PART C – Decision under Appeal

The decision under appeal is the Ministry of Social Development and Social Innovation ("ministry") reconsideration decision dated June 6, 2016 in which the ministry found the appellant was not eligible for designation as a Person With Disabilities ("PWD") because he did not meet all of the criteria in Section 2(2) of the *Employment and Assistance for Persons with Disabilities Act* ("EAPWDA"). The ministry was satisfied that the appellant has reached 18 years of age and that his impairment is likely to continue for at least 2 years. However, based on the information provided in the PWD Designation Application ("PWD application") and Request for Reconsideration, the minister was not satisfied that:

- the appellant has a severe mental or physical impairment; and
- the impairment, in the opinion of a prescribed professional, directly and significantly restricts his ability to perform daily living activities ("DLA") either continuously or periodically for extended periods; and
- as a result of these restrictions, the appellant requires help to perform those activities through an assistive device, the significant help or supervision of another person, or the services of an assistance animal.

PART D – Relevant Legislation

Employment and Assistance for Persons with Disabilities Act – EAPWDA - section 2

Employment and Assistance for Persons with Disabilities Regulation – EAPWDR - section 2

PART E – Summary of Facts

The evidence before the ministry at the reconsideration consisted of the following:

1. A one-page medical report on a ministry form signed by the appellant's family physician on January 12, 2016, indicating the following:

- Primary medical condition: "CVA" [cerebral vascular accident - stroke], date of onset 2014;
- Secondary medical condition: "CAD" [coronary artery disease], date of onset 2005;
- The overall medical condition is described as moderate;
- The medical condition is episodic in nature with the comment, "3 strokes since 2014";
- Restrictions specific to the medical conditions are described as, "poor memory after CVA, vision gets blurry at times, poor endurance, unable to walk more than 5 - 10 minutes."
- The physician has been the appellant's medical practitioner for 6 months or less and has examined his previous medical records.

2. A PWD application comprised of the Applicant Information and Self-report ("self-report") signed by the appellant on January 11, 2016, as well as a Physician Report ("PR") and Assessor Report ("AR") both dated September 12, 2016 and both completed by the appellant's general practitioner ("the physician"). The appellant is a new patient at the physician's practice; he has seen the appellant a few times, his colleagues have seen him as well (altogether more than 10 times in the past year), and he has reviewed the appellant's files. The physician completed the forms by way of an office interview, file/chart information, and information from the appellant's neighbours/ caretakers and he will continue to coordinate the appellant's medical care while practicing in the community.

The PWD application included the following information:

Diagnoses

<u>PR and AR</u>

In the PR, the appellant is diagnosed with myocardial infarction - CAD, date of onset 2005, and cerebral vascular accident, date of onset 2014. In the PR, *Health History*, the physician adds that the appellant had PCI twice (2005 and 2009) and CVA three times since 2014. He also reports "decreased heart function (25-30%), dyslipidemia, hypertension, and obesity." Ever since the CVA attacks, the appellant has been having poor memory and blurry vision. Under *Degree and Course of Impairment* in the PR and *Mental or Physical Impairment* in the AR, the physician reports poor heart function, and three strokes since 2014 that caused the memory and vision problems.

<u>Self-report</u>

The appellant describes the impact of his strokes, including his memory problems. He also runs out of breath and energy when doing simple tasks and he experiences dizziness, balance issues, increased risk of falling, and problems with communication.

Functional Skills

PR

The physician provided the following information regarding any functional limitations:

• The appellant can walk 1-2 blocks unaided on a flat surface;
• climb 5+ steps unaided;
• lift 5-15 pounds;
• has no limitation with remaining seated;
• has no difficulties with communication; and
• has significant deficits with cognitive and emotional function in 5 out of 12 listed areas: Consciousness [orientation, confusion] with the comment, "sometimes", Executive, Memory, Perceptual psychomotor, and Emotional disturbance.

AR

The physician provided the following information for *Mental or Physical Impairment* (Abilities):
• Ability to Communicate: Speaking, Reading, Writing, and Hearing – *Good* with the comment, "off a bit because of his vision";
• Mobility and Physical Ability: The appellant is independent with all listed functions: Walking indoors, Walking outdoors, Climbing stairs, Standing, Lifting, and Carrying/holding with the comments, "cannot carry more than 15 lbs, cannot walk for long distances";
• Cognitive and Emotional Functioning: The physician indicates that the appellant's impairments impact his functioning in 5 out of 14 areas:

- Language and Other emotional or mental problems - minimal impact;
- Executive, Memory, and Other neuro-psychological problems – moderate impact;
- Comments: "Patient has had vision and memory problems after suffering from his strokes…Due to his impairment, patient gets emotional and depressed at times. Patient and neighbour state that patient has a hard time explaining things that he says at times."

