GUIDELINES

for the

MEDICAL ASSESSMENT

of

DISABILITY

for

SOCIAL ASSISTANCE PURPOSES

INTRODUCTION

In the absence of a policy document on disability related medical assessments, this document seeks to plug this policy gap and provide guidelines for health professionals concerned with such assessments.
Policy related matters that deal with the eligibility criteria for the different types of disability grants are dealt with in the Social Assistance Act of 2004 and its Regulations as would be amended and/or repealed from time to time.

The Disability Management Model, currently under development and for possible implementation in the 2008/9 financial year, would provide a broad management framework and ensure that the to-be Harmonised Assessment Tool would be seamlessly rolled out.
The model, once finalized, would comprehensively address governance, legal and other matters impacting on the delivery of disability related services within the social assistance domain.

BRIEF SYNOPSIS OF SOME OF THE APPLICABLE LEGAL PRESCRIPTS

Activities related to the determination of disability for social assistance purposes are governed by a plethora of legal directives, some enacted via parliamentary processes, whilst others are brought about by court judgements.

Some of the most important pieces of legislation applicable in the determination of disability are the Constitution of the Republic of South Africa and the Social Assistance Act and its Regulations. Here we address only these two acts (including the 2005 Regulations to the Social Assistance Act) as they have a direct bearing on the legal test for disability.
Other pieces of legislation such as the SASSA Act, PAJA and others would be comprehensively dealt with in the new model.

Constitution of the Republic of South Africa, Act 108 of 1996

Chapter 2 of the Bill of Rights in section 27 states that:
(1) Everyone has the right to have access to-
(c) social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.

The Social Assistance Act No 13 of 2004

Section 9 (b) of this Act states that:
A person is eligible for disability grant if he or she:
“is owing to a physical or mental disability, unfit to obtain by virtue of any service, employment or profession the means needed to enable him or her to provide for his or her maintenance”

REGULATIONS IN TERMS OF THE SOCIAL ASSISTANCE ACT 13 of 2004

These 2005 regulations were made by the Minister of Social Development in terms of section 32 of the Social Assistance Act and are currently in force.

Section three of these regulations deal with eligibility for disability grants as follows:

(1) In addition to the requirements set out in regulation 2(2), a person is eligible for a disability grant if-

(a) he or she is a disabled person who has attained the age of 18 years;

(b) the disability is confirmed by a valid medical report of a medical officer and the report specifies whether the disability is permanent or temporary, provided that-

(i) in the case of temporary disability, the medical report issued by a medical officer must, at the date of the application not be older than three months; and

(ii) in the case of permanent disability, the Agency may accept a medical report which was issued by a medical officer more than three months from date of application.

(c) as a result of the disability-

(i) the applicant is certified incapable of entering the labour market; and

(ii) he or she does not refuse to accept employment which is within his or her capabilities and from which he or she can generate income to provide fully or partially for his or her maintenance.

(d) he or she does not, without good reason, refuse to undergo the necessary medical or other treatment recommended by a medical officer, a medical practitioner, or psychiatrist.

Persons eligible for a Grant-In-Aid are covered under section 8 as indicated below

(1) A person is eligible for a grant-in-aid if he or she is in receipt of a social grant and, owing to his or her physical or mental condition, is certified by a medical officer as requiring full time attendance by another person.

(2 The Agency must, on such conditions and from the date as it determines, award a grant-in-aid to the person referred to in sub-regulation(1).

(3) A grant-in-aid is not payable by the State for the housing and care of a beneficiary who is in any State funded home or institution.

CONTEXT AND MAGNITUDE OF DISABILITY

A World Health Organization survey conducted in 1998 indicated that:

- Worldwide, there were 610 million People Living With Disabilities (PLWD)
- 380 million of this group are aged between 15 - 65years
- Unemployment for PLWD stood at 8 – 13% in developed countries and up to 80% in developing countries

Up to a third of South African households (~18 million people) are living in poverty.
South Africa is characterized by large-scale unemployment in the formal sector of the economy especially among women and PLWDs.

Employment in the informal sector in the main lends itself to millions of poor individuals being excluded from health insurance and income protection programmes.
The current inability of our economy to provide sufficient employment opportunities for all those who want to work leads to the increased vulnerability of many households to poverty.

Because people do not have secure and sustainable livelihoods, ***many turn to the welfare system for income maintenance and social support.***
One of the major elements of the social security system in our country is Social Assistance provided in the form of **Social Grants.**

This narrow and brief explanation of the relationship between poverty and the demand for social grants aims to put into perspective, for the medical assessor, the context in which medical assessments for disability assessments are provided.

IMPAIRMENT versus DISABILITY versus EMPLOYABILITY.

These concepts form the cornerstone of ones understanding of the broad meaning of disability and its application in the social assistance context.
All too frequently, people, health professionals included, seem to use disability and impairment interchangeably believing that they have the same meaning.
A brief description of these concepts is provided hereunder.

Impairment

It is known that parts of the body and its organs perform certain necessary functions in daily life. Any deviation from the norm found is recorded by the doctor as the diagnosis. It is then necessary to determine to what extent this abnormality is interfering with the normal functioning of that organ or body part. An abnormality that interferes with function is called impairment.
Thus, a diagnosis alone does not necessarily constitute impairment nor, for that matter, does it describe the extent of impairment present. It is necessary that patients must have some amount of impairment present to be considered disabled.

Doctors are probably the best skilled professionals to be able to determine to what extent impairment exists, particularly when the abnormality involves internal body

organs. In many cases where the abnormality involves external body parts such as limbs, other professionals like physiotherapists and occupational therapists are indeed better skilled than doctors in determining the degree of impairment and thence disability..

Disability

Disability, however, may vary from one person to another even though they have the same extent of impairment present. The varying degrees of disability can be related to and will depend upon social and life circumstances, e.g. opportunities and resources available to them.

