APPLICATION FORM FOR ASSESSMENT OF WORK ABILITY / DETERMINATION OF THE DEGREE OF SEVERITY OF A DISABILITY

Please check the suitable version with an X for all multi-choice questions.

I GENERAL PART

1.1. DETAILS OF THE APPLICANT

First name:	Surname: .....
Personal identification code: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	
If you don't have an Estonian ID code, please enter your date of birth: ____ ____, _____ and gender: ☐ ☐	
E-mail address:	Telephone: ..... If you have a permanent speaking or hearing impediment and because of this you cannot communicate over the telephone, please specify how or through whom you can be contacted: .....
Postal address:	

A citizen of the Republic of Estonia residing in Estonia or an alien residing in Estonia on the basis of a residence permit or the right of residence, **whose residence is in several countries**, is entitled to the assessment of work ability and work ability allowance if he or she is a resident for the purposes of §6 (1) of the Income Tax Act or resides in Estonia permanently for the purposes of the Aliens Act.

If your **residence is several countries**, please confirm that:

My residence is in several countries	**YES**	**NO**
	☐	☐

I am, for the purposes of the Income Tax Act, an Estonian resident registered with the Tax and Customs Board, i.e., my residence is in Estonia or I stay in Estonia on at least 183 days in 12 consecutive calendar months.	**YES** ☐	**NO** ☐
I reside in Estonia permanently for the purposes of the Aliens Act, i.e., I have stayed in Estonia for at least 183 days within six months before submission of my application. Please provide information regarding the period of your residing in Estonia. ……..... ……......	**YES** ☐	**NO** ☐

If you live/work abroad or have lived/worked abroad, please specify the country in which you live/work or lived/worked

Country	Period

DETAILS OF THE APPLICANT'S REPRESENTATIVE

If the applicant's active legal capacity is restricted or the applicant is between 16 and 18 years of age or has appointed another person to perform acts on his or her behalf, please provide the details of the parent, guardian, or authorised representative.

Guardian/parent ☐ Authorised representative ☐

First name/Name:	Surname: .....
Personal identification code/Registry code: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	
E-mail address:	Telephone: .....
Address:	

If the representative of the applicant is a legal person, please provide the details of the authorised representative of the legal person.

First name:	Surname: .....
Personal identification code: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	
E-mail address:	Telephone: .....
Address:	

If someone else filled in this questionnaire for the applicant or the applicant's representative, please provide the details of the person who filled in the questionnaire.

- ☐ Employee of the Unemployment Insurance Fund
- ☐ Employee of the Social Insurance Board
- ☐ Family member
- ☐ A person close to the applicant
- ☐ Social worker
- ☐ Other, please specify:

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First name:	Surname: .....
E-mail address:	Telephone: .....

Please provide the reasons you are filling in the questionnaire on behalf of the applicant or the applicant's representative.

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I APPLY FOR ASSESSMENT:

☐	For the assessment of work ability
☐	For the determination of the degree of severity of disability
☐	Assessment of work ability under other laws: .....

1.2. OPTION FOR RECEIVING THE DECISION ON THE ASSESSMENT FOR WORK ABILITY

THE DECISION ON THE ASSESSMENT FOR WORK ABILITY TO BE ISSUED	
To applicant ☐ **To guardian/parent** ☐ **To authorised representative** ☐	
Please check **just one** method with X from the list of delivery methods.	
☐	**By e-mail** (in order to open a document in the DigiDoc format attached to the e-mail, your computer must have the DigiDoc software; to open a document in pdf format you need to have Acrobat Reader or other software)
☐	**By registered letter** (a registered letter is delivered to the place of residence or a local post office)
☐	**From an office of the Unemployment Insurance Fund** I wish to receive a preliminary notice to come for the decision: **by e-mail** ☐ **over the phone** ☐

Irrespective of your choice, the decision on the assessment of work ability is always available to you via the self-service portal of the Estonian Unemployment Insurance Fund at www.tootukassa.ee.

Which office of the Unemployment Insurance Fund you wish to contact in case of problems and questions?

