# Form 1

# Assessment of Attendant Care Needs

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# Chapter 1: Create a Form 1 & Tab 1

Form 1: Assessment of Attendant Care Needs is required when an injured claimant applies for attendant care (AC) benefits in accordance with the Statutory Accident Benefits Schedule (SABS) S. 42(1). The Form 1 may only be prepared by specified regulated health professionals as described in S. 42 (1) (b). The Form 1 in HCAI is to be used for accidents that occur on or after March 31, 2008. To learn more about the Form 1, refer to the Attendant Care Hourly Rate Guideline, which can be found on FSCO's website here: https://www.fsco.gov.on.ca/en/auto/superintendent_guidelines/Pages/Default.aspx

**To Create a Form 1:**

- Login to HCAI at www.hcai.ca
- The default home screen is the Plans tab and the Work in Progress sub-tab.
- At the top of the page, select Form 1 from the dropdown list and click CREATE NEW. A blank Form 1 will open in a new window.

Use the drop-down menu to select Form 1 and click on "Create New".

## Form 1 Tabs

The Form 1 in HCAI is organized under seven (7) tabs. These tabs correspond to the parts of the paper Form 1 and include similar sections. To navigate between the tabs, simply click on the number along the top or bottom of the screen, or use the NEXT ▶ button located beside the tabs.

Once you have begun working on your Form 1, you can click the SAVE button at any point to ensure your progress so far is saved. This will create a *draft* version of the Form 1, which will appear on the Plans global tab and the Draft sub-tab. By working off a recently created draft, facilities can save steps when creating new Form 1s.

### *Tab 1*

- Claim Identifier
- Document Identifier
- Applicant (Patient) Information
- Auto Insurer Information
- Attendant Care Assessment Information

### *Tab 2*

- Signature of Assessor

### *Tab 3*

- Part 1 – Level 1 Attendant Care

### *Tab 4*

- Part 2 – Level 2 Attendant Care

### *Tab 5*

- Part 3 – Level 3 Attendant Care

### *Tab 6*

- Part 4 – Calculation of Attendant Care Costs

### *Tab 7*

- Additional Comments

## *Tab 1*

### Claim Identifier

- All fields marked with an asterisk (*) are mandatory.
- Enter Claim Number and/or Policy Number
  - The Applicant must provide the Claim Number (if known) and his/her Policy Number.
  - The Claim Number and/or Policy Number can be obtained from the insurance Adjuster.
  - The Policy Number is also available on the Motor Vehicle Liability Insurance Card (pink slip).
  - The Claim Number and Policy Number may be the same.

- Enter the date of the accident, using the drop-down calendar or by typing in the year, month and date (yyyy/mm/dd)
  - If the Applicant/Patient has overlapping injuries from more than one accident, use the date of the accident that is most relevant to the injuries being treated.

### Applicant Information

- The Applicant or substitute decision-maker should provide this information to the Facility.
- Enter the date of birth of the Applicant/Patient using the drop-down calendar.
- Select the gender of the Applicant/Patient using the radio buttons.
- Enter the Last Name, then the First Name of the Applicant/Patient.
- Input the Applicant/Patient's address.

Either a Claim Number or Policy Number must be provided.

**Claim Identifier**

Please provide the required claim details. Either the Claim Number or the Policy Number must be provided, as does the Date of Accident.

Claim Number: AAAA

Policy Number: BBBB

* Date of Accident: 2016/07/09

**Document Identifier**

Document Type: Form 1

Date: 2016/09/13

Source: Web

Version Effective Date: 2016/07/22

Archival Status: Not Archived

**Applicant Information**

Please provide all information requested. Values marked with an asterisk (*) are mandatory fields required for submission. Collection, use and disclosure of this information is subject to all applicable privacy legislation.

* Date of Birth: 1990/07/09

* Gender: Male Female

* Last Name: Fox

* First Name: June

Middle Name:

* Address 1: 123 Cash St

Address 2:

* City: Greenville

* Province/State: ON - Ontario

* Postal/ZIP Code: L3L 4K5

Phone:

## Auto Insurer Information

- The Applicant or substitute decision-maker should provide this information to the Facility, including:
    - The Insurance Company Name and Branch Name, both of which can be selected from the drop-down list.

What about independent adjusting companies and independent Adjusters?

Independent adjusting companies may be hired by Insurers to adjudicate Claims, but the HCAI application does not list independent adjusting companies.