The test for disability for social assistance purposes is set out in:

- the definition of a "disabled person" in section 9 of the Social Assistance Act and
- section 27(1)(c) of the Republic of South Africa Constitution Act, 1996

It requires that the Agency must not merely consider if the applicant suffers from a medical condition, but whether the applicant can "enter a labour market".
This means that the Agency must:

a) Consider the impact of the disability on the applicant's ability to function (as reported on by the medical officer) and
b) then decide if this person is unable to obtain work in the open labour market in the area in which he or she resides.

This requires a consideration of the nature and severity of the disability, the age and skills of the particular person, the nature of the work the applicant can perform and knowledge of the relevant labour market.

Employability

Employability refers to the ability of a disabled individual in finding suitable employment taking into account issues like educational standard attained, skills, intellectual capacity, reasonable accommodation, ergonomics, etc.

Employability is an important concept because according to the Social Assistance Act of 2004 the individual's disability should prevent him from performing work that could reasonably be expected to sustain himself/herself. An individual may be disabled but not to the extent that it affects his employability or ability to work. On the other hand an individual may have an impairment that does not affect his ability to work but may make getting to work very difficult and this in turn impacts on his employability.

Certainly most of our population live in very poor social circumstances that cause a lot of suffering, but this alone does not constitute grounds for a disability grant.
However, if the doctor assesses the applicant and discovers that there is significant impairment, but the degree of disability and indeed employability would depend on other issues, it is then that further involvement of other role players may be crucial. The critical role of social workers in determining socio-economic circumstances impacting on an individual's disability cannot be overemphasized. Indeed

comprehensive reports by social workers can sway the decision particularly in borderline cases.
This highlights the importance of a multidisciplinary approach in dealing with the holistic determination of disability particularly for the social security domain.

FUNCTIONS OF MEDICAL ASSESSORS

Activities of medical officers are governed by the Health Professions Council of South Africa (HPCSA). This body sets standards for medical registration, clinical performance and ethical conduct for medical professionals.
Medical Officers conducting disability assessments for social assistance purposes must abide by the ETHICAL RULES of CONDUCT for practitioners registered under the HEALTH PROFESSIONS ACT

Duties of medical officers who conduct disability assessments are the following:

- Confirm the identification of the person to be assessed
- Interrogate the referral letter from referring health professional
- Examine the client and confirm the existence of impairment, if any
- Interrogate the adequacy of treatment prescribed and compliance by the applicant
- Assess applicant for disability according to the guidelines
- Complete the disability assessment form supplied by the region and provide an objective opinion with respect to applicant's disablement, if any
- Advise on further management of the impairment in cases of suboptimal treatment and refer as appropriate.

General Responsibilities of Medical Officers performing medical assessments are to:

- Keep proper medical certificates, records and reports of an applicant or a beneficiary examined by such Medical Officer in connection with the administration of social assistance in terms of the Act.

- Provide the Agency with certified copies of any such certificates, records or reports.

- Report to the Agency in writing within 7 days of gaining any such knowledge of any act, conduct or omission of an applicant or beneficiary in connection with medical treatment of the applicant or beneficiary in relation to such applicant's application for social assistance or the beneficiary's grant, which act, conduct or omission is contrary to the provisions of the Act.

- Report to the agency in writing within 7 day of gaining any such knowledge of any failure or refusal by an applicant or beneficiary to undergo medical treatment recommended by the medical officer or a medical practitioner.

- Report to the Agency within 30 days of gaining any such knowledge of any act, conduct or omission contrary to the provisions of the Act or any other law,

of any other Medical Officer, Medical Practitioner or other health practitioner in connection with the administration of social assistance in terms of the Act.

GENERAL CONSIDERATIONS FOR MEDICAL ASSESSMENTS

1) The medical assessment form is completed by the medical officer in order to assist the Agency in the process of adjudicating applications for disability grants.

2) As much detail as possible is required for an accurate assessment of impairment. It is therefore necessary to supply information regarding the individual's signs and symptoms, and investigations as evidence for the diagnosis given. A diagnosis alone does not allow an accurate assessment of impairment as it gives no indication of the stage or severity of disease. Please attach or report on any relevant documentation available, i.e. medical reports, specialist opinions and investigations, pathology reports, treatment charts.

3) In order to determine permanent impairment the medical problem should have been adequately treated and documented. There must be adequate evidence of the existence of a medical condition and the medical condition should have been stabilised, treated optimally and the individual rehabilitated as far as resources will allow. Alternatively, if this is not the case, on completing the medical form please record in your assessment that further investigation and treatment is still required.

4) If the individual has not been adequately investigated or the field of speciality is beyond your scope please ensure that the necessary specialist reports and ancillary investigations are first done and complete the form once this is available to you. Alternatively, when completing the medical assessment, please state the type of special investigation or specialist opinion still required.

5) It is necessary that every effort has been made to achieve optimal control of treatable conditions, e.g. modifying dosages, combining or changing drugs, monitoring blood drug levels. If a patient's condition is not adequately controlled, please ensure that the patient's treatment is reviewed, optimised and monitored appropriately.

6) A history of good compliance with treatment on the part of the client is essential. Any individual who deliberately defaults treatment can be refused social assistance regardless of the degree of impairment present. Similarly, if an applicant's condition has been accommodated or corrected with assistive technology resulting in mitigation of the disability, such applicant may no longer qualify for a disability grant.

7) Please be aware that when considering a person for a disability grant we are looking for a medical condition that is causing significant functional loss and limitation of normal daily activities. You should be able to define the specific activities or functions that the individual cannot perform due to and related directly to his medical condition. Medical conditions that can be controlled on

medication have little impact on daily function and therefore do not cause any significant impairment.

DECISION-MAKING RELATED TO THE REJECTION OR AWARD OF GRANT

Quite often people have the mistaken impression of thinking that medical assessors are the final arbiters regarding the award or rejection of the grant.
It is in fact the Agency that decides if a person qualifies for any of the disability grants on the basis of:

- a factual report by medical officer and
- the interview conducted with the client by a grants administration official.

Medical officers do not have lawful authority to decide on disability related applications. Their only function is to furnish the Agency with an objective opinion on the applicant's disablement, if any.