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1.3. METHOD FOR RECEIVING THE DECISION ON THE DETERMINATION OF THE DEGREE OF SEVERITY OF DISABILITY

I WISH TO RECEIVE THE DECISION ON THE DETERMINATION OF THE DEGREE OF SEVERITY OF DISABILITY Please check **just one** method with X from the list of delivery methods.	
☐	**By e-mail**[1] (a document in the pdf format attached to the e-mail needs Acrobat Reader or other software to open)
☐	**By e-mail in an encrypted form** (the document attached to the e-mail is encrypted and in order to open it you need an ID card, ID card reader and software DigiDoc, as well as Acrobat Reader or other software to open documents in the pdf-format)
☐	**By non-priority mail to the address of residence stated in the application**[2] (a non-priority letter is sent to your mail box)
☐	**By registered letter to the address of residence stated in the application**[2] (a registered letter is delivered to the place of residence or a local post office)
☐	**At the customer service of the Social Insurance Board** I wish to receive a preliminary notice to come for the decision ☐ **by e-mail** or ☐ **over the phone**

[1] *An encrypted document is sent to you in an open form, meaning that anyone who has access to your e-mail address can see the contents of your document. The Social Insurance Board cannot ensure the security and confidentiality of the data forwarded to you.*

[2] *If the letter is sent as a non-priority letter, the Social Insurance Board cannot ensure that the information released to you reaches you.*

1.4. DOCTORS AND OTHER SPECIALISTS

If you apply for the assessment of your work ability you must have had a medical appointment with a family physician, a medical specialist who is mainly treating you or an occupational health doctor in the past six months.

Have you had a medical appointment with a family physician, a medical specialist who is mainly treating you or an occupational health doctor in the past six months?

YES ☐ NO ☐

If you have not had a medical appointment in Estonia in the past six months but have had it in another country, please specify the country from where we can request your health data: ….**.....**

1.4.1. Specify the family physician, medical specialist(s) who is (are) mainly treating you and/or an occupational health doctor who has (have) information about disorders that are essential for assessing your work ability/degree of severity of your disability.

The health care provider/employee of the Social Insurance Board, who has completed medical training, that carries out the expert assessment is not required to contact the doctors named by you; however, if necessary he or she may clarify your health data with them.

Provide the name of the doctor and other details known to you in the table.

At least one doctor must be specified.

FAMILY PHYSICIAN	
First name and surname	
Organisation	
Contact data (e.g., telephone or e-mail)	
MEDICAL SPECIALIST WHO IS MAINLY TREATING THE APPLICANT	
First name and surname	
Speciality	
Organisation	
Contact data (e.g., telephone or e-mail)	
MEDICAL SPECIALIST WHO IS MAINLY TREATING THE APPLICANT	
First name and surname	
Speciality	
Organisation	
Contact data (e.g., telephone or e-mail)	
OCCUPATIONAL HEALTH DOCTOR	
First name and surname	
Organisation	
Contact data (e.g., telephone or e-mail)	

1.4.2. If you wish, you can provide the contact data of specialists who could give additional data for the assessment of your work ability/disability.

The health care provider/employee of the Social Insurance Board, who has completed medical training, that carries out the expert assessment is not required to contact the specialists named by you; however, if necessary he or she may request additional information in order to assess your work ability/determine the degree of severity of your disability.

Provide the name of the specialist and other details known to you in the table.

SOCIAL WORKER	
First name and surname	
Organisation	
Contact data (e.g., telephone or e-mail)	
PSYCHOLOGIST	
First name and surname	
Organisation	
Contact data (e.g., telephone or e-mail)	
PROVIDER OF SOCIAL SERVICES (incl. a support person, provider of special care services or rehabilitation services)	
First name and surname	
Organisation	
Contact data (e.g., telephone or e-mail)	
OTHER (please specify)	
First name and surname	
Organisation	
Contact data (e.g., telephone or e-mail)	

1.5. EDUCATION OF THE APPLICANT

Which is the highest level of education that you have acquired?

☐	No primary education
☐	Primary education
☐	Basic education
☐	Vocational education without basic education
☐	Basic education with vocational education

☐	Secondary vocational education on the basis of the basic school
☐	General secondary education
☐	Vocational education on the basis of the basic school
☐	Vocational secondary education
☐	Professional higher education (higher vocational education)
☐	Bachelor of arts
☐	Master of arts
☐	Doctorate

Please specify the speciality (specialities) you have acquired:

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Are you currently studying?

YES ☐ NO☐

If you are studying, which level of education are you pursuing?

