

“Best Practices” for Completing Successful ODSP Applications

Context: When the provincial Harris government came to power in 1995 it got rid of the Family Benefits Act (FBA) benefit and replaced it with the Ontario Disability Support Program (ODSP) benefit. Thousands of people formerly receiving FBA were summarily cut off and many remain cut off. At the same time the General Welfare Act (GWA) was replaced with the Ontario Works Act (OW). Additionally, social assistance rates were cut by 21.6%.

The ODSP application process has been critiqued by income security advocates as deeply flawed:

- The forms are designed with a very narrow definition of “disabled” which favours severe, incapacitating physical disability and ignores severe mental health disability (eg asks can person feed self, dress self, transfer from bed to chair, etc).
- To be found eligible requires a huge amount of detail and supporting documentation, but the format of the application package (small boxes in which one is to write the restrictions arising from the disabling condition) means that it is often filled out in a cursory way and then rejected for lack of detail.
- Neither clients nor providers are prompted to include how the primary disabling diagnosis affects secondary diagnoses
- Clients who have had longstanding complex but untreated mental health issues, while often obviously disabled, are almost always found ineligible because they lack specialist documentation. This group of people often has lengthy histories of social isolation, homelessness and incarceration but rarely have had ongoing therapeutic relationships with health providers, making applying for ODSP (not to mention qualifying) next to impossible.

While time consuming to complete an application, successfully getting people on ODSP is a critically important high impact health intervention. It is very often the difference between homelessness and being able to afford housing. It provides people with about twice as much money as they receive on OW (a little over \$11,000/year as opposed to \$6000/year for a single person). It provides a much greater level of stability in people’s lives because they do not have the constant threat of being cut off nor do they have to constantly “prove” their eligibility for income support as is the case with OW.

Explanation of the process:

- 1) person is referred to ODSP by their Ontario Works (OW) worker. (Person can request a referral from their OW worker).
- 2) Person is given an application package and the OW worker makes a computerized referral to the Disability Adjudication Unit (DAU) which determines that the package must be received within 90 days.

- 3) Person must find health provider willing to fill out the forms.
- 4) Yellow forms can be filled out by MD, RNEC,
- 5) Pink form is filled out by the person applying (the self report form). People often need help with this part.
- 6) Pink and yellow forms + 2 consent forms + supporting documentation are then returned to the DAU.
- 7) Determining eligibility can take anywhere from 2-3 weeks (rarely) to upwards of 6-8 months.
- 8) Person is notified in writing of the decision. If found ineligible, can appeal. The appeal process requires applicant to provide original submission date and rejection date – both of which the information system already has in its data base, and which many clients do not know. The appeal process can take another 8-10 months.
- 9) If found eligible, will take 2-3 months before file is transferred from OW to ODSP and person actually starts receiving their cheque from ODSP. Person will have to go to the ODSP office for interview determining financial eligibility. Generally, the whole process takes about 1 year.€
- 10) If health provider needs more than 90 days to complete the application, can request an extension from the DAU by faxing a letter to (416) 326 3374. It is helpful to accompany this request with a signed consent from the client so that the DAU can respond directly to you with the new due date.
- 11) If the due date comes and goes, and forms are not done, just get the person to see their OW worker to make a new referral. Sometimes if person's life is very chaotic (eg frequent incarceration, long absences from contact – can wait until forms are completed before getting the referral, just so deadline does not expire repeatedly).
- 12) If person is found to qualify for ODSP, they will get a retroactive payment back to the date on which the application package was received.
- 13) If person wants to appeal their decision, it is very helpful to refer them to Sarah Shartal (lawyer) who will advise you on how to improve the application and also represent the person at the appeal hearing.

Determining the diagnoses:

- People rarely qualify for ODSP on physical problems alone, unless they are sufficiently serious. Examples of qualifying diagnoses include HIV/AIDS, cancer, severe cardiac disease, severe chronic lung disease, end stage liver disease, severe head injury. Diagnoses which usually do not qualify someone include any type of MSK pain, including back pain, sequelae of old MSK injuries, asthma, asymptomatic hepatitis C.
- Mental health diagnoses are often more successful because these issues tend to be functionally disabling, meaning that they affect the person in all spheres of day to day

functioning. Examples include refractory major depressive disorder, anxiety disorder, PTSD, poorly controlled psychotic illnesses such as schizophrenia, bipolar disorder, developmental delay, severe head injury.

- In the case of someone with multiple diagnoses, it sometimes works to argue that the presence of 8 or 10 diagnoses, while not substantively disabling individually, combine to create cumulative disability when taken together.
- The ODSP legislation specifically prohibits using an addiction as a qualifying diagnosis. However, the presence of an addiction of longstanding duration should prompt an evaluation of the person's underlying mental health issues. Have they developed an addiction in the process of attempting to ameliorate symptoms arising out of untreated MDD, GAD, PTSD, for example? In most cases, the answer will be 'yes.'
- Although not usually considered "diagnoses" in the strictest sense, one can sometimes insert issues such as "long term homelessness" or "lengthy incarceration history" accompanied by a detailed explanation of the ways in which those experiences have created adjunctive trauma or have interrupted any meaningful opportunity for existing conditions to be adequately assessed and treated.

