AIDP Eligibility Verification Form

The Alberta Innovative Disabilities Program (AIDP) will use this Disability Verification Form as one of the criteria to determine a patient's eligibility to receive the free acupuncture treatments funded by the Alberta government. Please ensure that the information represents this patient's disability(ies) and functional limitations. Incomplete forms will result in denial and/ or delays for the applicant.

For more information about:
- Alberta Innovative Disabilities Program: please visit https://www.abidp.ca.
- Huatuo Clinic: Please visit https://www.huatuoclinic.com/

Section 1: Patient Information (to be completed by the patient or guardian)		
Last Name:	First Name:	Date of Birth:
Preferred contact method (fill one or both) Name of Contact:	Phone:	Email:

Section 2: Verification of Disability (must be completed by the Medical Assessor)
Permanent Disability means any impairment, including a physical, mental, intellectual, cognitive, learning, communication or sensory impairment, or a functional limitation that restricts the ability of a person to perform the daily activities necessary to pursue studies or to participate in the labour force and that is expected to remain with the person for their lifetime. **Persistent or Prolonged Disability** means any impairment, including a physical, mental, intellectual, cognitive, learning, communication or sensory impairment, or a functional limitation that restricts the ability of a person to perform the daily activities necessary to pursue studies or to participate in the labour force and has lasted, or is expected to last, for a period of at least 12 months but is not expected to remain with the person for their lifetime.
Please review and answer the following based on the definitions above: (if either statement is left blank, it is assumed the patient does not meet either criteria.) **Does the applicant have a permanent disability?** ❑ Yes ❑ No **Does the applicant have a persistent or prolonged disability?** ❑ Yes ❑ No

Section 3: Nature of Disability (check and complete all that apply)
(must be completed by the Medical Assessor)

❑ **Mobility/Agility Impairment:** *To be completed by physician or medical specialist.*
Diagnosis:

❑ **Hearing Impairment:** *To be completed by Audiologist or physician and include the degree of hearing loss.*

- ❑ Mild
- ❑ Moderate
- ❑ Severe
- ❑ Profound
- ❑ Uses aided hearing
- ❑ Would benefit from amplification devices in an educational

❑ **Visual Impairment:** *To be completed by Optometrist or Ophthalmologist or physician and include the degree of vision loss.*
Degree of visual loss:

❑ **Brain Injury/Cognitive Impairment:** Include details about the diagnosis with supporting reports – Neuro-psychological Assessment and/or Brain Injury/Cognitive Impairment Report/Assessment.

❑ **ADD/ADHD:** To be completed by physician, psychologist, or psychiatrist.

❑ **Psychiatric/Psychological (include the DSM)**: *To be completed by physician, psychologist or psychiatrist.*
DSM Diagnosis:

❑ **Pervasive Development Disorder (ex. Autism, Asperger's)**: *To be completed by physician, psychologist or psychiatrist.*
Diagnosis:

❑ **Other/Chronic Illness:** *Specify. To be completed by the appropriate medical professional.*
Diagnosis:

Section 4: Functional Limitations (must be completed by Medical Assessor)		
Mobility and Movement Impacts: *Check all that apply.*		
❑ Standing	❑ Sitting	❑ Ambulation (cane, wheelchair, walker, etc.)
❑ Stair Climbing	❑ Handwriting	❑ Lifting/Carrying/Reaching
❑ Fatigue	❑ Keyboarding	❑ Grasping/Gripping/Dexterity
❑ Other - specify:		
Cognitive and/or Behavioral Impacts: *Check all that apply.*		
❑ Memory	❑ Social Interactions	❑ Information Processing (verbal and written)
❑ Attention and Concentration	❑ Stress Management	❑ Organization and Time Management
❑ Communication	❑ Other – Specify:	

Section 5: Medical Assessor Authorization (must be completed by Medical Assessor)	
Name of Qualified Medical Assessor:	Registration Certificate No:
Specialty:	Medical Office Stamp and/or Medical Office Address (required)
Signature:	
Date Signed (YYYY-MM-DD):	
Telephone No.:	