☐	Primary education
☐	Basic education
☐	Vocational education without basic education
☐	Basic education with vocational education
☐	Secondary vocational education on the basis of the basic school
☐	General secondary education
☐	Vocational education on the basis of the basic school
☐	Vocational secondary education
☐	Professional higher education (higher vocational education)
☐	Bachelor of arts
☐	Master of arts
☐	Doctorate

Please specify the speciality you are acquiring:

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1.6. EMPLOYMENT OF THE APPLICANT

When answering, please take into account all forms of employment (including voluntary work etc.).

Do you work?

YES ☐ NO☐ I have never worked ☐

If you do not work or have never worked, please provide the reason of not working:

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II STATES OF HEALTH PRECLUDING WORK ABILITY

For the states of health listed below, your application will be processed under a simplified procedure and you may skip filling in the rest of the questionnaire. **If you wish that besides the assessment of work ability, the degree of severity of your disability is determined, the entire application form has to be filled in.**

If the state of health precluding work ability is not confirmed by the expertise, you will be later asked to fill in the application for assessment of work ability in full. If you wish, you can fill in the application in full even if there is a precluding state of health.

2.1. Do you have / have you been diagnosed with any of the conditions listed below?

YES ☐ **NO** ☐

- Stage IV cancer;
- Dialysis treatment (renal replacement therapy);
- Controlled ventilation (artificial ventilation of the lungs, i.e., respiratory treatment as an in-patient);
- Established dementia;
- Severe or profound mental retardation;
- Permanently bedridden

I agree that the personal data of me / the person under my guardianship stored in the health information system will be processed by employees of the Unemployment Insurance Fund, who have completed medical training, and health care providers that have been involved to assess my work ability.

I agree that in processing the application for assessment of work ability, an employee of the Unemployment Insurance Fund will send an inquiry to the health information system in order to verify that the requirement to have had a medical appointment in the past six months has been met, that the doctor has entered data in the health information system, as well as the name and surname of the doctor that submitted the data.

I agree that if I apply in addition to the assessment of work ability for the determination of the degree of severity of disability, the personal data of me / the person under my guardianship stored in the health information system will be processed by employees of the Social Insurance Board who have completed medical training. I agree that if I apply in addition to the assessment of work ability for the determination of the degree of severity of disability, an employee of the Social Insurance Board will send an inquiry to the health information system regarding the first name and surname of the doctor who provided information.

I am aware that this consent also covers the personal data stored in the health information system, access to which I have denied for health care providers.

I am aware that provided the data for the assessment of work ability is sufficient, the Estonian Unemployment Insurance Fund will make the decision on the assessment of work ability within 30 working days. If during the assessment it is found that the health information system lacks data or it is insufficient to assess work ability, the processing time may be extended.

I am aware that simultaneously with the application for assessment of work ability I can submit an application for work ability allowance. The work ability allowance is payable to a person with partial work ability or no work ability from the day of submission of the application.

2.2. If you checked YES as a precluding state of health under question 2.1 and do not wish to continue filling in the application form, please sign the form.

_____ _____

(date) (name and signature of the applicant)

_____ _____

(date) (name and signature of the representative of the applicant)

III WORK EXPERIENCE

3.1. WORK EXPERIENCE OF THE APPLICANT

Please specify your jobs for the past five years and the period you worked there.

Job or duty	Time worked

If any of your employment relations ended because of your health problems, please specify the reasons.

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3.2. WORKING APPLICANT

1. Do you have in your current job difficulties with performing a duty because of your state of health?

NO, I am capable of performing all the duties in my current job ☐

YES, I have difficulties with performing some duties ☐

If you answered YES, please describe any work duties that you cannot pursue due to the state of your health.

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2. Will your state of health deteriorate if you were to continue in your current job?

YES ☐ NO ☐

If you answered YES, please specify what causes your state of health to deteriorate.

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3. Do you have problems with colleagues due to restrictions or obstacles arising from your state of health?

YES ☐ NO ☐

If you answered YES, please specify the problems due to your state of health that you encounter with colleagues.

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3.3. NON-WORKING APPLICANT

Do you have/would you have difficulties in working?

YES ☐ NO ☐

If you checked YES:

1) describe what work could you do and how many hours you could work:

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2) please describe any activities that you cannot pursue due to the state of your health:

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IV AID, PERSONAL ASSISTANCE, REHABILITATION AND OTHER SERVICES

Aid

Do you use aid in your daily life and activities?

YES ☐ NO ☐

If you checked YES, please specify all the aid you use and how often and for which activities you need them.

