practitioners, specialists and/or other allied medical professionals.
- ☐ Write legibly in blue or black ink if completing by hand.
- ☐ Complete each section of the AISH Application Part B - Medical Report or it may be returned.
- ☐ Use Section 9 or add pages if extra space is needed to answer questions or give more information.
- ☐ Attach medical reports, assessments and other documentation from you, your consulting specialists, and/or allied health practitioners that relate to the applicant's presenting condition(s), diagnosis(es), and impairments - do not send their entire medical record. It may be helpful to advise the applicant to also submit any supporting medical evidence they may have.
- ☐ Ensure a physician who is registered with the College of Physicians and Surgeons of Alberta approves and signs the completed AISH Application Part B - Medical Report or the application will not be processed.
- ☐ Make copies of the AISH Application Part B - Medical Report and supporting documents for your files.
- ☐ Submit the AISH Application Part B - Medical Report and supporting documents to AISH by:
  - mailing them to PO Box 17000 Station Main, Edmonton, AB, T5J 4B3; or
  - faxing them to 587-469-3006 (Edmonton Area) or 1-877-969-3006; or
  - submitting them online at https://aish-apply.alberta.ca; or
  - giving them to the applicant to submit to AISH.

Physicians' Guide Quick Reference

Section 1: Application Information - Physicians' Guide page 4.
Identify and confirm applicant's personal information.

Section 2: Relationship with Application - Physicians' Guide page 4.
Give information about you and your relationship with the applicant, and your history treating the medical condition(s) that relates to the AISH application.

Section 3: Diagnosis(es) - Physicians' Guide page 4.
Provide information about the medical condition(s) that is relevant to the AISH application.

Section 4: Medical History - Physicians' Guide page 5.
Give more detail about the applicant's medical history and supporting evidence for their medical and/or psychiatric condition(s) and diagnosis(es).

Section 5: Levels of Impairment - Physicians' Guide page 6.
Indicate the symptoms that cause impairment, causal relationships between symptoms and functional limitations, and levels of impairment the applicant may experience on a regular and ongoing basis.

Section 6: Medication - Physicians' Guide page 7.
Describe the applicant's medication history and how the medication(s) impact their functioning.

Section 7: Treatment - Physicians' Guide page 7.
Describe how the applicant's medical condition(s) has been impacted by past, current, and planned treatment(s). Or, indicate why no treatment(s) have been planned or tried.

Section 8: Prognosis - Physicians' Guide page 7.
Explain the duration and predictability of the applicant's medical condition(s) and related symptoms.

Section 9: Additional Comments/Information - Physicians' Guide page 8.
Provide relevant information that was not addressed in previous sections.

Section 10: Certification - Physicians' Guide page 8.
Ensure an Alberta-registered physician approves and signs this section or the application will not be processed.

Use the Physicians' Guide at alberta.ca/aish for more information.

To be completed by the Applicant's Physician

AISH Application - Part B
Medical Report

Note: The AISH Application Part B - Medical Report is an important document, but it is not the only factor in assessing AISH eligibility. Alberta Community and Social Services has the responsibility to determine eligibility after reviewing all pertinent circumstances.

Section 1 - Applicant Information

Last Name

First Name

Middle Name

Date of Birth: Year Month Day

Gender ◯ Male ◯ Female

Alberta Personal Health Number

Phone

Section 2 - Relationship with Applicant

1. Are you the: ◯ Physician ◯ Specialist

Identify specialty:

2. How long have you been treating the applicant?

3. When did you last treat the applicant? yyyy-mm-dd ____________________

4. On average, how often do you see the applicant?

◯ once per week ◯ 11-20 times per year ◯ 6-10 times per year ◯ 2-5 times per year ◯ once per year

◯ other (specify): ____________________

To be completed by the Applicant's Physician

Section 3 - Diagnosis(es)

Diagnosis(es) - Use chart below as a reference.

Medical / Psychiatric Condition(s)

1. Specify Diagnosis(es) and the AISH Medical Code(s) and/or DSM V Code(s).

		Date of Onset: yyyy-mm	AISH Medical or DSM Code
(i) Primary			
(ii) Secondary			
(iii) Tertiary			
Additional relevant diagnosis(es)			
Additional relevant diagnosis(es)			

2. Provide details about the diagnosis(es) (e.g. relevant etiology, classification, stage/grade/type of disease). Further detail can be provided in Section 9.

AISH Medical Codes - For Reference Only

Physical

Neurological Disorders

01 Multiple sclerosis
02 Cerebral palsy
03 Epilepsy
04 Parkinson's disease
05 Cerebrovascular disease *(stroke, cerebral aneurysm)*
13 Paraplegia
14 Quadriplegia
15 Other paralysis
16 Muscular dystrophy
20 Brain injury
32 Learning disability *(dyslexia, ADHD)*
33 Substance-related neurological disorders *(fetal alcohol syndrome)*
34 Dementia
35 Other neurological disorders

Multi-System Disorders

10 Cancer - malignant disease
18 AIDS *(includes HIV)*
36 Connective tissue disorders *(lupus, scleroderma)*
37 Other multi-system disorders

Cardiovascular Disorders

07 Cardiovascular disease *(heart disease, heart attack, pulmonary embolism)*

Respiratory Disorders

08 Respiratory disease *(COPD, asthma, sleep disorder)*

Muscular-Skeletal Disorders

09 Arthritis *(osteoarthritis, rheumatoid arthritis)*
11 Amputation
38 Fibromyalgia/CFS
39 Degenerative disc disease
40 Low back pain syndrome disorders
41 Spinal stenosis
42 Other muscular-skeletal disorders