To direct OCFs appropriately, you should ask the Applicant/Patient or the independent Adjuster the name of the licensed Insurer that insures the Applicant/Patient.

### Policy Holder Details

- If the injured person seeking treatment is the Policy Holder, select “Yes” to the question “Is the Policy Holder the same as the Applicant?”
- If the injured person is not the Policy Holder, select “No”. Two new fields appear. Enter the last name of the Policy Holder. The name of the Policy Holder can be obtained from the pink slip or the proof of insurance Form.

**Auto Insurer Information**

Please provide the applicant's automotive insurer details.

* Company Name: Nova Insurance
* Branch: Peterborough
Phone: (519) 555-5555

**Policy Holder Details**

* Is the policy holder the same as the applicant? No Yes
* Policy Holder Last Name: Smith
Policy Holder First Name:

## Attendant Care Assessment Information

- Provide the details of the assessment including:
    - Date of the assessment
    - Is this the first Attendant Care Assessment? Indicate if this is the first Attendant Care Assessment by selecting “Yes” or “No”
        - If you do not know whether this is the first Attendant Care Assessment, select “Unknown”
    - If “No” is selected, the Last Assessment Date field will appear. Insert the date of the previous assessment.
        - This is not a mandatory field. If the date of the previous Attendant Care Assessment is unknown, leave this field blank
    - Is the Attendant Care Assessment being conducted for an Insurer Examination?
        - Indicate if this Attendant Care Assessment is being conducted at the request of the insurer for the purpose of an Insurer Examination by selecting “Yes” or “No”. This field is not mandatory.
    - Current Monthly Allowance. Insert the amount of the current monthly Attendant Care Allowance.
        - This field is not mandatory. If you do not know the amount of the current Attendant Care Allowance, leave this field blank

**Attendant Care Assessment Information**

Provide the details of this assessment and of any prior assessments, including current monthly allowance amounts, if known. All fields with an asterisk (*) are required.

* Assessment Date: 2016/07/14
* First Assessment? No Yes Unknown
Last Assessment Date: 2016/07/10
Is this an Insurer Examination? No Yes
Current Monthly Allowance:

# Chapter 2: Tab 2

**Part 5 – Signature of Assessor**

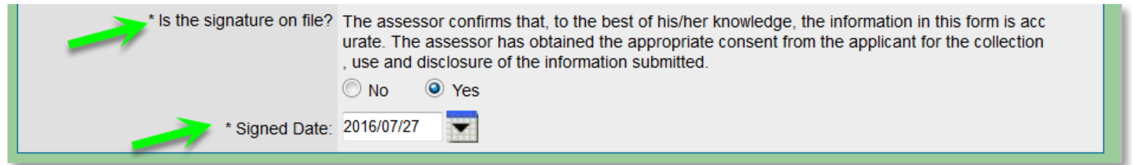
### Name of Assessor

- All fields marked with an asterisk (*) are mandatory.
- Using the drop-down menu, select the Registered Nurse (RN) or Occupational Therapist (OT) from your Facility’s Provider list
    - The assessor must be associated with the facility that is preparing and submitting the Form 1

**Signature of Assessor**
Identify the assessor who completed the assessment and indicate if the assessor's signature is on file. All fields with an asterisk (*) are required.
* Name of Assessor: Jones, Jenny
* Profession: Registered Nurse (65784)
Assessor E-mail:

