# Thalidomide Survivors Contribution Program
## Reassessment Application
## Instructions

Confirmed Canadian Thalidomide Survivors have access to the Thalidomide Survivors Contribution Program which includes an ongoing tax-free payment once per year to help Survivors meet their health care and living needs to assure they will age with dignity. The yearly amount each Survivor receives is based on their level of disability due to Thalidomide as assessed by Health Canada in 1991 or at the time of reassessment.

| Assessed Level in 1991 | 2015 Level Equivalent | Ongoing yearly payment |
|---|---|---|
| Level 1 or 2 | Level 1 | $25,000 |
| Level 3 | Level 2 | $75,000 |
| | Level 3 | $100,000 |

Ongoing payments are indexed to inflation at 2% per year and may be issued in monthly installments or as one lump sum once per year as per the Survivor's preference.

Ongoing payments continue for the Survivor's lifetime without the need to reapply or submit receipts unless the Survivor requests to be reassessed or if the Survivor requests to change their payment preference. Survivors may request **reassessment once per year** or more urgently on a case by case basis. Any change to your level will only apply from the time of assessment. To request a change to your payment preference, please complete and submit an Ongoing Support Payment Form available by contacting the Administrator or by download at www.tscp-pcst.ca.

**Reassessment:**

If a Thalidomide Survivor believes that their health has deteriorated since the 1991 assessment or since their last reassessment as a result of Thalidomide-related injuries, the Survivor may ask that their health status be reassessed. Reassessment may result in a Survivor moving up a level based on the results of the reassessment.

**To be reassessed, the Thalidomide Survivor must:**

1. Complete the attached Reassessment Application in full.
2. Provide the requested medical records as indicated in the Reassessment Application or complete the attached Consent for Release of Medical Information form to allow the Administrator to get the records for you. The Administrator will reimburse you for the cost of these records if you choose to get them yourself once per fiscal year.
3. Provide the required government issued photo identification.
4. Return the completed Reassessment Application, medical records, and identification to the Administrator **by March 31, 2020 by mail, email or fax:**

Thalidomide Survivors Contribution Program
c/o Crawford Class Action Services
3-505 133 Weber St N
Waterloo ON N2J 3G9
tscp-pcst@crawco.ca; 1-888-842-1332

QUESTIONS? NEED HELP?
1-877-507-7706 ● 1-877-627-7027 (TTY) ● www.tscp-pcst.ca

# Thalidomide Survivors Contribution Program Reassessment Application



**Privacy Statement:**

The information requested in this Thalidomide Survivors Contribution Program Reassessment Application is being collected, used and retained by the Thalidomide Survivors Contribution Program Administrator ("Administrator") and its Agents for the purpose of operating and administering the Thalidomide Survivors Contribution Program Administration pursuant to the *Personal Information Protection and Electronic Documents Act*, S.C. 2000, c. 5 ("PIPEDA"). The information will be provided to the Government of Canada in order to facilitate the administration of the Thalidomide Survivors Contribution Program. Personal information is protected under federal legislation, including PIPEDA and the *Privacy Act*, and personal information may be used or disclosed in accordance with applicable legislation. You have the right to request access to your personal information. To do so, call 1-877-507-7706 or 1-877-627-7027 (TTY).

| **Section 1: Thalidomide Survivor Contact Information** | |
|---|---|
| Language Preference: | ☐ English ☐ French |
| Communication Preference: | ☐ Mail ☐ Email |
| Sex at Birth: | ☐ Male ☐ Female |
| Gender Identity: | ☐ Male ☐ Female ☐ Other: _____ |
| Marital Status: | ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/er ☐ Other (specify): _____ |
| First Name: | |
| Middle Name(s): | |
| Last Name: | |
| Date of Birth (mm/dd/yyyy): | |
| Mailing Address: | |
| City/Town: | |
| Province/Territory/State/Country: | |
| Postal Code/Zip Code: | |
| Primary Telephone Number: | (  )  – |
| Alternate Telephone Number: | (  )  – |
| Email Address: | |