Evaluating Functional Disability:

To qualify for ODSP, the DAU must be satisfied that the applicant is "substantively disabled" in all areas of functioning: activities of daily living, social interaction, and vocationally. In the case of people with little or no documentation, the strategy is to "create" this supporting documentation yourself, based on your assessment of their functional abilities.

Once the list of disabling diagnoses has been developed, one conducts a detailed assessment of functional ability. It is very important to ask people to answer your questions while thinking about how they manage "on a bad day" – which recognizes that disability fluctuates. Perhaps while they are sitting in your office, they are having a "good day" because on a bad day they would not be able to get out of bed to keep their appointment. Preface every question you ask with "On a *bad* day, can you.....?"

- 1) Activities of daily living: Ask about things they cannot do, or cannot do unassisted on a bad day. Probe around getting out of bed, going out of their apartment, ability to be around others in a shelter setting, do they live outside because they cannot tolerate being around others, can they attend to routine household chores such as laundry, cooking, shopping, cleaning. If unable to leave apartment, for how long at a time, how many times a month? Can they make a grocery list and go shopping. Do they cook or do they rely on soup kitchens for meals (may be related to living situation) but probe for basic skills. Do they know how to read/write/make change in a store. Do they know if they are being shortchanged? Do they know how/where to do laundry, or do they throw out their clothes when they become unwearable. Where do they get new clothes? Can they use public transit, do they know how to get to unfamiliar places in the city, can they read street signs or a map? If person is housed, do a home visit and note your observations about their living space – food in the fridge? Garbage emptied? Dishes clean? Do they even have dishes? Any evidence of cooking for self? Cleaning? Safety concerns? Toileting concerns?

- 2) Social interaction: do they have any friends, do they have anyone they could rely on in a crisis (who is not paid to intervene), can they use a telephone, do they answer their door, can they walk into a bank, can they use an ATM, can they walk into an unfamiliar office (eg doctor's office, lab) and navigate their way to being seen, can they fill out an application form eg for a new health card. Can they keep health appointments or do they always walk in for care? Even with written cues, can they still not keep appointments? Do you only have a relationship with this person because you accommodate them walking in for unscheduled care? Have they only been able to attend referrals because a support staff person accompanied them? Have appointments had to be booked and rebooked repeatedly because of missing appointments? Why do they miss – poor memory, anxiety, something else? Do they do anything for leisure or relaxation? Do they participate in the life of their community in any way?
- 3) Vocational realm: How far did they go in school? If early school leaving, what was the reason? Probe for chaotic early home life, foster care, being bullied or picked on for being different, etc. Ask about literacy, numeracy, were they ever in a special education class, for how long, what specifically did they have trouble with. People over the age of forty often came out of school environments where learning disabilities were not appropriately detected or treated thus you can argue for some folks that they had all the hallmarks of a profound LD but were never treated or documented. Ask if they or their parents might have early school reports which may contain information about behavioural issues or learning problems. Have they ever had a job? Doing what? What was the longest job they had. Did they have any job training? If they left jobs after a short time, probe for why (eg could not keep up on the assembly line, kept getting into fights with supervisor, etc).
- 4) Criminal justice system: Did they have early interactions with the criminal justice system, probe for reasons (eg if theft, did they steal for \$ because couldn't get a job? If drugs, were they using to ameliorate mental health symptoms? If mischief or property damage, were they acting out behaviourally and really should have received health care not jail; if assaults, why were they getting into fights repeatedly, was there anger/aggressiveness arising out of undiagnosed/untreated abuse/trauma, etc).
- 5) Homelessness: Were they ever homeless, for how long (cumulatively). If it adds up to years, call it long term homelessness which one can argue is itself traumatizing. Ask about their experiences of homelessness – did they use shelters, did they experience violence or theft in shelters, did they stay outside in public spaces, why did they leave shelters, did they experience violence or injury related to being outside (eg frost bite, hypothermia, heat injury or illness, cuts, lacerations, fires, burns). Ask about police harassment or violence, were they ever afraid for their lives while homeless, were they ever threatened with death, did they witness violence, were they raped, did they engage in sex work to survive, how many of their friends died while they were homeless. Talk about how difficult/impossible it was for person to attend to health issues while their lives were in chronic chaos.
- 6) Chronicity of pathology: Can often argue in someone who has a long history of social isolation, homelessness, incarceration, etc that they in fact had severe mental health issues which were never detected or treated and that as such their prognosis is poor given

the intractability of symptoms untreated for over 2 years. You will almost always uncover issues that will lead you to suspect mental health pathology of longstanding duration which can be characterized as “symptoms consistent with Major Depressive Disorder with anxiety” and then proceed to explicitly detail those symptoms and how they affect person’s functional ability.