Self-report

The appellant reports that his strokes have taken a lot of his memory and he can no longer keep track of day to day tasks such as taking his medications and attending doctor's appointments, blood tests, and picking up medications and food. He easily runs out of breath and energy and if he walks down the street he has to stop after only two blocks. Communication is now difficult and he has problems connecting what he is thinking to what he is trying to say.

Daily Living Activities (DLA)

PR

The physician checked *No*, the appellant has not been prescribed medication/treatment that interferes with his ability to perform DLA. In Part E - *Daily Living Activities*, the physician check marked that the appellant's impairment directly restricts his ability to perform DLA:
• 5 out of 10 DLA are not restricted: Personal self-care, Mobility inside the home, Mobility outside the home, Use of transportation, and Social functioning.

• 5 DLA are continuously restricted: Meal preparation, Management of medications, Basic housework, Daily shopping, and Management of Finances;
• No comments are provided for the restricted DLA, except for assistance required [summarized in the next section below].

AR

The physician provided the following information:

• The appellant is independent with all areas of Personal care, Pay rent and bills, and Transportation;
• He requires periodic assistance from another person with all areas of Basic housekeeping: Laundry and Basic housekeeping;
• He requires continuous assistance from another person in 4 out of 5 areas of Shopping: Going to and from stores, Reading prices and labels, Making appropriate choices, and Paying for purchases. He is independent with Carrying purchases home;
• He requires continuous assistance with all areas of Meals: Meal planning, Food preparation, Cooking, and Safe storage of food;
• He also requires continuous assistance with all areas of medications: Filling/ Refilling prescriptions, Taking as directed, and Safe handling/ storage;
• Regarding Social Functioning, the appellant is independent in 3 of the 5 listed areas: Appropriate social decisions, develop/ maintain relationships, and Interacts appropriately with others. He requires periodic support/ supervision in dealing with unexpected demands, and securing assistance from others. The physician checked that the appellant has good functioning with his immediate social network and marginal functioning with his extended social network. The physician did not identify any safety issues, or provide comments for any DLA except for describing the assistance required.

Self-report

The appellant reports that his strokes left him unable to do everyday tasks such as dishes, "takes me 3 rest breaks to get through." For medications, he cannot remember to take them or whether he took them. He reports that he can no longer cook his own meals because he cannot even finish doing the dishes. For personal care, he reports that he even gets dizzy when he is in the shower. Due to his balance issues and risk of falling, he avoids going into stores and has someone shop for him.

Need for Help

PR

• The physician check marked *No*, the appellant does not require any prostheses or aids for his impairment. Under *Health history*, he reports that the appellant has "poor function, endurance, and unable to cope by himself, needs to have help from his neighbours to cope." For DLA, the physician reports that neighbours help the appellant, "gets help 2 or 3 times"[per day as indicated in the AR], and overall, "this gentleman needs a lot of medical and social help."

AR

• The appellant lives alone and "neighbours come to help 2 - 3 times per day."
• Under Cognitive and emotional functioning, the physician indicates that due to vision and memory

problems from the strokes, the appellant "gets help from helpful neighbours to cope with his ADL's."
• For the DLA of Social functioning, the physician states that "the patient needs to continue getting help from his neighbours/ social worker" in order to be maintained in the community.
• Under assistance provided by other people, the physician checked that help is provided by friends and volunteers;
• In response to the question, If help is required but none is available, please indicate what assistance would be necessary, the physician wrote, "Patient copes with help from neighbours, and now he will also get help from community service agencies."
• The physician did not mark that the appellant uses any assistive devices and he checked *No*, the appellant does not have an assistance animal.

Self-report

The appellant reports that due to his impaired memory and problems with energy and balance, he cannot cook his own meals and he requires assistance with going to the store (waits in the car while a friend shops for him).

3. A Request for Reconsideration signed by the appellant on May 18, 2016, with a hand-drawn line dividing the form into two halves. At the hearing, the appellant explained that the top portion, signed on May 15, 2016 was completed by a friend. The bottom portion was completed and initialed by the physician.