### Is the signature on file?

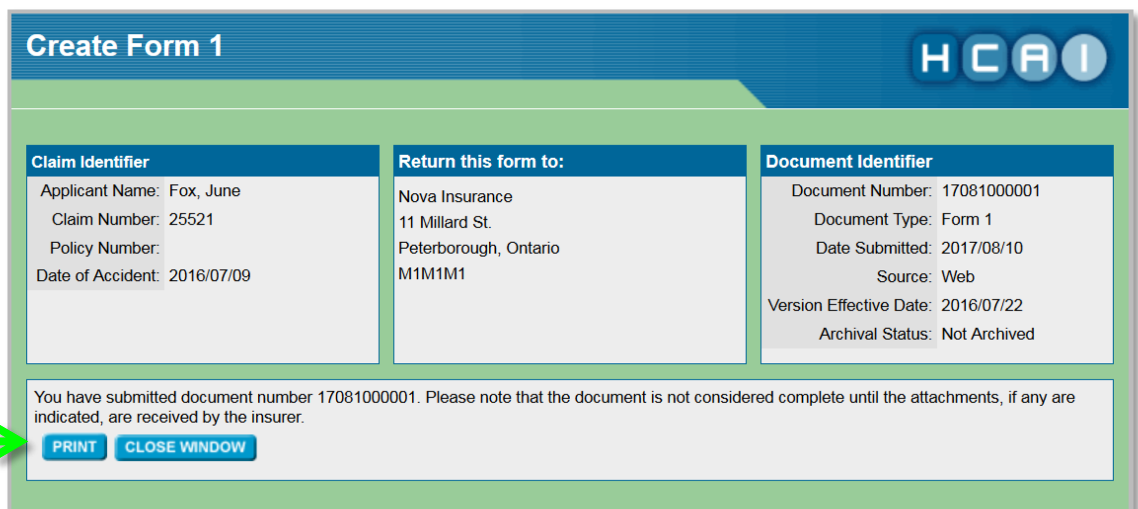
- The assessor who signs the Form 1 attests that the information in the form is accurate and that the assessor has obtained the appropriate consent from the applicant for the collection, use and disclosure of the information submitted. Once the Form 1 is complete, it must be printed, reviewed, and physically signed by the Health Practitioner and stored in the Applicant/Patient file at your facility. Before obtaining signatures, the entire form should be completed.
- Select the “Yes” or ”No” radio button to indicate that the signature is on file and the Form 1 has been reviewed by the assessor
    - The Form 1 cannot be submitted unless the answer to this question is ”Yes”.
    - Use the drop-down calendar menu or type in the date of signature (yyyy/mm/dd) in the field beside “Signed Date:”




## Printing the completed form

- Signatures are not transmitted to the Insurer; however, hard copies of the form must be printed, signed by the Assessor and the applicant/substitute decision maker, and kept on file at the Facility.
- To print a form at any time, click on the PRINT button located at the top and bottom of the page.
- You can also print the form after it has been submitted. After pressing the submit button, the successful submission window will appear. Click on the PRINT button. When printing after submission, the HCAI document number will be displayed on the printed form.
- Depending on your internet browser settings, the document may immediately download or you may need to select whether to open or save the document.
    - For more information on changing your internet browser's pop-up settings, please review the Pop-ups section of HCAIinfo's Computer Requirements & Tips page

Click the print button after submission to print the completed form



# Chapter 3: Tab 3

**Part 1 – Level 1 Attendant Care**

- For each activity listed in Level 1 Attendant Care, enter:
    - The number of minutes required for each activity.
    - The number of times per week required for each activity
- If attendant care is not required for an activity that is listed, you may leave the corresponding boxes empty.

Part 1: Level 1 Attendant Care

Level 1 Attendant Care is for routine personal care. Please assess the care requirements of the applicant for each activity listed. Estimate the time it takes to perform each activity, and the number of times each week it should be performed.
Line may be left empty if attendant care is not required.

CALCULATE

| | Description | Minutes | x | Times Per Week | = | Minutes Per Week |
|---|---|---|---|---|---|---|
| Dress | Upper Body (for example, underwear, shirt/blouse, sweater, tie, jacket, gloves, jewelry) | 10 | | 5 | | 50 |
| | Lower Body (for example, underwear, disposable briefs, skirt/pants, socks, panty hose, slippers shoes) | 10 | | 5 | | 50 |

Assessed Subtotal: 100

- HCAI will calculate the number of minutes per week for each activity
- HCAI will calculate an Assessed Subtotal for each activity described in Part 1
- HCAI will calculate a Part 1 Assessed total, using the Assessed Subtotals for each of the activities described in Part 1

| | Description | Minutes | Times Per Week | Minutes Per Week |
|---|---|---|---|---|
| Extra Laundering | launders applicant's bedding and clothing as a result of incontinence/spillage | 30 | 2 | 60 |
| | launders/cleans orthotic supplies that require special care | | | 0 |

Assessed Subtotal: 60
Part 1 Assessed Total: 310

CALCULATE

# Chapter 4: Tab 4

**Part 2 – Level 2 Attendant Care**

- For each activity listed in Level 2 Attendant Care, enter:
    - The number of minutes required for each activity.
    - The number of times per week required for each activity
- If attendant care is not required for an activity that is listed, you may leave the corresponding boxes empty.

**Part 2: Level 2 Attendant Care**

Level 2 Attendant Care is for basic supervisory functions. Please assess the care requirements of the applicant for each activity listed. Estimate the time it takes to perform each activity, and the number of times each week it should be performed.
Line may be left empty if attendant care is not required.