Aid to treat an individual

For instance, inhalers, respirators, oxygen devices, support stockings/gloves against swellings, dialysis treatment devices, disposable syringes.

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Orthoses and prostheses

For instance, orthotic foot supports, orthopaedic footwear, prostheses for upper and lower limbs, cosmetic prostheses.

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Self-care and self-defence aids

For instance, toilet seats and bowls, tracheostomy tubes, ostomy bags and accessories; diapers and undersheets; baths, shower chairs; aids for washing, clothing and self-care.

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Personal mobility aid

For instance, adjusted cars, means of transport, wheelchairs, walking aids, transfer and movement aids, lifts to move people, orientation aids.

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Aid for household chores

For instance, aid to prepare food and drinks, eat and drink, and to clean.

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Furnishings at home and other rooms, their adjustment

For instance, tables, chairs and benches with adjustable height, depth, width and tilt; rotatable and spot lights, beds with adjustable height and tilt, supporting handrails, devices to open and close gates and doors, car lifts to move a person.

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Communication, information and signalling devices

For instance, seeing, reading, writing, drawing, computing, calling aids; security alarms, voice amplifiers; computer mouse devices, keyboards and screens; speech recognition devices, printers.

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If you have been prescribed / issued aid but you do not use it, please explain the reason:

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Personal assistance

Do you use personal assistance in your daily life and activities?

YES ☐ NO ☐

If you checked YES, please specify the activities where you need help from others:

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Rehabilitation

Rehabilitation service means a service provided to facilitate a person's independent coping, social inclusion and working or finding work.

Do you have an ongoing rehabilitation plan?

YES ☐ NO ☐

Additional information

If the local self-government or any other authority provides other social services to you, please specify:

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If you consider necessary to add other relevant information, please write it here:

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V PHYSICAL AND MENTAL ABILITIES

Please assess below how freely you are able to perform different activities, taking into account your physical and mental state. When answering, please also take into account your will and performance.

Everything you write about yourself is very important for ASSESSMENT of your work ability. When answering, please take into account that completing something without difficulties means that you are able to engage in the activity safely and repeatedly without excess efforts.

Use the option "My ability ... varies" under each question if the specified activity can sometimes be performed and sometimes cannot be performed. Use this option also when the available options do not include one that matches your situation.

Do you have enough will for mental and physical activities?

Think about your daily life activities. Are you able to do the following, with normal effort: for instance, bring food home from a shop, speak to a friend over the phone or meet a friend, read news, go to work and the like?

YES ☐ NO ☐

If you checked NO, please describe how often and with which activities you have problems with will.

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Do you have enough strength for mental and physical activities?

Think about your daily life activities. Are you able to do the following, with normal effort: for instance, bring food home from a shop, speak to a friend over the phone or meet a friend, read news, go to work and the like?

YES ☐ NO ☐

If you checked NO, please describe how often and with which activities you have problems with performance.

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1. Moving

In this part you are asked about how easily you can move around in your daily life, move on stairs, stand still and sit. If you use aid (e.g., a wheelchair, crutches, a cane, a guide dog, etc.) to move about or stand upright independently, in describing them you should also take into account with possible difficulties, such as those caused by weather.

1.1. Moving on different surfaces

Moving on different surfaces means that a certain distance is covered on the same level and movement on steps. Moving must be possible without difficulties or obstacles, including without pain, fatigue, lack of air or balance.

I am able to move up and down stairs on my own without difficulties. YES ☐ NO ☐

If you checked YES, please proceed to question 1.2. If you checked NO, please continue answering to the questions below.

How long distances are you able to cover safely and repeatedly without having to stop because of fatigue, pain, lack of air or balance?

☐ More than 200 metres

☐ 200 metres

☐ 100 metres (roughly the length of a football stadium)

☐ 50 metres (roughly the length of five buses)

☐ Not able to move independently at all

☐ My ability to move varies

Please clarify the answer you chose. Please describe how you move, how far you are able to move and what may hinder your free movement. If you use aid, please describe how this affects your mobility.

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Are you able to go up or down two steps at a time, without assistance from others, if you can hold on to a handrail?

☐ Yes

☐ With mild difficulties

☐ With moderate difficulties

☐ With big difficulties, almost impossible

☐ No

☐ My ability to move up or down stairs varies

Please clarify the answer you chose. Please describe movements on stairs.