The friend's information indicates the following:

• The appellant is currently taking 3 pills including blood thinner medication;
• "Repeating fainting spells - May 7, 2016";
• "3 numbness in shoulder (3 times since April 22, 2016)";
• "Most recent - sagging limp left side - May 16, 2016";
• "Memory lapse - May 14, 2016;
• The physician prescribed sleeping pills for "Stress disorder", May 19, 2016;
• "Sharp stinging pain - cranium";
• "May 21 - hurts on right side and brain pain."

The physician indicates the following:

• "Patient cannot do most of his ADL's (except self-care, mobility) without the help of his neighbours."
• "His strokes left him with poor memory and concentration."
• "He cannot exert himself for more than 10 minutes."
• "This gentleman needs assistance from others in order to have a decent quality of life."

4. A *Persons with Disabilities Designation Denial Summary* ("Denial Summary") dated April 22, 2016 and completed by a ministry adjudicator. Original checkmarks indicate the appellant met the criteria for age and duration of impairment and did not meet the criteria for severity of the impairment, DLA, and help required with DLA. For the criteria that were not met, these check marks are crossed out and replaced with check marks indicating that the criteria are met with the comment, "per Dr.__" (the physician's name).

Additional submissions

Subsequent to the reconsideration decision, the appellant filed the following documents:

1. Two Notices of Appeal signed by the appellant:
• June 9, 2016 indicating "conflicting report of evidence"; stating that the physician said, "this man should be on disability assistance"; and indicating that the appellant's medications consist of 7 pills per day - "stroke, brain damage."
• June 13, 2016 in which the appellant states that he would benefit from a different assessor who can provide a clearer picture of his "impairments of ADL function in the community."

2. A one-page fax to the tribunal from a registered social worker, dated June 13, 2016, stating that the appellant plans to have a new assessor to work with him and his physician to clarify his medical condition and ADL situation.

3. A submission from the social worker consisting of the following documents:

(a) An assessment by the social worker dated June 15, 2016, based on an office interview with the appellant, and indicating the following:
• The appellant moved to his current community in the fall of 2015. He first presented to the Emergency department in November 2015, requesting an "INR test" and additional medications. He reported that he had run out of medications and had not had his lab work done for some time. He was provided with a prescription for his medication.
• He first saw the physician in January 2016 and has attended weekly visits since that time for a total of approximately 24 visits with the physician.
• As a "skilled assessor", the social worker interviewed the appellant at length to determine his level of impairment and ability to perform DLA. She reports the following:

- The appellant walks with one cane on good days and two canes on days when his symptoms are worse. He does not leave his home when he is feeling especially unwell, and he reports being able to walk about half a block without his canes.
- He reports that he tries to go for a walk every day for exercise and to stave off boredom. However, he often experiences chest pain and shortness of breath, usually after walking a block or two. Cardiology reports from November 2015 and January 2016 indicate abnormal heart rhythms.
- He reports that most days he finds it difficult to get out of bed due to numbness and weakness in his right arm and leg, and he usually experiences dizziness when pushing himself off the bed. As such, he holds onto the walls to steady himself.
- He reports right-sided numbness and weakness due to multiple strokes. His CT scan in February 2016 indicates "infarcts resulting from past CVA's".
- His right-sided numbness impairs his ability to mobilize safely. While he reports one to two falls in the past year, he experiences "near misses" on a daily basis. He states that he trips over his foot and must walk very slowly to make sure he does not fall.
- He states that he would not be able to survive without support and assistance from his friends and neighbours and they have been helping him with groceries and sundry items since he moved to the community.
- He states that he is not comfortable with shopping as he cannot read labels and prices. He reports that in the past, he has had girlfriends shop for him so that he would not have to worry

about reading fine print, and now his neighbours help out.