It remains the Agency's duty to consider the facts in the report by the medical officer, and come to a decision on whether the applicant meets the definition of a "disabled person" as stated in section 9(b) of the Social Assistance Act.

SPECIFIC GUIDELINES

Epilepsy

This is a treatable condition and with adequate medication can be well controlled, causing little permanent impairment.
Consideration of the following is essential:

- When the diagnosis was made
- Has treatment been adequately reviewed and optimised to achieve the best possible control.
- Documentation of the frequency of seizures
- Any associated mental retardation, psychotic behaviour, and physical abnormalities (Do a quick mental status assessment and estimate IQ level or mental age).
- Whether the patient has worked previously
- Any history of substance abuse.
- Recent drug levels as evidence of compliance and optimisation of treatment.

Cancer

Describe:

- The type of cancer, i.e. organ involved and histological findings.
- The extent of cancer, e.g. staging, i.e. local invasion and metastatic disease and symptoms secondary to this

- Treatment and response, i.e. is the patient in remission or is there recurrent disease.

HIV/AIDS

Record the following:

- When first diagnosed and current symptoms.
- General physical condition.
- Record BMI or degree of weight loss over period of time.
- Any recurrent/opportunistic infections. Please describe the specific details of each.
- CD4 count and viral loads are not essential. These results should be provided, however, if available
- Stage the disease according to WHO staging, motivating clinically your reasons for this staging.

Remember early HIV is asymptomatic and patients can still work.
WHO stages 3 and 4 will be considered for a disability grant.
With the availability of antiretroviral therapy, beneficiaries must be aware that compliance with treatment is vital and that any evidence of defaulting treatment or non-compliance disqualifies grant eligibility.
Please note: There is no special HIV grant.

Hypertension

This is not impairment per se as it is treatable and can be well controlled on medication causing little, if any, permanent impairment.
Few patients are uncontrollable on medication.
Mention should be made of the following:
- when diagnosed
- treatment - compliance and has it been optimised
- recent BP levels

Describe any secondary organ involvement, e.g. retinal, neurological, cardiac, and renal.
Attach any relevant report on investigations, e.g. CXR, ECG(electrocardiogram), CT scan, U + E(urea and electrolytes or kidney function test), eye testing that provides evidence of involvement of this organ, extent of damage and assessment of visual acuity.
Early target organ damage also mostly can be controlled with treatment and causes little impairment.

Diabetes Mellitus

This condition can also be well controlled on regular medication causing little permanent impairment.
Record the following:

- When diagnosed.
- Type I vs type II.
- Current treatment and whether treatment is optimal.
- Is insulin required?
- Recent blood glucose levels
- Evidence of compliance.

If there is any secondary organ involvement, attach relevant reports or investigations, e.g. eye test, renal function, ECG that describes the type and extent of damage.

Psychiatric Illness

Describe :

- The course of illness
- When diagnosed
- Hospital admissions
- Frequency of relapses
- The findings on mental status examination.
- Symptoms during acute illness, and those during remission.
- Treatment, i.e. type of neuroleptic drug and dosage
- Compliance with treatment (a clinic card showing regular attendance).
- Any substance abuse. (Be sure to exclude psychosis secondary to intoxication.)

All cases require a full assessment of mental status, i.e.

i) perceptual disturbances
ii) thought process
iii) mood
iv) cognition i.e. memory, calculations, language ability, judgement, insight

Many psychiatric conditions are treatable and can be well controlled with medication, or are chronic but low grade causing minimal impairment that does not significantly affect the individual's ability to work.

Conditions considered are:

a) Schizophrenia where adequately documented and on satisfactory treatment with adequate doses of neuroleptic drugs.
b) Bipolar mood disorder where mood stabilisers and neuroleptic drugs are required to control symptoms
c) Any evidence of mental retardation where no mainstream schooling or skills training has been possible due to below average mental ability.

Mental retardation:

Describe : IQ level
Mental age
Cognitive function

Mild mental retardation = IQ 60 - 84 = mental age +-10 yrs
Moderate mental retardation = IQ 49 - 59 = mental age +-6yrs

Severe mental retardation = IQ 25 - 49 = mental age +-3yrs
Profound mental retardation = IQ <25 = mental age 2 yrs or less

Neurological

Describe:

- The disease process present and whether early, late or residual stages of disease.
- Whether upper versus lower motor neuron lesion
- Whether central versus peripheral neurological involvement
- Grade of power, tone, position, deformity secondary to contractures, etc. of limbs involved.
- Symptoms and signs of any deficits in higher functioning, e.g.
  cerebellar signs – ataxia, inco-ordination
  temporal signs - speech, memory problems
  parietal signs - spatial disorientation - speech changes
  frontal signs - dementia, - behavioural changes
- CT scan findings.

NB: Stroke patients must be given 3 months recovery and must receive rehabilitation especially physiotherapy.

EAR NOSE AND THROAT (ENT)

Malingering is common. Clinical evaluation and judgement is important. Test clinically, e.g. does he respond to normal conversation, sudden unexpected noise or if called from behind.
Any patient complaining of poor hearing, but who responds well to normal conversation does not qualify for a grant, however, he may still require further investigation.
Any severe deficit should be confirmed by report from ENT clinic with an audiogram or alternatively if the patient has not been adequately investigated, but clinically there is obvious hearing impairment, please record this, as a temporary grant can be recommended and he must go for appropriate management and investigation during this time. It must be established whether the patient does or will benefit from a hearing aid.
The exact cause of deafness must be documented. “Deaf and dumb since birth” is not enough information.