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1.2. Safe moving around

Safe moving around means secure movement to the desired place without getting lost, including crossing the road and visiting new places. Here safe movement in terms of seeing and hearing is included.

I am able to move safely around indoors and outdoors.

YES ☐ NO ☐

If you checked YES, please proceed to question 1.3. If you checked NO, please continue answering to the questions below.

Can you cross a road safely on your own?

☐ Yes

☐ With mild difficulties

☐ With moderate difficulties

☐ With big difficulties, almost impossible

☐ No

☐ My ability to cross a road safely on my own varies

Please clarify the answer, incl. the use of the aid. Please describe problems that hinder safe crossing of the road. If you use aid, please describe how this affects your mobility.

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Are you able to go safely, without personal assistance, to a place that you have never been to?

☐ Yes

☐ With mild difficulties

☐ With moderate difficulties

☐ With big difficulties, almost impossible

☐ No

☐ My ability to go to an unknown place on my own varies

Please clarify the answer, incl. the use of the aid for movement. Please describe problems that hinder going to new places and safe movement.

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1.3. Standing and sitting

Standing means independently staying erect in one place and, if necessary, changing the posture. This includes standings with the help of aid or a supporting surface but without using help of others.

Sitting means independently staying in a seated position on a chair, without arm supports, and, if necessary, changing the posture.

I am able to stand in one place and sit from one chair to another on my own, without hindrance and feeling pain.

YES ☐ NO ☐

If you checked YES, please proceed to question 1.4. If you checked NO, please continue answering to the questions below.

Can you sit from a chair to a chair next to it without help from anyone?

☐ Yes

☐ With mild difficulties

☐ With moderate difficulties

☐ With big difficulties, almost impossible

☐ No

☐ My ability to sit from a chair to a chair next to it varies

Please clarify the answer you chose. Write which of activities you have problems with and why.

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Are you able to stay in one place, without assistance from others, either standing, sitting, or alternating, without experiencing pain or fatigue?

(posture may be changed)

☐ Yes

☐ With mild difficulties

☐ I am able to for up to three hours

☐ I am able to for less than one hour

☐ No

☐ My ability to remain in one place while sitting or standing varies

Please clarify the answer you chose. Please describe standing and sitting; how low can you remain seated or stand and why sitting/standing may be difficult for you.

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1.4. Other problems related to mobility

If you have difficulties with moving or standing but the questions above did not enable to describe them, please describe them here.

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Write about pain and fatigue and whether the situation throughout the day.

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2. Manual performance

In this part you are asked about how easily you can stretch your arms in daily activities, take hold of and move large objects, and make precise movements with your fingers. If you use aid for targeted manual performance (e.g., a prosthesis, a gripper, etc.), please take this into account when describing manual performance. Manual performance must be without pain and excess effort.

2.1. Stretching arms

Stretching arms means extending both arms away from the body at different heights, bending the arms from shoulder or elbow joints, including reaching for or throwing something.

I am able to stretch both arms up without problems.

YES ☐ NO ☐

If you checked YES, please proceed to question 2.2. If you checked NO, please continue answering to the questions below.

Are you able to raise your one arm, for instance, at least so high as to reach to an object on a shelf?

☐ With mild difficulties

☐ With moderate difficulties

☐ With big difficulties, almost impossible

☐ No

☐ My ability to lift and bend arms to complete an activity varies

Please clarify the answer you chose. If you are not able to lift your arms, please write the reason and whether both arms are affected.

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2.2. Lifting and moving objects

Lifting and moving objects means taking hold of an object with hands and lifting it to a desired place or moving it next to the body.

I am able to lift and move objects with both hands without difficulties.

YES ☐ NO ☐

If you checked YES, please proceed to question 2.3. If you checked NO, please continue answering to the questions below.

Are you able to lift and move a 1L liquid filled container?

☐ Yes

☐ With mild difficulties

☐ With moderate difficulties

☐ I am able to lift a container of up to 0.5L

☐ Not able to lift any objects irrespective of their weight

☐ My ability to lift and move such a container varies

Please clarify the answer you chose. Write which of activities you have problems with and why.

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Are you able to freely lift and move a big but a light object, for instance, a pillow or a cardboard box?

☐ Yes

☐ With mild difficulties

☐ With moderate difficulties

☐ With big difficulties, almost impossible

☐ No

☐ My ability to lift and move such an object varies

Please clarify the answer you chose. If you are not able to lift objects, please write the reason.