- Also due to his vision problems, he states that he is unable to use public transportation or read maps and schedules with any success.
- He states that he never learned how to budget money and relied on girlfriends to manage household finances. All of his money currently goes to paying rent and he gets food from his neighbours.
- He also states that he never learned to cook and therefore rarely does any cooking, although he can fry a hamburger or boil water for Kraft Dinner. However, he has dropped the frying pan a few times and almost burned himself when dropping a pot of boiling water. Daily, he must remind himself not to pick up things with his right hand as he has little or no grip strength on that side.
- He states that he is unable to bend at the waist or straighten up again as he gets very dizzy and tends to fall over. He is unable to lift or reach for things due to the lack of strength and grip on his right side.
- He reports that he has a Grade 6 education, and although he can read a little bit, he has a lot of difficulty making sense of what he is reading. He feels this is due to the strokes more than his lack of education.
- He reports that he has a very difficult time following conversations with more than one person and will stay quiet and not contribute if there are multiple people in the conversation.
- He also reports significant memory loss, and forgets names, addresses, phone numbers, appointments, and directions for the proper use of medications. He finds it difficult to process information since his strokes, and has trouble with shaving as he cannot see his face clearly in the mirror. He reports that he has a hard time describing what he sees out the window and how he is connected to the world around him.
- The social worker observed a noticeable drop on his right foot when walking, his right shoe shows wear from dragging his toe, and she noted that his walking pace is very slow with a pronounced limp on his right side and a slow and awkward gait. Regarding his communication, the social worker reports that he used simple language and described daily routines in an “almost childlike” manner. He stated that he is often embarrassed when talking and will forget what he is talking about during the conversation.

Cardiologists’ letters

(b) A letter from Dr. __ (“Cardiologist A”) to a physician in the appellant’s former community, dated February 21, 2014, summarizing the appellant’s diagnoses of heart problems, recent stroke, and treatment that included a stent in 2005. He indicates that the appellant’s heart function of 25-30% is an “ejection fraction” with “possible thrombus”. He also listed the appellant’s medications (5 altogether), cardiac risk factors, and co-morbidities. Cardiologist A reports that the appellant was recently discharged from the hospital following a stroke, has been compliant with his medications, and “has made a full neurological recovery” and plans to return to work and to the gym for cardiac exercise. Cardiologist A describes medical test results and indicates that the appellant has visual loss for which he “has made an excellent recovery”, is able to pursue an exercise program, requires a follow up medical test, and will need to take his medications for life.

(c) A letter from Dr. __ (“Cardiologist B”) to the appellant’s current physician, dated February 15, 2016, describing the appellant’s history of coronary artery disease and previous myocardial infarctions with exertional shortness of breath but no chest pain. The appellant has occasional

palpitations and no syncope, PND, or reported leg swelling. His current medication list consists of four prescription medications. Cardiologist B describes the appellant's future medication needs and orders a Holter monitor and other tests to rule out other abnormalities related to "significant coronary artery disease".

Medical test reports: February - March, 2016

(d) A Medical Imaging Report for an echocardiogram dated March 7, 2016, describing various cardiac measurements and functions. The stated conclusions include:
• "left ventricle severely enlarged";
• "moderate to severe dysfunction…No significant valvular abnormalities noted."
• "moderate left atrial enlargement."
• In comparison to a 2013 Echo report "which suggested severe left ventricular dilatation…there has been no change in LV size but a mild improvement in LV function and mild improvement in mitral regurgitation."
(e) A medical Diagnostic Report for a Holter Monitor dated February 24, 2016 (with two attached print-outs of the appellant's heart rhythms). Comments describe the appellant's heart abnormalities and recommend a work up for "possible coronary artery disease as well as echocardiogram for LV function."
(f) A Medical Imaging Report for a CT scan of the appellant's head dated February 4, 2016 and dictated by a neurologist. The report describes, in technical language, various brain features including any abnormalities as a result of the appellant's strokes.

The ministry had no objections to admitting into evidence the appellant's and his social worker's submissions, the letters from two cardiologists, and the three medical test reports. Regarding the submissions from the appellant and social worker, the panel finds that they provide updated assessments of the appellant's functional abilities and capacity to perform DLA. Although the assessments provide a different opinion in some areas compared to the physician's information in the PR and AR, they corroborate the appellant's self-reported restrictions in the reconsideration record. Regarding the cardiologists' letters and the medical test reports, the panel finds that they corroborate the physician's diagnoses of heart disease and stroke and provide additional detail about the appellant's medical history. The panel therefore admits all of the submissions under section 22(4)(b) of the *Employment and Assistance Act* ("EAA") as evidence in support of the information and records before the minister at the time the decision being appealed was made.

Oral submissions

The appellant attended the hearing with a friend in the capacity of a support person. He does not have a formal advocate and explained that he is without reliable assistance because although his friends want to help him out, they have their own health concerns and lack of resources. While the appellant has his license and is still able to drive, transportation to appointments is costly. He summarized his medical conditions and impact on his function, including walking and communication difficulties as reported in the PWD application.