Visual Acuity

Patients complaining of poor eyesight need a report from the eye clinic documenting:

- the cause or pathology
- the visual acuity and refractive error in both eyes, as well as the degree of visual acuity, once corrected with spectacles
- any visual field loss
- any corneal scarring /cataracts

- retinal findings
- can the patient be treated, e.g. cataract surgery/ spectacles for a refractive error

Cardiovascular System

Describe:

- Clinical findings, e.g. HR, apex, BP, pulses, any extrasystoles, heaves, murmurs, fainting spells, symptoms and signs of right or left heart failure example, lung congestion, pedal oedema, liver congestion.
- Frequency of such symptoms
- Response to anti-failure treatment
- Evidence of dysfunction from investigations, e.g. CXR findings, ECG, cardiac enzymes, LFT, ECHO (if possible)

If patient has received heart surgery, please describe cardiac function after surgery as cardiac function may be satisfactory and well controlled on medication following corrective surgery.
Important information regarding impairment include: whether **Cardiac Failure** is present, it's response to treatment, and whether it is episodic or continuous requiring frequent hospital admissions. The patient's effort tolerance and grading of the degree of dyspnoea present are also important.

Chronic Rheumatic Heart Disease

- The illness usually affects young children and recovery by adulthood is usually reasonable.
- Those requiring valve replacement surgery should be evaluated once this has been completed.
- After surgery many individual's cardiac function is adequate.

Ischaemic Heart Disease

Document :
- symptoms at rest or on effort
- describe ECG changes, cardiac enzymes
- attach specialist report

Respiratory System

It is important to describe the respiratory function clinically and according to findings on relevant investigation.
The following must be recorded:

- Grade dyspnoea according to NYHC 1,2,3,4
- Smoker or previous smoker
- Any history of previous TB
- Hyperinflation, consolidation, wheezing, crepitations
- Presence of cor pulmonale
- Describe CXR findings
- The regular PEFRs recorded at the clinic
- PEFR on the day of examination (if possible)

If possible a lung function test (reflecting adequate patient effort) should be attached.
Describe the patient's treatment, efforts to optimise treatment, as well as patient's response and compliance with treatment

Tuberculosis (TB)

Record the following important points:

- When diagnosed
- How many times affected with TB
- Has the patient received adequate treatment
- Is patient presently on treatment
- Whether TB is acute versus chronic.
- Acute TB is treatable and most individuals recover well with no significant residual permanent impairment. Grants for acute TB are discouraged except under exceptional circumstances of severe respiratory compromise where sufficient motivation is required.
- Chronic TB will be considered depending on degree of respiratory compromise and response to bronchodilator treatment. These patients should have received an adequate trial of bronchodilation with regular monitoring of the Peak Expiratory Flow Rate at clinic visits in order to document his/her response to therapy.
- It is important to always give a good clinical assessment of respiratory function and grade the degree of dyspnoea.
- Description of the chest x-ray (CXR), lung function test (LFT), peak expiratory flow rate (PEFR).

Asthma

This is generally a treatable condition and is usually well controlled with regular adequate medication, causing little permanent impairment.

Chronic Obstructive Airways Disease

This is treatable to a point, i.e. symptoms can be reversible or controlled with treatment. The patient should have been on a trial of bronchodilators to determine response and degree of reversibility of symptoms. Adequate evidence of lung damage must be provided through description of clinical and CXR findings and documentation of PEFR before and after bronchodilation. Lung function tests are preferable but not essential if enough information is provided.

13. Morbid Obesity

This condition is generally not considered to cause permanent impairment. Patients must be encouraged to lose weight.
Record the weight and height of patient. (BMI)
Only gross obesity is considered where there is obvious limitation to activities of daily living and there is evidence of a metabolic syndrome, e.g uncontrolled hypertension and diabetes associated or where there is severe secondary osteoarthritis.

14. Abdomen/Urogenital System

Describe:

- The current condition of the patient (symptomatically and clinically)
- Investigations, surgical procedures and treatment undergone
  e.g. Liver function test/renal function test
  Ultrasound/CT scan findings
  Endoscopic investigations
  Any long term treatment e.g. dialysis
- Record the following:
  - weight of the patient
  - any recent weight loss
  - whether the condition is controlled
  - describe current treatment
- An important measure of degree of impairment is weight loss. Record Body Mass Index (BMI) or degree of weight loss over period of time.
- Describe the presence of any anaemia, metabolic disturbances or bleeding tendencies secondary to kidney or liver failure.
- The stage of the illness, e.g. early mild disease, in remission, chronic, but controlled, late stages

Musculoskeletal

This includes patients with polio, congenital limb defects, fractures, and arthritis.
Describe:

- Each joint involved individually, e.g. position, any deformity, any loss in range of movement (ROM).
- Any muscle wasting and grade out of 5 the muscle power for each specific group of muscles.
- Changes in muscle tone, e.g. flaccidity or spasticity/contractures and any other neurological deficit.
- Whether this patient does or would benefit from any orthopaedic/ prosthetic device?

The following conditions do not qualify for a grant as they cause insignificant impairment:

a) Chronic fatigue syndrome, malaise, musculoskeletal pains, or general body pains
b) Backache with no evidence of pathology
c) Joint pains with no evidence of pathology, e.g. arthralgia, fibromyalgia
d) Mild to moderate muscle wasting in one limb with minimal functional impairment
e) Gout

f) Old healed fractures
g) Fractures with internal fixation
h) Healed fractures with mild to moderate deformities and mild functional impairment
i) Osteomyelitis is treatable and requires adequate orthopaedic management
j) Mild to moderate arthritis with no evidence of joint deformity or limitation of movement in the joint
k) Mild to moderate kyphoscoliosis
l) Achondroplasia with height > 1,4metres

Endocrine

In most disorders of undersecretion of hormone it is possible to replace the hormone. Disorders of hypersecretion are also generally treatable with surgery or radiology and then replacement therapy.
Therefore, in most instances patients should have no impairment, unless symptoms of hypersecretion cannot be controlled (e.g. Cushings disease) or where chronic undersecretion (e.g. thyroid) has caused irreversible damage, e.g. cognitive slowing and mental retardation.

