政府總部
勞工及福利局
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政府總部

LABOUR AND WELFARE BUREAU
GOVERNMENT SECRETARIAT

Central Government Offices
Tim Mei Avenue
Tamar, Hong Kong

本函檔號 Our Ref.: LWB T4/18/29

來函檔號 Your Ref.:

5 December 2018

Clerk to Panel on Welfare Services
Legislative Council Complex
1 Legislative Council Road
Central Hong Kong
Mr Colin CHUI

Dear Mr Chui,

Medical Assessment Form for Disability Allowance

At the meeting of the Legislative Council Panel on Welfare Services on 13 March 2017 and 4 May 2017, Members and attending deputations/individuals provided comments on the draft amendments to the Medication Assessment Form (MAF) for Disability Allowance (DA). The Government pointed out at the meeting on 4 May 2017 that the relevant amendments were proposed with a view to better assist doctors in conducting their medical assessment on DA applicants. The Government had no intention to change the policy intention of or to tighten the existing eligibility criteria for the DA. In view of the comments from Members and the attending deputations/individuals, the Government stated that it would follow up with the Hospital Authority (HA).

2. In consultation with the HA, the amended version of the MAF is at **Annex** for Members' reference. This form has reflected the suggestions made by Members and the relevant deputations/individuals. The Social and Welfare Department will prepare for the implementation of the MAF. The HA and the Department of Health will also brief their doctors accordingly. We expect that the form would be put into use in the first half of 2019 at the earliest.

Yours sincerely,

(Ms Heidi IP)
for Secretary for Labour and Welfare

c.c.

Director of Social Welfare	(Attn: Miss Rita LAU)
Director of Health	(Attn: Dr LO Yim Chong)
Chief Executive, Hospital Authority	(Attn: Dr Cissy CHOI)

Medical Assessment Form for the Disability Allowance

SOCIAL SECURITY ALLOWANCE (SSA) SCHEME

MEMO

From: Supervisor, Social Welfare Department	To: Doctor-in-charge ______ *Hospital/Clinic via *MSSU/MRO/Designated person
Ref.: ______	
Tel.: ______	Your Ref.: ______
Date: ______	dated: ______

Re: *Mr/Ms ______ (Chinese ______)
*HKIC/BC No.: ______ Age: ______
Address: ______ Tel. No.: ______
*Hospital/Clinic: ______ Ref. No.: ______
Next follow-up date: ______ *Specialty/Ward: ______

The above-named, who claims to be suffering from ______ *(a disabling physical or mental condition)*, has applied for Disability Allowance (DA) under the SSA Scheme. *He/She has given us permission to make the medical enquiry.

2. Available information on *his/her *DA and/or medical record is as follows:

☐ New application
☐ Existing Normal DA (NDA) recipient
☐ Existing Higher DA (HDA) recipient

3. A copy of the latest medical assessment form (MAF)^ is *attached/not available/not applicable.

4. I should be grateful if you would fill in the relevant sections in the form overleaf taking into account the information in paragraphs 1 to 3 above and return the original copy of the completed form to the undersigned **on or before** ______. If telephone discussion is desirable, please contact the undersigned or ______ on Tel. No.: ______.

Signature: ______
Name in block letters: ______
for Supervisor, ______

(For new applications only) From: Medical Social Worker ______ *Hospital/Clinic	To: Supervisor, Social Welfare Department
Ref.: ______	
Tel.: ______	Your Ref.: ______
Date: ______	dated: ______

Re: *Mr/Ms ______ (Chinese ______)
*HKIC/BC No.: ______ Age: ______
Address: ______ Tel. No.: ______
Hospital/Clinic: ______ Ref. No.: ______

The above-named has applied for DA under the SSA Scheme.

2. I forward overleaf a medical report on the above-named. Additional remarks are as follows: ______
______.

(Space for official chop)

Signature of Medical Social Worker:..
Name in block letters:..
....*Hospital/Clinic*

* Delete whichever is inapplicable.
^ The latest MAF refers to (a) for an active DA case, the last MAF certifying the applicant's severe disability or (b) for a previously ineligible DA case re-applying for DA, the last MAF certifying that the applicant is not severely disabled, with date of assessment falling within one year counting back from the date of the current application.