He stated that his condition has gotten worse since his physician filled out the PR and AR six months ago. He also finds it difficult to tell his physician the full story about his impairments out of fear and also embarrassment to admit his limitations. For example, he reports that he can only walk half a block but he told the physician he can walk 1-2 blocks. He has been using a cane for a couple of

months for balance but did not bring it to his doctor's appointments and the physician therefore reported that he does not use any assistive devices. He stated that he also requires a brace for his right foot (to keep his shoe from hitting his foot) but has not yet made the appointment. Further, he was scared to discuss the extent of his dizziness with the physician and he in fact has chest pain every day, despite Cardiologist B's letter (February 15, 2016) stating that he has no chest pain.

The panel finds that the appellant's testimony adds detail about his limitations as presented in his self-reports in the reconsideration record. The panel admits the oral submission under section 22(4)(b) of the EAA as evidence in support of the information and records before the minister when the decision being appealed was made. The ministry summarized its argument per the reconsideration record and did not provide any additional evidence. The panel will address both parties' arguments in the next section, *Part F - Reasons for Panel Decision*.

PART F – Reasons for Panel Decision

The issue in this appeal is whether the ministry's reconsideration decision of June 6, 2016, which found that the appellant was not eligible for PWD designation, was reasonably supported by the evidence or was a reasonable application of the applicable enactment in the circumstances of the appellant. Based on the information provided in the PWD application and Request for Reconsideration, the ministry was not satisfied that the following criteria in EAPWDA section 2(2) were met: the appellant has a severe mental or physical impairment; and the impairment, in the opinion of a prescribed professional, directly and significantly restricts his ability to perform DLA either continuously or periodically for extended periods; and, as a result of these restrictions, he requires help to perform those activities.

The eligibility criteria for PWD designation are set out in section 2(2) of the EAPWDA as follows:

(2) The minister may designate a person who has reached 18 years of age as a person with disabilities for the purposes of this Act if the minister is satisfied that the person has a severe mental or physical impairment that
(a) in the opinion of a medical practitioner is likely to continue for at least 2 years, and
(b) in the opinion of a prescribed professional
(i) directly and significantly restricts the person's ability to perform daily living activities either
(A) continuously, or
(B) periodically for extended periods, and
(ii) as a result of those restrictions, the person requires help to perform those activities.
(3) For the purposes of subsection (2),
(a) a person who has a severe mental impairment includes a person with a mental disorder, and
(b) a person requires help in relation to a daily living activity if, in order to perform it, the person requires
(i) an assistive device,
(ii) the significant help or supervision of another person, or
(iii) the services of an assistance animal.

The “daily living activities” referred to in EAPWDA section 2(2)(b) are defined in section 2 of the EAPWDR:

Definitions for Act

2 (1) In this section:
"assistive device" means a device designed to enable a person to perform a daily living activity that, because of a severe mental or physical impairment, the person is unable to perform;

For the purposes of the Act and this regulation, **"daily living activities"** ,
(a) in relation to a person who has a severe physical impairment or a severe mental impairment, means the following activities:
(i) prepare own meals;
(ii) manage personal finances;
(iii) shop for personal needs; (iv) use public or personal transportation facilities;
(v) perform housework to maintain the person's place of residence in acceptable sanitary condition;

(vi) move about indoors and outdoors;
(vii) perform personal hygiene and self-care;
(viii) manage personal medication, and
(b) in relation to a person who has a severe mental impairment, includes the following activities:
(i) make decisions about personal activities, care or finances;
(ii) relate to, communicate or interact with others effectively.

Decision

First, regarding an inconsistency in the evidence, the panel finds as fact that the appellant uses a cane as an assistive device despite the physician's information that he does not have any assistive devices for his impairment. The appellant reported that he has been using a cane for balance for the past couple of months (but did not bring it to his doctor's appointments out of embarrassment). The social worker, in her recent assessment of June 15, 2016, observed him with a cane and he reported that he sometimes uses two canes.

Second, the panel notes that while the ministry's Denial Summary (of April 22, 2016) was changed to check mark that the appellant meets all of the criteria for PWD designation, with the comment, "per Dr.__" (the physician's name), the amendments are not endorsed by the physician in the form of an updated signature, or initials, or a new date. There is no explanation regarding who made the changes and the narrative remains unchanged for all criteria. Also, this assessment is not the subject of the panel's review for the reason that it comprises the ministry's original decision and not the reconsideration decision.