Record the following:

- The type of hormonal problem
- Any ablative procedures undergone
- Current hormone or other therapy
- Recent relevant hormone levels

TABLES OF ESTIMATED IMPAIRMENT PERCENTAGES

AMPUTATIONS (Without accommodation by prosthesis) with a good fitting prosthesis the impairment is minimised	**%**
Amputations (without accommodation by prosthesis) with a good fitting prosthesis the impairment is minimised	
Amputation of two limbs	90
Amputation of both hands (all fingers + both thumbs)	90
Amputation of arm at shoulder	60
Amputation of arm between elbow and shoulder	50
Amputation of arm at elbow	50
Amputation of arm between wrist and elbow	50
Amputation of hand at wrist	40
Amputation of 4 fingers + thumb of one hand	40
Amputation of 4 fingers	30
Amputation of thumb (both phalanges)	20
Amputation of thumb (one phalange)	10
Amputation of index finger (3 phalanges)	8
Amputation of finger (2 phalanges)	4
Amputation of middle finger (3 phalanges)	6
Amputation of middle finger (2 phalanges)	3
Amputation of middle finger (1 phalange)	2
Amputation of ring finger (3 phalanges) (2 phalanges) (1 phalanx)	3 2 1
Little finger (3 phalanges) (½ phalanges)	2 1
Amputation of metacarpels (1^{st}, 2^{nd}, 3^{rd}) (4^{th}, 5^{th})	4 2
Amputation of leg at hip	60
Amputation of leg above knee	50
Amputation of leg at knee	50
Amputation of leg below knee	40
Amputation of all toes	15
Amputation of both big phalanges	5

Amputation of one phalanx	3
Amputation of all toes other than big toes	7
Amputation of 4 toes	5
Amputation of 3 toes	3
Amputation of 2 toes	2
Amputation of one toe	1
DEFORMITIES OF LIMBS (Estimates for Arthritis) Non-functional deformities of the limbs can be equated to the amputated part of the limb. Where the limb remains partially functional the impairment estimate is obviously less than that of amputation of that part.	
EPILEPSY A treatable condition that does not qualify unless patient remains uncontrolled in spite of optimal treatment and strict compliance	
Controlled (i.e. 0 - 2 seizures monthly) or lack of documentation	5
Uncontrolled (>2 seizures monthly), despite evidence that treatment has been optimised and compliance is satisfactory.	30
With complications : Physical spasticity Mental retardation Psychosis	80 80 50
HYPERTENSION Treatable condition, not qualifying for DG unless significant permanent secondary organ damage	
Controlled	0 - 5
Uncontrolled : Mild Moderate Severe	10 15 20
With complications : Heart failure NY I (early Cardiomyopathy) NY II NY III NY IV	20 30 50 60
Retinopathy Stroke Renal failure	30 - 40 or more, depending on loss of function in system involved
DIABETES Treatable condition that does not qualify unless significant permanent secondary organ damage	
Treatable condition that does not qualify unless significant	

permanent secondary organ damage	
Well controlled	0 - 5
Uncontrolled (depends on efforts to optimise treatment)	10 - 20
With complications : - Retinopathy, Renal failure, CVA/stroke, Neuropathy other Vascular Disorders	30 - 40 or more
ASTHMA Treatable condition, not qualifying for disability grant	
Controlled	0 - 5
Uncontrolled	10 - 20
COAD	
Dyspnoea Grade I - II Grade III – IV	10 30 - 40
FVC/PEF 80% of expected >60% of expected <50% of expected	10 20 40 - 50
TUBERCULOSIS Acute - treatable, no disability	
Chronic TB : Multiple drug resistance Lung damage/fibrosis	30 30 - 50
HIV	
Unsymptomatic early disease (stage 1 & 2 does not qualify for a DG)	0 - 5
Opportunistic infections	20 - 40
AIDS	50 - 90
MUSCULOSKELETAL	
The amputation of the affected part can be used as a point of reference and loss of function can be equated proportionally with this. It is clear that it is only with severe deformities that impairment is significant and many qualify for DG.	
VISION	
Total loss of vision both eyes	90
Total loss of vision one eye	20 - 25
Poor vision both eyes (and not correctable with spectacles) i.e. worse than 6/36 in both eyes	50
HEARING LOSS	
Loss of hearing both ears	90
Loss of hearing one ear	10
Poor hearing	

Unable to hear normal conversation Sensorineural depending on audiometry/correction with hearing aid (if congenital + associated dumbness) Conductive (usually treatable)	30 50 - 75 80 30 - 40
CENTRAL NERVOUS SYSTEM	
Of one limb: Total paralysis Partial paralysis (paresis) power > 3/5 Partial paralysis power <3/5	50 20 30 - 40
Hemiplegia	75
Paraplegia	75
Quadriplegia	100
Parkinson's Disease (Other neurological disorders) - Early disease - Late disease	 15 - 40 >50
LANGUAGE DISTURBANCE i.e. Disturbance of the central mechanism of language comprehension and production	
Minimal to moderate disturbance, but understandable	5 - 25
Cannot comprehend or produce any language	>50
ORGANIC BRAIN SYNDROME Defects such as : Lack of orientation to time, place and person Inability to understand abstract/normal concepts Loss of memory (long/short) Poor judgement Unable to make decisions Inability to carry out instructions/complete a task Unacceptable social behaviour	
Ability to carry out most activities, but not all as well as before	5 - 20
Supervision needed in daily activities and instructions	25 - 40
Confined to home or special care	>50
Constant supervision and inability to perform most or all activities of daily living	80 - 90
CRANIAL NERVES Oculomotor, trochlear and abducent nerves, i.e. III, IV ad VI - refers to guides chapter on impairment of vision	
Facial nerve VII: Unilateral (complete) Bilateral	15 45
Trigeminal Nerve V Complete sensory loss (unilateral) (bilateral) Motor loss	 10 25