CALCULATE

| | Description | Minutes | x | Times Per Week | = | Minutes Per Week |
|---|---|---|---|---|---|---|
| Hygiene | Bathroom: cleans tub/shower/sink/toilet after applicant's use | 5 | | 5 | | 25 |
| | Bedroom: changes applicant's bedding, makes bed, cleans bedroom, including Hoyer lifts overhead bars, bedside tables | | | | | 0 |
| | Bedroom: ensures comfort, safety and security in this environment | | | | | 0 |
| | Clothing Care: assists in preparing daily wearing apparel | | | | | 0 |

- HCAI will calculate the number of minutes per week for each activity described in Part 2
- HCAI will provide an Assessed Subtotal for each activity in Part 2
- HCAI will calculate a Part 2 Assessed Total, using the Assessed Subtotals for each of the activities described in Part 2

| | | | | |
|---|---|---|---|---|
| Coordination of Attendant Care | applicant requires assistance in co-ordinating/scheduling attendant care (maximum 1 hour per week) | 30 | 1 | 30 |
| | | | **Assessed Subtotal:** | **30** |
| | | | **Part 2 Assessed Total:** | **55** |

CALCULATE

# Chapter 5: Tab 5

**Part 3 – Level 3 Attendant Care**

- For each activity listed in Level 3 Attendant Care, enter:
    - The number of minutes required for each activity.
    - The number of times per week required for each activity
- If attendant care is not required for an activity that is listed, you may leave the corresponding boxes empty.

**Part 3: Level 3 Attendant Care**

Level 3 Attendant Care is for complex health/care and hygiene functions. Please assess the care requirements of the applicant for each activity listed. Estimate the time it takes to perform each activity, and the number of times each week it should be performed.
Line may be left empty if attendant care is not required.

CALCULATE

| | Description | Minutes | x | Times Per Week | = | Minutes Per Week |
|---|---|---|---|---|---|---|
| Genitourinary Tracts | performs catheterizations | 5 | | 5 | | 0 |
| | positions, empties and cleans drainage systems | | | | | 0 |
| | cleans applicant and equipment after procedure/incontinence | | | | | 0 |

- HCAI will calculate the number of minutes per week for each activity
- HCAI will provide an Assessed Subtotal for each activity in Part 3
- HCAI will calculate a Part 3 Assessed total, using the Assessed Subtotals for each of the activities described in Part 3

| | Description | Minutes | Times Per Week | Minutes Per Week |
|---|---|---|---|---|
| Skilled Supervisory Care | applicant requires skilled supervisory care for violent behaviour that may result in physical harm to themselves or others | 2 | 6 | 12 |

**Assessed Subtotal:** 12
Part 3 Assessed Total: 82

CALCULATE

**Part 4: Calculation of Attendant Care Costs**

**Enter the hourly rates for Parts 1, 2 and 3**

- Determine the Hourly Rate
    - For accidents occurring between March 31, 2008 and August 31, 2010, the rates are:
        - Part 1 - $11.23
        - Part 2 - $8.75
        - Part 3 - $17.98
    - For accidents occurring on or after September 2, 2010, please refer to the hourly rates as set out in the Superintendent's Guideline issued under S. 19 (2) (a) of the Statutory Accident Benefits Schedule (SABS). Download the correct "Attendant Care Hourly Rate Guideline" from FSCO's website: https://www.fsco.gov.on.ca/en/auto/superintendent_guidelines/Pages/Default.aspx
    - The Guideline publishes the maximum hourly rates the insurer is required to pay for accidents that occur on or after specific dates. Please pay attention to the date of the accident and ensure you refer to the appropriate Attendant Care Hourly Rate Guideline.
        - Sep 1/10 – May 31/14 See Superintendent's Guideline 03/10
        - Jun 1/14 – Sep 30/15 See Superintendent's Guideline 04/14
        - Oct 1/15 – Sep 30/16 See Superintendent's Guideline 02/15
        - Oct 1/16 – Sep 30/17 See Superintendent's Guideline 03/16
        - Oct 1/17 – Dec 31/17 See Superintendent's Guideline 02/17
        - Jan 1/18 – April 13/18 See Superintendent's Guideline 03/17
        - On or after April 14/18 See Superintendent's Guideline 01/18

