Reasons for Decision:

Order # AP1516-0324

The appellant appealed that the appellant was not provided with disability benefits for the months of <reference removed>.

The appellant had been in receipt of disability benefits. The appellant's medical eligibility was up for review at the end of <date removed>. The appellant provided a Disability Assessment Report and medical panel determined that the information did not support eligibility for disability benefits. The doctor sent a letter dated <date removed> providing some additional information in the hopes that this would be sufficient to reinstate disability benefits. It was not clear at the hearing, when the program received this letter, and whether or not it was reviewed by medical panel.

A second set of the Disability Assessment forms were released to the appellant and the appellant's doctor completed them on <date removed>. At some point in time the appellant learned that the Employment and Income Assistance Program did not receive this information and the appellant went to the doctor who advised that the forms had been sent in. In the meantime the appellant had requested that the appellant's income assistance file be closed effective <date removed>.

The Department provided the Board with a copy of a letter from the appellant dated <date removed> indicating that the doctor's receptionist had given the appellant the hard copy of the appellant's disability papers. The appellant stated that the appellant dropped off these papers a couple of days later on <date removed> or so. The Department indicated that they did not get them until <date removed> and as the appellant's case was closed, they were not sent to medical panel. The copy of the Disability Assessment Report which the Department brought to the hearing was different than the one provided to the Board in their report. The Board's copy did not have a date received stamp on it, and the Department had the original copy, while the Board had the electronic version that would have been submitted by the doctor.

The appellant stated that the appellant has many debilitating conditions and is not capable of working. The appellant stated that the appellant's health has gotten worse, not better, the appellant was a person with a disability when the appellant was on assistance, and the appellant feels it is only fair that the appellant be provided with the disability benefits for the entire period of time the appellant was on assistance before the appellant's file was closed. The appellant feels the appellant should not be penalized for the appellant's doctor not providing sufficient information, or forms being lost. The appellant stated that the appellant was always on top of the situation and did everything the appellant could as soon as the appellant could do it. With respect to the program's request for specialists' reports for <reference removed>, the appellant stated that it takes months to get these appointments, and the appellant should have

been provided with an extension to the appellant's disability benefits in order to provide the time needed to obtain this information.

After carefully considering the written and verbal information the Board considered two questions:

1. Should the Employment and Income assistance Program have accepted and reviewed medical information that was received after the appellant's case was closed?
2. If the Board determines that the appellant's medical information should have been reviewed, then does it meet the eligibility criteria under section 5(1)(a)?

It is the Board's opinion that the appellant needs to be given the benefit of the doubt as the appellant's doctor's office would normally submit the medical assessment forms directly to the Employment and Income Assistance Program when they submitted their invoice for payment. The program clearly did receive an electronically generated document at some point in time, as the Board's copy of the assessment had the patient information imbedded on it on pages 1 and 3. However the Board had no information as to when they actually received this information. Therefore the Board believes that the Disability Assessment forms should be processed as if the program had received them shortly after the doctor completed them on <date removed> which was prior to the appellant's case closure.

The medical assessment form states the appellant's primary diagnosis as <reference removed>. The doctor stated that the prognosis is unknown and the objective findings are <references removed>. The doctor also lists secondary diagnoses of <references removed>. The doctor also indicates that there are <reference removed> that have been seen on CT. The doctor comments that the <reference removed> was very severe resulting in <reference removed> which causes severe symptoms. The appellant's <reference removed> has been causing pain for years and the only treatment left is surgery. The doctor states that the appellant has an appointment pending with the <reference removed>. The doctor lists the appellant's medications as <references removed>. In the section regarding work activity, the doctor has indicated "not able to work" and estimated a period of <reference removed>. The doctor states that what is functionally stopping the patient from working is that due to <reference removed> the appellant has only a five minute walking tolerance; the appellant is unable to <reference removed>. The appellant uses a <reference removed> for mobility. The appellant has severe pain requiring regular meds and experiences pain and swelling in <reference removed> which get worse with <reference removed>

After carefully considering the written and verbal information the Board has determined that information submitted on the appellant's Disability Assessment form is sufficient to show that the appellant meets the eligibility criteria of a person with a disability. The doctor has clearly stated that the appellant is not capable of working and provided information about the frequency and severity of the appellant's

symptoms. The appellant is not managing pain well, and has been referred to a specialist for surgical options. The Board has determined that disability eligibility should have been granted for a period of six months to provide the appellant time to access specialist information from the <reference removed>.

Therefore the decision of the director is varied and the Board orders that the appellant be provided with a deficit payment for the month of <date removed> for the difference between what the appellant did receive and what the appellant would have received as a person with a disability.