(unilateral) (bilateral - affecting chewing, swallowing +speech) Neuralgia	20 35 5 - 10
Glossopharyngeal, Vagus, Accessary (IX, X, XI) Difficulty in swallowing : Semisolids Fluids only Nasogastric feeding	 10 35 55
AUTONOMIC NERVOUS SYSTEM DYSFUNCTION	
RESPIRATION	
Spontaneous respiration, but restricted ambulation	45
Limited to bed	80
BLADDER	
Good reflex activity, but no voluntary control therefore trainable e.g. 2 hourly bladder emptying	20
Bladder has poor reflect activity and no voluntary control	40
No control	>50
ANORECTAL FUNCTION	
Faecal incontinence c partial control	10
Faecal incontinence c complete loss of control	25
SEXUAL FUNCTION	
Total impotence or absence of sex organs	15 - 20
PSYCHIATRIC/MENTAL/BEHAVIOURAL DISORDERS	
MENTAL RETARDATION Mild mental Retardation	25 - 40
Moderate (IQ 45 - 60) mental age 6 - 7 yrs	50 - 75
Severe (IQ 25 - 45) mental age 3 - 6 yrs	>80
Profound (IQ 25) mental age <2	90
SUBSTANCE ABUSE	
If there is any evidence that suggests present or ongoing substance abuse the applicant does not qualify for DG. Only those where permanent impairment has resulted as a complication will be considered. Impairment is based on secondary organ involvement, i.e. liver impairment or organic brain syndrome	30 -75
SCHIZOPHRENIA	50 - 80
BIPOLAR MOOD DISORDER	40 - 75
Unipolar depression and anxiety disorders as well as emotional and behavioural disturbances and personality disorders do not	

qualify for DG except where daily functioning is severely affected and motivated by a specialist psychiatrist. Symptoms may range from irritability to outbursts of aggression and rage to panic attacks and generalised anxiety; from eupharia and involving laughing to depression and agitation and from fluctuations in emotional states to blunted or dull effects. e.g. Mild to moderate disturbance under abnormal stress Mild to moderate disturbance under day to day stress Moderate to severe disturbance under day to day stress requiring sheltered care Severe disturbance, danger to oneself or others requiring constant care	 10 20 50 60 - 90
GASTRO-INTESTINAL TRACT	
Laparotomy for penetrating wound or ruptured viscera resulting in adhesions	0 - 10
OESOPHAGUS	
No loss of weight - is within 5% of norm	0
Loss of weight up to 10% of norm	10
Loss of weight up to 20% of norm	25 - 40
Only soft diet	30 - 40
Liquid diet only	50 - 80
PARTIAL GASTRECTOMY	
No complications	10
With dumping syndrome	25 - 30
TOTAL GASTRECTOMY	
Loss of weight up to 20% of norm	25 - 30
Loss of weight in excess of 20% of norm	40
Loss of weight in excess of 20% of norm and anaemia and hypoproteinaemia	60
SMALL BOWEL	
No loss of weight	0 - 5
Loss of weight up to 10% of norm	<25
Loss of weight in excess of 20% of norm/BMI<18	50 – 60
LARGE BOWEL	
Permanent colostomy	20
Faecal incontinence	25
LIVER	

Ruptured liver with no sequelae	0 – 5
Chronic active Hepatitis B	15
Chronic active Hepatitis B with cirrhosis	40
Chronic active Hepatitis B with cirrhosis and progressive deterioration	60
SPLEEN	
Splenectomy - depends on whether there are morphologic abnormalities of red blood cells, recurrent overwhelming infections (usually less than 2% of cases) elevation of platelet count, leucocyte abnormalities	0 – 15
KIDNEYS	
Loss of one kidney	15
Progressive kidney failure	50 – 80
URINARY BLADDER	
Good reflex activity but no voluntary control	20
Weak reflex activity (intermittent leak or "dribble" & no voluntary control)	40
No reflex and voluntary control	>50
URETHRA	
Traumatic stricture	10
Urethral fistula	30
Traumatic stricture with secondary chronic pyelonephritis	40
DEEP VEIN THROMBOSIS	
Significant swelling of leg affecting gait	10
Swelling with significant stasis dermatitis or ulceration	20
ENDOCRINE A treatable condition only qualifies if symptoms are severe despite treatment	
Controlled on replacement hormone	0
Mild, moderate symptoms occasionally despite treatment	10
Moderate symptoms	20
Severe symptoms persist despite treatment	30 - 40

APPENDAGE: 3
SPECIFIC ELIGIBILITY CRITERIA FOR DISABILITY AND CARE DEPENDENCY GRANTS

PROTOCOL FOR ASSESSING A DISABILITY GRANT APPLICATION

The following principles should be abided by, to maintain uniformity in disability grant evaluation.

Factors to consider during evaluation

- Description of impairment based on medical diagnosis
- Level of functional independence (activities of daily living)
- Education + skills, employment history
- Discriminating factors:
  Age : < 50
  > 50
  Geographical area and socio-economic factors
  Opportunities for referral, community projects or sheltered workshops

Determination of grant eligibility:
Firstly the presence of medical impairment must be considered as follows:
According to the information supplied in the medical assessment the patient is estimated to fall into one of the following categories:

1) Minimal impairment, i.e. 0 - 25%
   The impairment is considered to be minor despite the social conditions and he/she does not qualify.

2) Significant impairment i.e. 25 - 40%
   The patient may qualify depending on above mentioned social factors

3) Major impairment i.e. >40%
   The patient automatically qualifies for Disability Grant unless he/she fails the means test

CONDITIONS THAT DO NOT QUALIFY FOR DISABILITY GRANTS

NB : Any evidence of poor treatment compliance may disqualify the applicant.

PSYCHIATRIC

Controlled epilepsy with no other associated physical or mental impairment
Generalised anxiety disorder
Panic attacks
Reactive depression
Low grade chronic depression
Minor depression
Dysthymia
Personality disorders require extensive well documented history of social and occupational impairment before being considered
Adjustment disorders

NEUROLOGICAL

Cerebro-vascular accident (CVA), i.e. a stroke < 3 months ago. A period of recovery and rehabilitation is first required)
CVA >3 months before with mild neurological fallout and good recovery after rehabilitation, e.g. power in limbs >4/5
Head trauma with no objective neurological deficit
Residual polio with a limp due to shortening of <5cm, mild wasting of muscles or power of grade 4 or more