Gastrointestinal Disorders

43 Crohn's disease
44 Irritable bowel syndrome
45 Ulcers
46 Liver disease *(cirrhosis, hepatitis)*
47 Other gastrointestinal disorders

Renal Disorders

17 Kidney disease
48 Chronic renal failure

Endocrinology Disorders

06 Cystic fibrosis
12 Diabetes
49 Obesity
50 Other endocrinology diseases

Sensory Disorders

21 Blindness
22 Visual impairment
23 Deafness
24 Hearing impairment
25 Other sensory disorders. Please specify.

Other Disorders

51 Organ transplant
19 Other physical

Mental Health

52 Psychosis/Schizophrenia
53 Affective disorder *(depression, bipolar, mania)*
54 Anxiety
55 Personality disorder
56 Substance use disorder *(alcohol, drugs)*
57 Post-traumatic stress disorder (PTSD)
58 Other mental illness

Cognitive / Developmental

27 Down syndrome
28 Mild developmental disability *(Wechsler I.Q. 50-55 to approx. 70)*
29 Moderate developmental disability *(Wechsler I.Q. 35-40 to 50-55)*
30 Severe/profound developmental disability *(Wechsler I.Q. 35-40 to below)*
31 Other developmental disability

To be completed by the Applicant's Physician

Section 4 - Medical History

1. Describe the medical history relevant to the condition(s)/diagnosis(es) identified in Section 3, including chronology of presenting symptoms and progression, if any.

2. For each of the diagnoses identified in Section 3, describe the symptoms causing impairment.

   Are documents supporting the above attached? ◯ Yes ◯ No

3. Has this person been referred for further medical assessment? ◯ Yes ◯ No

   If yes, list consultations and provide consultation reports.

Specialist Name	Specialty	Report Attached
		◯ Yes ◯ No
		◯ Yes ◯ No
		◯ Yes ◯ No
		◯ Yes ◯ No
		◯ Yes ◯ No
		◯ Yes ◯ No
		◯ Yes ◯ No

4. Is there other supporting medical evidence for the condition(s)/diagnosis(es) (e.g. diagnostic reports, investigations, and laboratory tests)? ◯ Yes ◯ No

   Are documents attached? ◯ Yes ◯ No

5. Admission to hospital(s) or other treatment facility(ies) relevant to the medical condition.

Date of Admission yyyy-mm-dd	Reason	Date of Discharge yyyy-mm-dd	Supporting Documents Attached
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No

To be completed by the Applicant's Physician

Section 5 - Degree of Impairment

1. Does this person have any difficulties/functional limitations with the following:

☐ Lifting/Carrying ☐ Standing ☐ Walking ☐ Sitting ☐ Concentrating ☐ Sleeping ☐ Remembering ☐ Breathing

☐ Communicating ☐ Regulating Emotions ☐ Personal Care (e.g. eating, dressing, grooming, toileting, etc.)

Provide details:

2. How and to what degree (minimal, moderate, major) does this person's medical condition impact their level of functioning?

a) Level of impairment due to **Physical** aspects:

◯ none/not applicable ◯ mild or slight impairment ◯ medium or moderate impairment ◯ major or complete impairment

Describe symptoms causing impairment:

b) Level of impairment due to **Mental Health** aspects:

◯ none/not applicable ◯ mild or slight impairment ◯ medium or moderate impairment ◯ major or complete impairment

Describe symptoms causing impairment:

c) Level of impairment due to **Cognitive** aspects:

◯ none/not applicable ◯ mild or slight impairment ◯ medium or moderate impairment ◯ major or complete impairment

Describe symptoms causing impairment:

3. Considering all the above, what is the cumulative level of impairment?

◯ none/not applicable ◯ mild or slight impairment ◯ medium or moderate impairment ◯ major or complete impairment

Describe symptoms causing impairment:

To be completed by the Applicant's Physician

Section 6 - Medication

Complete the chart below or attach a list of relevant medication(s). ☐ List attached.

Type	Start Date	Dosage and Frequency	Purpose of this Medication	Effect on Functioning

Section 7 - Treatment

1. Describe treatment history and results inclusive of the timeframe.

2. Describe the current treatment plan. Include when the treatment was initiated, anticipated results, and how often the treatment plan is reviewed.

3. If further treatment is anticipated, describe the treatment and include anticipated results and estimated timeframe.

4. If no treatment/remedial approaches for the medical condition have been tried to date or are planned, explain why.

To be completed by the Applicant's Physician

Section 8 - Prognosis

1. Duration of the medical condition(s) is likely to be:

   ◯ Temporary - The medical condition will improve over time with further treatment. Estimated duration? ____________________

   ◯ Episodic - Episodes recurring as follows: (Please indicate frequency, length of episodes, severity of episodes, and total duration of illness.)

   ◯ Indefinite - The medical condition is not expected to change or improve over time with treatment.

   ◯ Undetermined - It is unclear whether the medical condition will improve over time with further treatment.

   Explain:

2. Are there other medically-related issues impacting the applicant's response to treatment? ◯ Yes ◯ No If yes, please explain:

3. Is the applicant following the recommended treatment plan? ◯ Yes ◯ No If no, please explain:

To be completed by the Applicant's Physician

Section 9 - Additional Comments / Information

Section 10 - Certification

I am licenced by the College of Physicians and Surgeons of Alberta (CPSA) to practice medicine in the Province of Alberta.

- I have completed and/or approved the information submitted in this report.
- This report (and attached documents) contains medical reports, clinical findings and my medical opinion at this time.

Physician's Name (please print)

CPSA Registration #

Phone

City/Town

Province/Territory

Postal Code

Date yyyy-mm-dd

Physician's Signature

Office Address