Third, while the appellant argues that the social worker's assessment is more relevant as it is dated six months after the PR and AR and supported by copies of specialist's letters and reports, the weight that the panel gives the information in determining the reasonableness of the reconsideration decision is impacted by the following factors:
• The panel does not know whether the appellant has ongoing appointments with the social worker (as he does with his physician; i.e., weekly appointments with the physician were reported) or whether the social worker considered the physician's assessments in making her own assessment.
• While the social worker states she is a "skilled assessor", she based her assessments on the appellant's self-reports, and the specialist's letters and reports that don't speak directly to the appellant's function or ability to perform DLA (as explained below). While she directly observed the appellant's mobility (walking down the hallway) and communication style (speaks slowly and uses simple language), her assessment indicates that these functions are also impacted by his low level of education. His ability to do his DLA is further impacted by never learning how to cook or manage his finances and it is therefore unclear from the assessment, the extent to which his restrictions are due to the mental and physical impairments reported by the physician.
• Regarding the medical specialists' letters and test result reports, Cardiologist A. reports that the appellant made a "full neurological recovery" from his stroke in 2014 and an "excellent recovery" from his vision loss, while Cardiologist B and the neurologist who dictated the CT scan report do not provide information in layperson's terms regarding the impact of two more recent strokes on the appellant's physical and mental function and ability to do his DLA. While the panel admitted the specialist's letters and reports as being in support of his diagnoses as set out in the reconsideration record, the panel does not have the medical training required to interpret technical, medical language and medical test results and correlate the information to the appellant's current mental and physical functioning.

Regarding the inconsistencies noted by the ministry in the reconsideration decision, between the appellant's reported physical and mental function and his ability to perform DLA, the panel will address below, the ministry's concern that there was no explanation for the discrepancies in the information. The panel provides the following analysis for the legislative criteria based on the evidence that the ministry considered at the reconsideration in conjunction with the additional information from the social worker:

Severe mental or physical impairment

The diagnosis of a serious medical condition does not in itself determine PWD eligibility or provide evidence of a severe impairment. To satisfy the requirements in section 2(2) of the EAPWDA, evidence of how, and the extent to which, a medical condition restricts daily functioning must be considered. This includes the evidence from the appellant and from a prescribed professional regarding the nature of the impairment and its impact on the appellant's ability to manage the DLA listed in section 2(1) of the EAPWDR. However, section 2(2)(b) of the EAPWDA clearly sets out that the fundamental basis for the analysis of restrictions is the evidence from a prescribed professional - in this case, the physician.

Appellant's position - Severe mental impairment

In his self-reports, the appellant argues that he has severe memory, vision, and communication impairments that affect his quality of life and ability to do daily tasks. His vision problems restrict his reading more than his lack of education does, and he also has severe headaches and pressing his hands to his head does not help. He his embarrassed by his communication and memory difficulties which leave him unable to express himself clearly or participate in conservations with more than one person at a time. He reports that his symptoms have gotten worse in the six months since the physician filled out the PR and AR.

Ministry's position - Severe mental impairment:

The ministry argues that the physician's information does not establish a severe mental impairment, noting the following evidence:
• The physician reports no difficulties with communication in the PR. In the AR as well, reading, writing, hearing, and speaking are reported to be good.
• In the PR, while the physician indicates significant deficits in nearly half of the areas of cognitive and emotional function, in the AR he does not indicate any major impacts to cognitive/ emotional functioning. While a moderate impact to Executive, Memory, and Other neuro-psychological problems is reported, the majority of areas are check marked *no impact*.

Panel's decision - Severe mental impairment

The panel finds the ministry reasonably determined on the basis of the information provided, that the appellant does not have a severe mental impairment. While the physician reports "poor cognitive function" in the PR as well as memory and vision problems, he reports no communication problems. In the AR, the appellant's ability to communicate is similarly reported as good, but "off a bit due to his vision." The social worker in her assessment, observed the appellant to speak slowly with simple language and he reports that he loses track of conversations and cannot communicate with more

than one person at a time. However, although she directly observed his communication and noted a somewhat impaired communication style, she does not indicate that he is unable to communicate without a significant struggle.

Further, there are no major impacts to cognitive and emotional function reported in the PR and AR, and as noted by the ministry, while the physician indicates in the AR, that the appellant gets "emotional and depressed", the physician also writes that this only happens "at times". In the one-page medical report of January 12, 2016, the physician notes that the appellant's vision gets blurry "at times", and his "significant deficit" with Consciousness (orientation, confusion) is also reported to happen "sometimes".