MUSCULOSKELETAL

1. Chronic fatigue syndrome, malaise, musculoskeletal pains and general body pains
2. Backache with no evidence of pathology
3. Joint pains/arthralgia/fibromyalgia with no evidence of pathology
4. Mild to moderate muscle wasting in a limb with minimal functional impairment
5. Gout that is well controlled on treatment
6. Old healed fractures
7. Fractures with internal fixation and no evidence of functional impairment
8. Healed fracture with mild deformity/malunion
9. Chronic osteomyelitis (treatable and requires specialist motivation)
10. Previous TB spine or any bone with minimal residual impairment following treatment
11. Kyphoscoliosis with no evidence of respiratory or neurological compromise
12. Achondroplasia with height.>1,4metres

EYE

Complete loss of vision in one eye with normal vision in remaining eye
Any visual impairment correctable with spectacles

HEARING

Total loss of hearing in one ear with normal hearing in other ear
Noise induced hearing loss at one frequency with no evidence of deterioration

CARDIOVASCULAR SYSTEM

Well controlled hypertension (HPT) i.e. high blood pressure
Newly diagnosed uncontrolled HPT, as this must first receive appropriate treatment
Previous cardiac surgery heart disease with adequate cardiovascular function on recovery
i.e. Dyspnoea of New York Heart Classification (NYHC) < 3
Infrequent episodes of heart failure that respond well to antifailure treatment

RESPIRATORY

Acute PTB
Acute and chronic asthma
Chronic obstructive airways disease responsive to bronchodilation or with mild dyspnoea

MEDICAL CONDITIONS WHICH MAY BE CONSIDERED FOR TEMPORARY DISABILITY GRANTS

These grants will be given out only when the temporary disability is severe and under highly specific conditions. It must be understood that the medical problem is expected to improve, usually to the extent that the individual will be able to return to work and for that reason will be terminated after the 6 or 12 month period. It is for relief during a crisis period where treatment and recovery from a severe medical condition may preclude work for a period of at least 3 months. Unfortunately, there is a tendency for temporary grants to create dependency and poor motivation for recovery. Due to this component of secondary gain these grants must be given out cautiously.

The following conditions (where severe functional impairment is present) may be considered for a temporary grant:

1) Acute PTB with severe respiratory compromise and motivated by exceptional circumstances, e.g. multiple drug resistant TB

2) Patient awaiting surgery/correction of a medical problem which without such correction causes severe functional impairment, e.g. joint replacement surgery, cataract surgery awaiting certain prosthetic devices, cardiac/valvular surgery

3) Severe major mood disorders, e.g. Major depression with psychotic features
   Bipolar mood disorder

4) Early cerebrovascular accidents with : a) Large intracerebral blood
b) Dense hemiplegia

These patients require intensive physiotherapy and rehabilitation and must be referred and receive this during this period of time.

5) Acute milary TB e.g. TB spine, hip
TB pericarditis/meningitis
TB abdomen

6) Patients who have obvious clinical evidence on your examination of severe functional impairment, but whose medical condition has not been properly documented, investigated and treated. Please ensure that you refer and or specify on your report the type of further management necessary.

7) A patient who has a combination of HIV and PTB and cannot automatically be classified as stage 3 disease, due to the fact that in our country TB is endemic, but is severely ill.

PROTOCOL FOR EVALUATING CARE DEPENDENCY GRANT

This is a grant for a child with significant medical impairment or a medical condition that requires care far in excess of that normally required by a child of his/her age. This can be approached from the following three dimensions:

Considering the degree of impairment:
USING THE GUIDELINES FOR EVALUATIONOF MEDICAL IMPAIRMENT

Conditions of minimal impairment, i.e. <25% as determined by our "guidelines to medical impairment" do not qualify.
Conditions with significant impairment, i.e. >25% but less than 40% where the child is not coping in mainstream schooling (as motivated by a letter form school teacher / principal or psychologists will be considered).
Severe impairment of >40% will qualify unless caregivers fail the means test.

OR

MAKING AN EVALUATION ACCORDING TO THE DEVELOPMENTAL MILESTONES TABLE:

Evaluation according to the table: "Guidelines for the Evaluation of Age Appropriate Skills and Abilities used to determine Impairment or extra care needs in a child"

AND

Considering the degree of care required:
Where, due to the child's medical condition or impairment, he/she requires:

- Assistance in basic self care needs or activities of daily living far in excess of that required by any other child of that age
- Lots of care and attention due to severe behavioural problems
- The care giver has to stay home from work or employ someone to care for the child
- Special schooling or extra assistance at school
- Treatment incurring high costs by the caretaker

If 3 or more apply – the child deserves a CDG
If one or two apply – may qualify depending on resources available
If none apply – the child does not qualify

GUIDELINES FOR EVALUATION OF AGE APPROPRIATE SKILLS AND ABILITIES IN ORDER TO ESTIMATE IMPAIRMENT OR EXTRA CARE NEEDS IN A CHILD.

	Health condition Age-Related Table				
AGE	**PHYSICAL & SENSORY IMPAIRMENTS**			**INTELLECTUAL, BEHAVIOURAL and MENTAL HEALTH**	
Age of child	**Motor (Physical abilities)**	**Visual (Sensory ability)**	**Hearing (Sensory ability)**	**Language/and behavioural Communication (Intellectual ability)**	**Personal-Social Development**
1-2 Year	**Sit: Yes No** Does the child sit Without help? **Grasp: Yes No** Does the child grasp objects? **Stand: Yes No** Does the child stand unaided? **Walking: Yes No** Does the child walk unaided?	**THESE POINTS APPLY TO ALL AGES:** **Watching: Yes No** Does the child watch a moving object? **Turn head: Yes No** Does the child turn head to visual stimuli?	**THESE POINTS APPLY TO ALL AGES** **Turn Head: Yes No** Does the child turn towards you when you call his/her name? **Hear well: Yes No** Does the child appear to hear well? **NB**. IF HEARING IMPAIRMENT IS SUSPECTED, CHILD MUST BE SENT TO HOSPITAL FOR TESTING.	**Babbling: Yes No** Does the child make a range of speech sounds? E.g. ma-ma-ta-da **Words: Yes No** Does the child say at least 1-2 words e.g. mama dada?	**Smile/laugh: Yes No** Does the child smile/laugh? **Initiate Contact: Yes No** Does the child raise her arms to be picked up?
2-3 Years	**Hands: Yes No** Does the child use BOTH hands to hold or play with objects? **Dominance: Yes No** Is dominance established? Does the child use one hand more than the other?	**ASK ALL ABOVE QUESTIONS** **Seeing: Yes No** Does the child appear to see well?	**ASK ALL ABOVE QUESTIONS** **Imitation: Yes No** Does the child imitate a range of sounds? **Noises: Yes No** Does the child respond to noises in the environment, e.g. the phone ringing, a bus going past?	**Vocabulary: Yes No** Does the child use approximately 50 words? **Sentences: Yes No** Does the child produce 2-3 word sentences? **Understanding: Yes No** Can the child point to 5 body parts? Can the point to 5 objects in the environment?	**Name: Yes No** Does the child respond own name? **Needs: Yes No** Does the child indicate needs e.g. crying when hungry? **Play: Yes No** Does the child engage with objects / toys in the environment?