MEMO

From :	Doctor-in-charge	To :	Supervisor, ____
	____ *Hospital/Clinic		Social Welfare Department
Ref. :	____		via *MSSU/MRO/Designated person
Tel. :	____	Your Ref. :	
Date :		dated :	

I refer to your memo under reference. Please find below the completed Medical Assessment Form on the following applicant of the Disability Allowance under the Social Security Allowance Scheme for your further action:

Re: *Mr/Ms ____ ***HKIC/BC No.** ____ **SSFU Ref.** ____ *(information to be filled by SSFU)*

MEDICAL ASSESSMENT FORM **SOCIAL SECURITY ALLOWANCE (SSA) SCHEME**

(I) General

Under the Disability Allowance (DA), the role of doctors is to perform medical assessment on the applicants using the Medical Assessment Form and inform the Social Welfare Department whether the applicants are severely disabled within the meaning of the Scheme. An applicant certified by medical officers of public hospitals/clinics under the Department of Health or the Hospital Authority as severely disabled can be eligible for DA under the SSA Scheme. To be regarded as severely disabled within the meaning of DA, a person must fall into one of the categories set out in Part (II)(a) below. The aim of the categories, as defined, is to cover all those who are severely disabled and as a result need substantial help from others to cope with daily life, even if they are able to do a paid job. (For this purpose, those who are in Part (II)(a) below are deemed to need this substantial help.) For new applications, the applicants will **NOT** be qualified for DA if their disablement is expected to last for less than six months. Subject to other eligibility criteria being met, an applicant who is severely disabled as defined above will be eligible for DA and the final authority for approval and granting of DA is vested in the Social Welfare Department.

(II) Nature/Degree of disability [Note: Please fill in Part (a) or (b); and tick the box(es) and fill in the blank(s) as appropriate]

(a) The patient is in a position broadly equivalent to one of (i) to (vii) below **OR** meets (viii) below+:

- ☐ (i) loss of functions of two limbs
- ☐ (ii) loss of functions of both hands or of all fingers and both thumbs
- ☐ (iii) loss of functions of both feet
- ☐ (iv) total loss of sight
- ☐ (v) total paralysis (quadriplegia)
- ☐ (vi) paraplegia
- ☐ (vii) illness, injury or deformity resulting in being bedridden
- ☐ (viii) any other conditions including visceral diseases as specified below:

The patient is suffering from ____
(a disabling physical or mental condition; including but not limited to organic brain syndrome, intellectual disability, psychosis, neurosis, personality disorder) which produces a degree of disablement broadly equivalent to that in (i) to (vii) above, that it is to say, the patient needs substantial help from others to cope with daily life, i.e. the severe disability produces significant restriction or lack of ability or volition comparing to other persons of the same age to perform **at least one or more** of the following activities in daily living to the extent that substantial help from others is required:

(1) working in the original occupation and performing any other kind of work for which he/she is suited (not applicable for patient aged below 15 years)

(2) coping with self-care and personal hygiene such as feeding, dressing, grooming, toileting and/or bathing

(3) maintaining one's posture and dynamic balance while standing or sitting, for daily activities, managing indoor transfer (bed/chair, floor/chair, toilet transfer), travelling to clinic, school, place of work

(4) expressing oneself, communicating and interacting with others, maintaining cognitive abilities (orientation, attention, concentration, memory, judgment, thinking, learning ability, etc.), maintaining emotional control and social behavior@

[please elaborate in Part (VII), if appropriate]

→ ***Please proceed to Part (III)***

(b) ☐ The patient is suffering from ____ *(a disabling physical or mental condition)* but the degree of disability is NOT TO THE EXTENT OF (a) above and hence not regarded as severely disabled.
(Remarks, if any) : ____

→ ***Please proceed to Part (VI)***

* Delete whichever is inapplicable.

\+ A profoundly deaf person who is certified to be suffering from a perceptive or mixed deafness with a hearing loss of 85 decibels or more in the better ear for pure tone frequencies of 500, 1 000 and 2 000 cycles per second, or 75 to 85 decibels with other physical handicaps which include lack of speech and distortion of hearing can also be eligible for NDA. Applicants suffering from hearing impairment should be assessed by ENT doctors of the designated specialist clinics/hospitals under the Hospital Authority using a different set of medical assessment form. A profoundly deaf person who is certified by the ENT doctors of the designated specialist clinics/hospitals is deemed to be qualified for DA.

@ "maintaining emotional control and social behavior" as defined under the context of a medical diagnostic system, such as the latest WHO "International Statistical Classification of Diseases and Related Health Problems".

Re: *Mr/Ms ______________ *HKIC/BC No. ______________ SSFU Ref. ______________ *(information to be filled by SSFU)*

(III) Whether the patient requires constant attendance [Note: For cases falling within Part (II)(a) above]
Patient certified to be in need of constant attendance will be eligible for Higher Disability Allowance which is twice that of the normal rate under the SSA Scheme.