Combined with the letter from Cardiologist A who states that the appellant made a "full neurological recovery" after his first stroke, and no information from Cardiologist B or the social worker to confirm that the subsequent strokes resulted in a severe impairment to mental functioning, the panel concludes that the ministry reasonably determined that the evidence supports a moderate rather than severe mental impairment. The legislation requires evidence of a severe impairment characterized by significant functional deficits and as the evidence indicates no major impacts to cognitive and emotional functions, the panel finds that the ministry reasonably determined the criterion of a severe mental impairment in section 2(2) of the EAPWDA was not met.

Appellant's position – Severe physical impairment

The appellant argues that weakness and numbness on his right side severely impacts his physical function in the areas of walking, balance (including increased risk of falling due to dizziness), getting out of bed, lifting, and performing tasks with his right hand.

Ministry's position - Severe physical impairment:

The ministry argues that inconsistencies and a lack of detail in the information provided for the reconsideration precludes the finding of a severe physical impairment. While the physician reports in the Request for Reconsideration that the appellant cannot do most DLA (except self-care and mobilizing) without the help of his neighbours, no change in the appellant's physical function was indicated: In the PR, the appellant can walk 1-2 blocks unaided, climb 5+ steps unaided, lift 5-15 pounds, and has no limitations with remaining seated. Further, the physician indicates in the AR that the appellant is independent with walking indoors and outdoors, climbing stairs, standing, lifting, and carrying/ holding (though he "cannot carry more than 15 pounds and cannot walk for long distances").

Panel's decision – Severe physical impairment

The panel finds that the ministry reasonably determined a severe physical impairment has not been established with the information provided and that the ministry reasonably required an explanation for the contradiction between the appellant's inability to do most DLA and his reported level of functioning in the PWD application. The legislation requires evidence of a severe impairment that significantly impacts daily functioning, and the physician's information that the appellant is able to walk up to 2 blocks, climb more than 5 steps and carry up to 15 pounds, does not meet the legislative test.

While the appellant argues that he underestimated his functional limitations at his medical appointments and that the more recent assessment by the social worker should carry more weight, the panel notes that the social worker also does not provide a clear picture of functional limitations. On the one hand, the appellant told her that he can only walk half a block without his cane and on the other hand, he tries to go for a walk every day but often experiences chest pain and shortness of breath "usually after a block or two". While she observed that the appellant walks "very slowly with a pronounced limp on his right side" and "significant foot drop to the right foot that made his gait appear slow and awkward", there is no indication that he cannot walk short distances as reported by the physician. Similarly, while he reported to her that he cannot lift or reach for things due to weakness and a lack of grip strength on his right side, there is no indication that he cannot use his left arm and hand, and no observations to refute the physician's information that he can carry loads up to 15 pounds.

The legislation requires evidence of a severe impairment characterized by significant functional deficits. Based on the totality of the evidence at the reconsideration and the additional information on appeal (including the lack of explanation for why the appellant cannot carry out daily activities independently in light of his moderate degree of physical function), the panel finds that the ministry reasonably determined a severe physical impairment under section 2(2) of the EAPWDA was not established.

Restrictions in the ability to perform DLA

Appellant's position

The appellant submits that his self-care and household chores are restricted by his visual and physical impairments in that he gets dizzy in the shower and cannot shave properly and it takes him three rest breaks to do the dishes and he cannot read prices or labels and therefore waits in the car while his friend does his shopping. Further, he cannot remember to take or fill his medications, or remember to set up alarms as a reminder to take hi medication. He has always had help with cooking and finances as he never learned to do those things.

Ministry's position

The ministry acknowledges that the appellant requires some help with DLA due to his heart function, limited vision, memory and concentration problems; however, as contradictory evidence was presented regarding the appellant's functional abilities, the ministry argues that the extent of restrictions to DLA are therefore unclear and a severe impairment that in the opinion of a prescribed professional, significantly restricts the ability to perform DLA either continuously or periodically for extended periods, was not established.