| **Section 2: Legally Appointed Personal Representative Information**<br>**(Leave this section blank if the Survivor does not have a Legally Appointed Personal Representative)** | |
|---|---|
| This section is to be completed only if you have been **legally** appointed to administer the Survivor's affairs. You MUST provide proof of your authority to act as the Personal Representative of the Thalidomide Survivor. Please complete both Section 1 on the previous page for the Survivor and Section 2 below for yourself. | |
| I have enclosed a **certified true** photocopy of one (1) of: | Please check (✓) the applicable box:<br>☐ Authority to Act<br>☐ Court Order<br>☐ Other: _____<br>☐ Authority to Act was previously submitted to the Administrator and has not changed (If this box is checked, no need to resend Authority to Act). |
| First Name: | |
| Last Name: | |
| Mailing Address: | |
| City/Town: | |
| Province/Territory/State/Country: | |
| Postal Code/Zip Code: | |
| Primary Telephone Number: | (  )  – |
| Alternate Telephone Number: | (  )  – |
| Email Address: | |
| Relationship to Survivor | |

| **Section 3: Person who helped complete this Reassessment Application**<br>☐ **Same as Section 2 (If this box checked, no need to complete Section 3 below)** | |
|---|---|
| First Name: | |
| Last Name: | |
| Mailing Address: | |
| City/Town: | |
| Province/Territory/State/Country: | |
| Postal Code/Zip Code: | |
| Primary Telephone Number: | (  )  – |
| Alternate Telephone Number: | (  )  – |
| Email Address: | |
| Relationship to Survivor | |

## Section 4: Health Assessment:

Under the original Extraordinary Assistance Plan, your level of disability was assessed using the 1991 assessment criteria.

Under the new Thalidomide Survivors Contribution Program, your disability level will be reassessed by reviewing how your daily living needs have changed as a result of the degeneration of your birth or secondary injuries due to Thalidomide since your last assessment. We will also review your health records to help evaluate your current physical condition. If more information is needed, we will contact you. Otherwise, your application will be reviewed and you will be notified in writing of the determination.

When requesting reassessment, providing complete information and detailed responses to the question in the Health Assessment section of the application is very important. The information you provide helps the medical assessor who is reviewing your file better understand you as a person and how the degeneration of your health over time has impacted your quality of life and your ability to live independently as you are aging.

Although optional, we highly recommend submitting photographs with your reassessment. The photographs may be helpful to the medical assessor to better understand the nature and extent of your physical injuries when information contained within the medical documentation is minimal or absent.

**Instructions:**

1. Please answer the questions in Parts 1 and 2 of Section 4 starting on the next page.
   Part 1 – Review of personal daily living needs
   Part 2 – Review of physical injuries

2. Please provide a complete copy of your medical file including clinical notes, opinions, test results, x-rays reports and any and all documents with respect to the physical condition and treatment of Thalidomide and any other illnesses for 18 months prior to your last healthcare visit. You may obtain the records yourself or, if you prefer, you may complete the enclosed Consent for Release of Medical Information form which will allow the Administrator to get them on your behalf. Please check (✓) the applicable box below:

   ☐ I am getting the records myself, **or**

   ☐ I have signed the enclosed Consent for Release of Medical Information form to allow the Administrator to get them for me

Incomplete responses may result in the delay of processing your application.

| **Section 4: Part 1 – Personal Daily Living Needs:** | | |
|---|---|---|
| Your answers to the questions in Part 1 will help us understand how the degeneration of your health as a result of either birth or secondary injuries (including pain) have further impacted your quality of life and your ability to live independently. | | |
| Has your need to receive help from others to perform the following activities changed since the 1991 assessment OR since your last reassessment? | Changed? | Current level of assistance needed |
| Moving positions from lying to sitting | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| Moving positions from sitting to standing | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| Getting in and/or out of the bathtub | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| Getting on and off the toilet | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| Toileting (i.e. cleansing/wiping following bowel and/or bladder elimination) | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| Climbing up and down stairs | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| Carrying items (e.g. purses, grocery bags) | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| Dressing and undressing | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |

| **Section 4: Part 1 – Personal Daily Living Needs continued:** | | |
|---|---|---|
| Has your need to receive help from others to perform the following activities changed since the 1991 assessment OR since your last reassessment? | Changed? | Current level of assistance needed |
| Cleansing (i.e. bathing, showering) | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| Washing and drying face/hands/ears | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| Brushing teeth | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| Finger/toe nail care | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| Communicating my needs or thoughts to another person due to physical, cognitive or emotional impairments | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| Monitoring my medical condition (e.g. application of suppositories, dispensing of medicine and/or injections, application of topical medicine etc.) | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| In case of an emergency, I need physical or emotional support to ensure my safety | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| I require assistance when using mobility devices to help me walk (e.g. cane, walker, rollator walker) | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| I require assistance when using a manual or power wheelchair for mobility | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |

| **Section 4: Part 1 – Personal Daily Living Needs continued:** | | |
|---|---|---|
| Has your need to receive help from others to perform the following activities changed since the 1991 assessment OR since your last reassessment? | Changed? | Current level of assistance needed |
| I require assistance when using grooming and/or eating aids/devices (e.g. button aid, zipper aid, reacher, dressing stick, dressing hook, wiping aid, cuff for use with eating utensils, specialized knives to cut food, long handle hair brush, electric tooth brush, etc.) | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| I require assistance with housekeeping activities (e.g. floor care, making/changing bedding, cleaning bathrooms, dusting, general clean up) | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| I require assistance with homemaking activities (e.g. laundry, preparation/cooking/ serving/clean up after meals, grocery shopping) | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| I require assistance with home maintenance tasks (e.g. lawn care, garden care, snow removal, handyman, assuming the person has such responsibilities in their home environment) | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| I require assistance to attend community outings (e.g. going to the bank, medical appointments, recreation activities, place of worship, shopping, social activities etc.) | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |
| I require assistance to transport me to various locations (e.g. someone to drive you or go with you) | ☐ Yes<br>☐ No<br>☐ Not Applicable | ☐ Always<br>☐ Sometimes<br>☐ Never |

| **Section 4: Part 1 – Personal Daily Living Needs continued:** | | |
|---|---|---|
| Has your need to use aids/adaptations to assist you to perform daily activities changed since the 1991 assessment OR since your last reassessment? | Changed? | Current level of assistance needed |
| I use mobility devices to help me walk (e.g. cane, walker, rollator walker) | ☐Yes<br>☐No<br>☐Not Applicable | ☐Always<br>☐Sometimes<br>☐Never |
| I use a manual or power wheelchair for mobility | ☐Yes<br>☐No<br>☐Not Applicable | ☐Always<br>☐Sometimes<br>☐Never |
| I have a hearing impairment which requires the use of a hearing device and cochlear implants | ☐Yes<br>☐No<br>☐Not Applicable | ☐Always<br>☐Sometimes<br>☐Never |
| I have a visual impairment which is correctable with lenses and/or requires additional low vision technical aids | ☐Yes<br>☐No<br>☐Not Applicable | ☐Always<br>☐Sometimes<br>☐Never |
| I require treatments such as massage therapy for my injuries. | ☐Yes<br>☐No<br>☐Not Applicable | ☐Always<br>☐Sometimes<br>☐Never |
| I require a prosthetic or orthotic aid | ☐Yes<br>☐No<br>☐Not Applicable | ☐Always<br>☐Sometimes<br>☐Never |
| I require the use of grooming and/or eating aids/devices (e.g. button aid, zipper aid, reacher, dressing stick, dressing hook, wiping aid, cuff for use with eating utensils, specialized knives to cut food, long handle hair brush, electric tooth brush, etc.). | ☐Yes<br>☐No<br>☐Not Applicable | ☐Always<br>☐Sometimes<br>☐Never |

## Section 4: Part 1 – Personal Daily Living Needs continued:

Please describe any other areas/activities that you require help with in your daily life. If additional pages are needed, please write the Survivor's full name at the top of each additional page.

## Section 4: Part 2 – Physical Injuries

**Part 2:** Your answers to the questions in Section 4: Part 2 will help us understand the Thalidomide related birth and secondary injuries you have. Please check all that apply.

| Description | Location of injury (Check (✓) all that apply) |
|---|---|
| Absence or malformation of a bone(s) in one or both thumbs | ☐ Left hand<br>☐ Right hand |
| Absence or malformation of a bone(s) in one or more fingers | ☐ Left hand<br>☐ Right hand |
| Absence or malformation of a bone(s) in one or more toes | ☐ Left foot<br>☐ Right foot |
| Absence or malformation of a bone(s) in one or more limbs (e.g. absence or deformity of a forearm bone) | ☐ Left arm<br>☐ Left leg<br>☐ Right arm<br>☐ Right leg |
| Absence of one or more limbs | ☐ Left arm<br>☐ Right arm<br>☐ Left leg<br>☐ Right leg |
| Malformation of one or both ears, but not their absence | ☐ Left ear<br>☐ Right ear |
| Facial paralysis | ☐ Left side<br>☐ Right side |
| Correctible atresia (blockage) or stenosis (narrowing) of the gastrointestinal tract (stomach and intestines), as in anal stenosis | ☐ Blockage<br>☐ Narrowing |
| Internal malformation(s) or condition(s) | ☐ Heart<br>☐ Stomach<br>☐ Intestines<br>☐ Kidney<br>☐ Spine<br>☐ Life threatening condition |