The patient is:

☐ Not in need of constant attendance

☐ In need of constant attendance: [please tick the appropriate box(es) as below]
IN ADDITION TO suffering from severe disability as assessed in Part (II)(a) of the Medical Assessment Form, **ALSO REQUIRES** from another person:

For patient aged 15 years or above

☐ **FREQUENT ATTENTION** throughout the **DAY AND PROLONGED** or **REPEATED ATTENTION** during the **NIGHT** in connection with his/her bodily functions, e.g. totally bedridden, quadriplegia, etc;

OR

☐ **CONTINUAL SUPERVISION** in order to avoid endangering himself/herself or others, e.g. severely demented/intellectually disabled, etc.

For patient aged below 15 years

☐ **SUBSTANTIALLY MORE FREQUENT ATTENTION** throughout the **DAY AND PROLONGED** or **REPEATED ATTENTION** during the **NIGHT** of that normally required by a person of the same age in connection with his/her bodily functions, e.g. totally bedridden, quadriplegia, etc.;

OR

☐ **CONTINUAL ATTENTION AND SUPERVISION SUBSTANTIALLY IN EXCESS** of that normally required by a person of the same age in order to avoid endangering himself/herself or others, e.g. uncontrolled hyperactivity or intellectually disabled etc.

→ *Please proceed to Part (IV)*

(IV) Duration of disabling condition [Note: For cases falling within Part (II) (a) and (III) above]

The disability resulting from the condition specified in Part (II) (a) and (III) is likely to last from *the date of application/the date after the expiry date of last certification, which is ______________________ (date to be filled by SSFU or MSSU) for:

☐ less than 6 months ____ (see #) *(specify number of months)*
☐ 6 months
☐ over 6 - 12 months
☐ over 1 year - up to 2 years
☐ over 2 years - up to 3 years
☐ from 3 years to ____ years (specify)
☐ up to and including ____ years old (specify for child assessment service)
☐ permanently

(V) Assessment for fitness for making a statement in relation to the application of SSA Scheme (applicable for applicant aged 18 or above ONLY)[∞]

☐ The patient is mentally **fit** for making a statement. ☐ The patient is mentally **unfit** for making a statement.

* Delete whichever is inapplicable.

\# For a new application, the patient will not be qualified for DA if his/her disablement specified in Part (II) (a) and (III) is expected to last for less than 6 months.

∞ Staff of Medical Social Services Units (MSSUs) or Social Security Field Unit (SSFU) should cross out this part [i.e. Part (V)] if the applicant aged under 18. Upon an applicant reaches the age of 18 or when further assessment on his/her mental fitness in making statement before expiry of last MAF is deemed necessary, please cross out the other parts of this MAF and leave only this part blank [i.e. Part (V)] for doctor to determine whether the applicant could receive DA payment on his/her own or an appointee should be appointed to act on behalf of the applicant to receive DA payment.

Re: *Mr/Ms ______________ *HKIC/BC No. ____________ SSFU Ref. ____________ *(information to be filled by SSFU)*

(VI) Recommendation ***(tick one item only)***

☐ The patient does **not** meet the eligibility criteria of Disability Allowance (DA) because:
(i) his/ her degree of disablement is not equivalent to severely disabled within the meaning of the DA, or
(ii) his/ her disablement specified in Part (II)(a) is expected to last for less than 6 months (applicable to new cases only).

☐ The patient meets the eligibility criteria of **Normal Disability Allowance** [see Part (II)(a)] but not Higher Disability Allowance. [For conditions of eligibility for Higher Disability Allowance, please refer to Part (III)]

☐ The patient meets the eligibility criteria of **Higher Disability Allowance** {i.e. meeting the criteria for Normal Disability Allowance [see Part (II)(a)] **and** additional conditions for Higher Disability Allowance [see Part (III)]}.

(VII) Change of assessment result compared to the last assessment and any other comments
[Note: To help other doctors assess the patient in future, please put down some physical findings and supportive evidence for assessment, where appropriate.]

(a) Change of assessment result

☐ Change **from permanent Normal Disability Allowance to non-permanent Higher Disability Allowance**, but condition and the higher care level is subject to review.

☐ Other changes of assessment (e.g. duration of disabling condition, from Higher Disability Allowance to Normal Disability Allowance). Please specify reason:

____

____

(b) Any other comments:

____

____

(Space for official chop) *(Signature of Doctor)* *(Name in block letters)* *(Date)*

* Delete whichever is inapplicable.