    - The total assessed monthly attendant care benefit is subject to the limits allowed under SABS.
- HCAI will calculate the Monthly Care Benefit using the data entered in Tabs 3, 4 and 5 multiplied by the hourly rate that is entered
- A Total Assessed Monthly Attendant Care Benefit will be displayed at the bottom of the page

**Part 4: Calculation of Attendant Care Costs**

Enter the Hourly Rate for Part 1, Part 2 and Part 3. For accidents occurring between March 31, 2008 and August 31, 2010, the rates are, respectively, $11.23, $8.75 and $17.98. For accidents occurring on or after September 1, 2010, please refer to the hourly rates as set out in the Superintendent's Guideline issued under s. 19 (2) (a) of the Statutory Accident Benefits Schedule (SABS). The total assessed monthly attendant care benefit is subject to the limits allowed under the SABS.

| | Total Minutes Per Week | ÷ 60 = | Total Weekly Hours | × 4.3 = | Total Monthly Hours | × | Hourly Rate | = | Monthly Care Benefit |
|---|---|---|---|---|---|---|---|---|---|
| Part 1 | 310 | ÷ 60 = | 5.16667 | × 4.3 = | 22.2167 | × | 11.23 | = | $249.49 |
| Part 2 | 55 | ÷ 60 = | 0.91667 | × 4.3 = | 3.9417 | × | 8.75 | = | $34.49 |
| Part 3 | 82 | ÷ 60 = | 1.36667 | × 4.3 = | 5.8767 | × | 17.98 | = | $105.66 |
| | | | | | | | Total Assessed Monthly Attendant Care Benefit: | | $389.64 |

CALCULATE

# Chapter 7: Tab 7

**Additional Comments & Attachments**

- HCAI permits Facilities to do the following:
    - Offer more information to Adjusters by using the space provided in Tab 7.
    - Advise Adjusters that additional documentation (attachments) are being sent which the Insurer requires to adjudicate the form.

### How should attachments be sent?

- Attachments must be faxed/mailed directly to the Adjuster.
    - Attachments cannot be sent electronically via HCAI and should not be sent to HCAI.
- To indicate that an attachment is being sent to the Adjuster, check off "Attachments being sent, if any."
    - If this box is ticked, the Facility must indicate the number of attachments.
    - The Facility can use the space below to describe the attachment being sent.

**Additional Comments**

Please note that the document is not considered complete until the attachments, if any are indicated, are received by the insurer. It is mandatory to indicate the number and types of documents/reports that are being sent.

☑ Attachments being sent, if any.

* Number of attachments: 1

Attendant Care narrative report / Description of attachments.

- To save the Form 1 as a Draft, click SAVE. A yellow bar across the top will indicate that the form has been saved successfully.

DELETE CANCEL PRINT SAVE SUBMIT

| Claim Identifier | |
|---|---|
| Applicant Name: | Fox, June |
| Claim Number: | 25521 |
| Policy Number: | |
| Date of Accident: | 2016/07/09 |

**Return this form to:**

Nova Insurance
11 Millard St.
Peterborough, Ontario
M1M1M1

| Document Identifier | |
|---|---|
| Document Number: | |
| Document Type: | Form 1 |
| Date: | 2016/07/28 |
| Source: | Web |
| Version Effective Date: | 2016/07/22 |
| Archival Status: | Not Archived |

Document was saved successfully

**Additional Comments**

Please note that the document is not considered complete until the attachments, if any are indicated, are received by the insurer. It is mandatory to indicate the number and types of documents/reports that are being sent.

- To submit the Form 1, click SUBMIT. The successful submission window will appear.
  - A unique HCAI document number is generated. This number is critical if you would like to track this form.
  - Insurance adjusters can also track this form in their system using this document number.
- To print the submitted OCF, click the "Print" button. The HCAI document number will be displayed on the printed form.

**Create Form 1** HCAI

| Claim Identifier | |
|---|---|
| Applicant Name: | Fox, June |
| Claim Number: | 25521 |
| Policy Number: | |
| Date of Accident: | 2016/07/09 |

**Return this form to:**

Nova Insurance
11 Millard St.
Peterborough, Ontario
M1M1M1

| Document Identifier | |
|---|---|
| Document Number: | 17081000001 |
| Document Type: | Form 1 |
| Date Submitted: | 2017/08/10 |
| Source: | Web |
| Version Effective Date: | 2016/07/22 |
| Archival Status: | Not Archived |

You have submitted document number 17081000001. Please note that the document is not considered complete until the attachments, if any are ndicated, are received by the insurer.

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