While the appellant is reported as continually restricted with meal preparation, managing medications, basic housework, daily shopping, and managing finances, the physician reports no restrictions with self-care, mobility, and use of transportation and only periodic assistance/ support is required with basic housekeeping and some aspects of social functioning while most areas of social functioning are marked as independent. The ministry argues that the amount of help required, how often, and for how long is not described, and that it is unclear why help is being provided when the overall

impairment is not characterized by severe functional limitations, and most DLA (5 out of 8 in the AR) are described as independent or requiring periodic assistance only.

Panel's decision – Restrictions to DLA

Subsection 2(2)(b)(i) of the EAPWDA requires the minister to be satisfied that in the opinion of a prescribed professional an applicant's severe impairment directly and significantly restricts DLA either continuously, or periodically for extended periods. In this case, the appellant's physician is the prescribed professional. DLA are defined in section 2(1) of the EAPWDR and are also listed in the PR, with additional details in the AR. Therefore, a prescribed professional completing these forms has the opportunity to indicate which, if any, DLA are significantly restricted by the appellant's impairments either continuously or periodically for extended periods.

The panel finds that the ministry reasonably determined the evidence does not establish that the appellant's DLA are directly and significantly restricted either continuously or periodically for extended periods. As noted earlier, a severe impairment that significantly restricts function was not established because the appellant's functional abilities are moderately, not severely, impaired. Further, while the appellant is taking between three and eight prescription medications at any one time, there is no evidence that these medications restrict his ability to perform DLA; in fact, they are required to stabilize his condition and help prevent further problems.

While three DLA are reported as continuously restricted in the AR, as noted by the ministry, there is no corresponding restriction to function. Why does the appellant require continuous assistance with shopping (and is independent with carrying purchases home) if he can walk short distances, carry up to 15 pounds, and has reading ability that is only "off a bit" due to his visual impairment? Further, is he unable to pay his bills due to his impairment? Or is it because of financial constraints (he reports that all of his money goes to rent) and never learning how to budget (as he reported to the social worker)?

The panel also notes that given the information in the PR and AR regarding restrictions to DLA, it is unclear how significant the restrictions are. For example, in the PR, Basic housekeeping is reported as continuously restricted; while in the AR (of the same date), the appellant requires only periodic assistance with housework. In addition, Pay rent and bills is reported as continuously restricted in the PR, but is marked as independent in the AR. The physician provides no additional explanation.

Given the evidence provided, the only DLA that nears the threshold of being significantly restricted due to a severe impairment is Medications as this is supported by the physician's information that the appellant has significant deficits in the area of memory. However, the appellant's impairment is also reported in the AR to have a moderate impact on his memory and executive function and although the physician reports in the Request for Reconsideration that the appellant "cannot do most of his ADLs" without help from his neighbours, there is no evidence of a greater degree of functional impairments or worsening of his memory deficits.

While the social worker conducted her own assessment of the appellant's ability to do is DLA, her assessment is based on the appellant's self-report and is not backed up by a medical opinion that specifically addresses the appellant's recent functional capacity and restrictions to his daily activities. The legislation requires significant restrictions to DLA either continuously or periodically for extended periods as a result of the applicant's impairment. The panel finds that the ministry reasonably

determined the information provided by the prescribed professionals does not confirm that these criteria in subsection 2(2)(b)(i) of the EAPWDA were met.

Help to perform DLA

Appellant's position

The appellant submits that he needs a cane for balance, a foot brace that he has not yet made an appointment for, and continuous help and support from friends and neighbours to perform his DLA.

Ministry's position

The ministry submits that as it has not been established that DLA are significantly restricted, it cannot be determined that *significant* help is required from other persons.

Panel's decision – Help to perform DLA

Subsection 2(2)(b)(ii) of the EAPWDA requires a prescribed professional to confirm that as a result of significant restrictions to DLA, the person requires help to perform an activity. Where another person is providing the help, the level of assistance or supervision required must be significant as set out in subsection 2(3)(b)(ii) of the EAPWDA. While the social worker indicates that the appellant uses a cane for balance and both the physician and social worker confirm assistance from friends and neighbours, the panel found that the information provided did not confirm significant restrictions to DLA as a result of the appellant's impairment. The panel therefore finds that the ministry reasonably determined the criterion for help under EAPWDA subsection 2(2)(b)(ii) was not met.

Conclusion

The panel finds that the ministry's reconsideration decision denying the appellant PWD designation under section 2 of the EAPWDA was a reasonable application of the legislation in the circumstances of the appellant. The panel confirms the decision pursuant to sections 24(1)(b) and 24(2)(a) of the *Employment and Assistance Act*.