- 7) Addictions: As well, it is sometimes fine to argue that the person with a longstanding untreated mental health issue such as depression or anxiety has coped with severe symptoms by self medicating with alcohol or drugs. It is okay to indicate this as long as you make it clear that even without the alcohol or drug use the person would still be substantively disabled from the underlying condition. It is really important to acknowledge and contextualize substance use if it is referred to in any of your supportive documentation (eg in a psychiatric consult).
- 8) May inquire (sensitively) about children in care of child welfare authorities, past or present; may indicate coping problems by parents, spousal violence problems not previously disclosed, legal issues, etc

→ the summary of your detailed functional assessment gets written up in the form of a letter, similar to a specialist’s consult letter, and is appended to the ODSP forms; on the yellow form, where it asks for examples of restrictions, write “see attached letter.” I usually open with a general statement of the person’s diagnoses/issues, followed by a chronology of their life, followed by detailed description of each diagnosis/issue with the attendant symptoms and resulting limitations in explicit detail.

Old records:

- Ask if they ever had a long term relationship with a health provider and try to get those records, even in another city/province
- Did they ever see a psychiatrist/where (often in jail or training schools – mostly impossible to get because are so old but can try and then document that you attempted and records were not retrievable) If it was fairly recent, likely will be able to get.
- Any overnight hospitalizations? Psych hospitalizations?
- Any documentation of learning disability or previous vocational assessments?
- ER records can be helpful in some cases, if only to support your diagnoses (eg perhaps they have never been diagnosed or treated for MDD but went to ER a few times suicidal)
- Best to exclude any reports which contradict your position unless you can explain why

Appropriate referrals:

- May be appropriate to refer to psychiatry for confirmation of a diagnosis(es); sometimes helpful to state in referral letter that you are assisting person to apply for ODSP; sometimes you get a consult note back which ends up being not helpful; usually best to exclude from the application package
- Can refer to Surrey Place if suspect developmental delay or learning disability
- Capitalize on any existing relationships eg with a housing worker or harm reduction worker – sometimes this person is willing to write a one or two page letter on the person

which you can add as supporting documentation to the application package; the more documentation the better, especially in the case of people who lack formal documentation

Medications:

- Review medications they have tried and which have not worked or which were discontinued due to side effects
- Review current meds and probe for side effects; eg does chronic opiate use cause chronic constipation or do HIV meds cause diarrhea, do narcotic analgesics cause daytime drowsiness or confusion, etc – can add the side effects of meds to the picture of cumulative disability
- If impaired liver function, can sometimes argue that the choice of medication therapy for a particular mental health disorder is very limited and if those choices are not tolerated by the person, treatment options are very limited and thus prognosis remains poor
- If medications are indicated but person cannot or will not take them, mention this (for example, made several attempts to use antipsychotics but unable to take consistently because believed pills were poison) or person may never have had sufficient stability required for a trial of medications

The Yellow Health Status Report (HSR)/Activities of Daily Living (ADL) Form:

- HSR can be completed by MD, psychologist, RNEC, optometrist
- ADL can be completed by the above plus OTs, PTs, audiologist, chiropractors
- Remember, it may be someone OTHER THAN one of these providers who knows the person's functional limitations the best so if possible, negotiate to work with one of these to do the forms together (usually other providers with less experience in doing the forms are happy to work collaboratively to avoid having to do it themselves)
- Do not let yourself be limited by the tiny boxes and spaces – write LOTS and LOTS of detail, on a separate page if easier.
- If using any type of mental health issue (MDD, GAD, PTSD) make sure you fill out the checklist and answer according to how person is on their worst day (should be mostly 4s with a few 3s)
- For the section on proposed/past treatment, explain why something did not or is unlikely to work; eg if you would like the person to see a psychiatrist but you know they will never be able or willing to do so, spell it out here eg “client expresses severe anxiety at mention of seeing a psychiatrist and may never be able to do so”
- Same for the ADL checklist in the second section – answer according to their worst day. For example if on a bad day they do not get out of bed, do not eat, etc can rate “can feed self” as a 3 or 4. Don't allow yourself to be limited by the way the form is constructed. If they drink heavily and become incontinent on a regular basis, rate “can toilet self” as a 3 or 4.

The Pink Self Report Form:

- To be completed by the applicant
- People often need help with this; can be useful to arrange a time with a support person (eg social worker, outreach worker who knows the client well, etc) to go over the form; support person reads the questions and records the answers on behalf of the person

- I usually ask the person to tell me what they would say if they were sitting down in front of the people at ODSP to explain why they can't work – and then I write this down on the pink form

Conclusion:

- Make a concluding paragraph reiterating the set of diagnoses/issues which render the person “substantively functionally disabled.”
- Add mention of any additionally complicating factors such as little formal education, no job skills, no ability to function in English, etc....
- State your opinion that they person is not capable of normal functional ability in activities of daily living, normal social activities or vocational activities.