3-4 Years	**Running: Yes No** Does the child run? **Climbing: Yes No** Does the child climb on and off objects easily? **Holding: Yes No** Does the child hold a bottle / cup to drink?	**ASK ALL ABOVE QUESTIONS** **Seeing: Yes No** Does the child see sufficiently to perform independently daily functions or to learn, appropriate for age?	**ASK ALL ABOVE QUESTIONS** **Hearing: Yes No** Does the child say words clearly? **Answering: Yes No** Does the child respond to immediately to a question (or must you touch her attention?)? **Watching: Yes No** Can the child easily understand what is said even if she cannot see the speakers face?	**Commands: Yes No** Does the child understand & respond to simple commands or questions? **Sentences: Yes No** Does the child speak in full sentences (small errors may still be present)?	**Toilet training: Yes No** Is the child dry by day and night? **Eating: Yes No** Does the child feed him / her self without assistance? **Routines: Yes No** Does the child fit into family or school routines?
5-6 Years	**ASK FOR PREVIOUS YEARS** **Hopping: Yes No** Can the child hop on each leg?	**ASK ALL ABOVE QUESTIONS**	**ASK ALL ABOVE QUESTIONS** Repetition: Yes No Does the child hear well the first time she is spoken to (or does she ask for repetition frequently)?	**ASK FOR PREVIOUS YEARS** **Conversation: Yes No** Can the child hold a conversation with another child or adult? **Commands: Yes No** Can the child respond to 2-3 short commands given together?	**ASK FOR PREVIOUS YEARS** **Independent: Yes No** Does the child feed, dress, wash, and toilet mostly independently? **Cultural Norms: Yes No** Does the child understand and adhere to cultural norms?
6-7 Years	**ASK FOR PREVIOUS YEARS** **Skipping: Yes No** Can the child skip?	**ASK ALL ABOVE QUESTIONS**	**ASK ALL ABOVE QUESTIONS**	**ASK FOR PREVIOUS YEARS** **Reasons: Yes No** Can the child give reasons for events? **Numeracy: Yes No** Can the child add and subtract number to 10?	**ASK FOR PREVIOUS YEARS** **Errands: Yes No** Can the child go on basic errands alone?

7-9 Years	**Writing: Yes No** Does the child hold pen correctly for writing? **Sport: Yes No** Can the child play sport easily e.g. soccer or netball?	**ASK ALL ABOVE QUESTIONS** **Vision: Yes No** Does the child see the board or read book at a normal distance?	**ASK ALL ABOVE QUESTIONS**	**ASK FOR PREVIOUS YEARS** **Reading: Yes No** Can the read like other children in the class? **Numeracy: Yes No** Can the child add and subtract number to 100? **Passed: Yes No** Has the child passed each school year?	**ASK FOR PREVIOUS YEARS** **Responsibility: Yes No** Does the child take responsibility for any household tasks?
10-18 Years	**ASK FOR PREVIOUS YEARS** **Gait: Yes No** Does the child walk with a completely normal gait? **Hands: Yes No** Are the child's hands as strong and efficient (fine motor activities) as other children?	**ASK ALL ABOVE QUESTIONS** **Vision: Yes No** Is the child's vision 100% normal?	**ASK ALL ABOVE QUESTIONS** **Hearing: Yes No** Is the child's hearing 100% normal?	**ASK FOR PREVIOUS YEARS** **School work: Yes No** Does the child have ANY problem with school work? **Passed: Yes No** Has the child passed each school year in high school?	**ASK FOR PREVIOUS YEARS** **Adolescence: Yes No** Does the child cooperate and get on adequately with other in the home? **Puberty: Yes No** Does the child cope with biological changes e.g. menstruation?

OVERALL IMPAIRMENT

TOTAL 'NO' RESPONSES

- 3 or more than three no responses: significant, severe, impairment where the child requires full time care and qualifies for Care Dependency Grant.
- One or two no responses: mild impairment where the child requires additional care, but with appropriate management / services can still attend mainstream schooling and eligibility depends upon access to these additional services.

- None – the child is not impaired and requires mostly age appropriate care and would not qualify for Care Dependency Grant.

CONDITIONS THAT DON'T QUALIFY FOR CARE DEPENDENCY GRANT

1. Children with a normal IQ, but with isolated learning difficulties.
2. Mild ADHD that is controlled on treatment and where the child is able to remain in mainstream schooling.
3. A musculoskeletal abnormality causing mild deformity and impairment, e.g.
   Mild residual polio
   Previous fracture of a bone
   Mild congenital deformities
4. Musculoskeletal abnormalities requiring orthopaedic surgery or prosthetic Correction This must be done first e.g. limb length discrepancy
   club foot
   contractures from burns
5. Conditions that can be controlled with medication e.g. asthma
   diabetes mellitus
   epilepsy
6. Loss of vision in one eye or loss of hearing in one ear

7. Congenital cardiovascular anomalies that have been surgically repaired or cause little functional limitation to child's normal activities.

8. Rheumatic heart disease that has been treated and although requiring chronic medication is well controlled, causing little compromise to cardiac function or the child's normal daily activities