## Section 4: Part 2 – Physical Injuries continued:

| Description | Location of injury (Check (✓) all that apply) | |
|---|---|---|
| Mental and/or emotional impairment impacting one or more functions | ☐ Memory<br>☐ Awareness<br>☐ Judgement<br>☐ Social withdrawal<br>☐ Depression | |
| Visual impairment | ☐ Yes | |
| Hearing impairment | ☐ Yes | |
| Weight gain that is restricting mobility | ☐ Yes | |
| Degenerative pain in one or more joints | ☐ Left shoulder<br>☐ Left elbow<br>☐ Left wrist<br>☐ Left hand<br>☐ Left hip<br>☐ Left knee<br>☐ Left ankle<br>☐ Left foot | ☐ Right shoulder<br>☐ Right elbow<br>☐ Right wrist<br>☐ Right hand<br>☐ Right hip<br>☐ Right knee<br>☐ Right ankle<br>☐ Right foot |

Please list any other physical or mental impairments not listed above which impact your quality of life. If additional pages are needed, please write the Survivor's full name at the top of each additional page.

_____

_____

_____

_____

## Section 5: Photo Identification and Privacy

Proof of identification is required by **ALL** eligible Survivors. Legally appointed representatives must provide identification for **both** the Survivor and the Representative.

Please submit a photocopy of one (1) of the following government issued pieces of identification for proof of identity purposes. The identification **must include your date of birth**:

- Birth Certificate
- Baptismal Certificate
- Valid Provincial Driver's License
- Valid Provincial Photo ID Card (must include date of birth)
- Canadian Passport

To protect your privacy and to help confirm your identity when we are speaking with you, please provide a security word, number or combination thereof that you will be asked to provide when you contact us. Please choose something that you will be able to remember.

**Please note:** If you previously created your Security Question and Answer, you only have to provide your Security Answer below.

**Security Question (hint in case you forget your security answer):**

_____

**Security Answer:** _____

## Section 6: Declaration and Signature

Section 6 must be completed by the Thalidomide Survivor or the Personal Representative with the legal authority to act on behalf of the Survivor. Please read the following declaration carefully before signing.

**Declaration:** I have completed the Thalidomide Survivors Contribution Program Reassessment Application and I understand that the Administrator will be reviewing my Application for completeness and may need to contact me to request additional information. I understand that completing this application does not automatically mean I move to a higher Disability Level.

I agree to the sharing of my personal information, including but not limited to my contact information, with the Administrator, the Government of Canada and necessary authorized third parties, only for the purpose of processing my request for reassessment.

By signing below, I indicate my agreement to the contents of this Declaration.

**Thalidomide Survivor/Personal Representative:**

Print Name: _____

Signature: _____

Date: _____
(mm/dd/yyyy)

All Thalidomide Survivors or legally appointed Personal Representatives must sign or sign with a mark in Section 6 in the presence of a witness who may be a relative. The witness must complete the Witness information below and sign the Witness Declaration on the next page.

| Witness' First Name | Witness' Last Name | |
|---|---|---|
| City/Town | Province/Territory/State | Country |
| Relationship to Thalidomide Survivor/Personal Representative | | |

**Witness Declaration:** I have witnessed the signature or mark of the Thalidomide Survivor or legally appointed Personal Representative. Where the Thalidomide Survivor or legally appointed Personal Representative signed with a mark, I have read the content of this Thalidomide Survivors Contribution Program Reassessment Application to the Thalidomide Survivor and/or his/her Personal Representative, who signed with a mark, who understands and confirms the information.

Print Name: _____

Signature: _____

Date: _____
(mm/dd/yyyy)

Please make sure the following have been included with your application when returning it to the Administrator:

- ☐ Signed Consent for Release of Medical Information form unless you have chosen to get the records yourself. If you have chosen to get the records yourself, you may return this completed Reassessment Application now and the medical records may follow separately when they are ready.
- ☐ Photographs of your disability or disabilities (optional, but helpful)
- ☐ Proof of identification for Survivor
- ☐ Proof of identification for legally Authorized Representative (if applicable)
- ☐ Certified true copy of their authority to act on behalf of the Survivor (if applicable)
- ☐ Security question and answer provided in Section 5
- ☐ Signed and dated Declaration for Claimant/Personal Representative in Section 6
- ☐ Completed, signed and dated Witness section by Witness in Section 6

Please return the completed Reassessment Application, medical records, and identification to the Administrator **by March 31, 2020 by mail, email or fax:**

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c/o Crawford Class Action Services
3-505 133 Weber St N
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