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2.3. Manual dexterity

Manual dexterity means activities performed with hands and fingers.

I am able to use hands and fingers without difficulties, for instance, to take hold of objects or push buttons.

YES ☐ NO ☐

If you checked YES, please proceed to question 2.4. If you checked NO, please continue answering to the questions below.

Can you use at least one arm and fingers of one hand: to press a button (for instance, on the telephone keypad), turn a page of a book, pick up a one-euro coin, use a pencil or a pen, use a suitable keyboard or mouse?

☐ With mild difficulties when completing a listed activity

☐ With moderate difficulties

☐ With big difficulties, almost impossible

☐ No

☐ My ability to use hands and fingers varies

Please clarify the answer you chose. Write which of the listed activities you have problems with and why.

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2.4. Other problems related to manual performance

If you have difficulties with manual performance but the questions above did not enable to describe them, please describe them here. Write about pain and fatigue and whether the situation throughout the day or each day.

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3. Communication: seeing, hearing and speaking

In this part you are asked about how freely you are able to communicate and act, taking into account your ability to see, hear, speak and convey messages. If you use aid for seeing, hearing or speaking, please specify:

..... and take them into account when describing your communication.

3.1. Communication with people

Communication with people means communication by means of speaking or writing, i.e., making oneself understandable to other people on one's own, taking into account seeing, hearing and speaking.

I am able to communicate with other people without difficulties, by peaking and expressing myself in writing.

YES ☐ NO ☐

If you checked YES, please proceed to question 3.2. If you checked NO, please continue answering to the questions below.

Are you able to convey a simple message to another person, clearly and understandably, for instance, that someone had been looking for them?

(a message may be given by speaking, in writing, by printing or by any other means without using the help of another person)

☐ With mild difficulties

☐ With moderate difficulties

☐ With big difficulties, almost impossible

☐ No

☐ My ability to convey simple messages varies

Please clarify the answer you chose. Please describe how you communicate. What could be the reason when you cannot communicate with other people (for instance, difficulties with speaking, writing or printing, or fear of communication, lack of will)?

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3.2. Other people's communication with you

In this part you are asked about how you understand others by listening to them and reading their writings, i.e., how you receive messages from other people, taking into account your seeing, hearing and speaking.

I am able to understand other people without difficulties, by listening to them and reading what they have written.

YES ☐ NO ☐

If you checked YES, please proceed to question 3.3. If you checked NO, please continue answering to the questions below.

Are you able to accept, without personal assistance, a simple message from another person by listening and/or reading lips, and react to warning cries?

(a simple message means, for instance, information about the location of a restroom, and response to a warning cry may, for instance, be a situation where you do not see the speaker)

☐ Yes

☐ With mild difficulties

☐ With moderate difficulties

☐ With big difficulties, almost impossible

☐ No

☐ My ability to receive oral messages varies

Please clarify the answer you chose. Write which of activities you have problems with and why.

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Are you able to receive a simple message from another person printed in a large font?

- ☐ Yes
- ☐ With mild difficulties
- ☐ With moderate difficulties
- ☐ With big difficulties, almost impossible
- ☐ No
- ☐ My ability to receive written messages varies

Please clarify the answer you chose. Write whether you are able to hear, read lips or otherwise understand people and what the reason might be when you are not able to do this. Please describe how you receive messages.

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3.3. Other problems related to communication

If you have difficulties with communication and activities because of seeing, hearing or speaking but the questions above did not enable to describe them, please describe them here.

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4. Staying conscious and self-care

In this part you are asked:

1) whether you have, and if yes, how often you have episodes of fainting, lack of awareness or loss of consciousness while being awake;

2) do you have difficulties in controlling your bowel movement or bladder, if yes, what kind of difficulties;

3) how freely can you eat and drink on your own.

4.1. Staying conscious while awake

Staying conscious means usual wakefulness and ability to contact while awake.

My staying conscious is always under control. I stay conscious without problems.

YES ☐ NO ☐

If you checked YES, please proceed to question 4.2. If you checked NO, please continue answering to the questions below.

How often you have episodes of fainting, lack of awareness or loss of consciousness while being awake?

(this also includes episodes of epilepsy and diabetic hypoglycaemia)

☐ Once in a couple of years

☐ A few times a year

☐ Every month

☐ At least once a week

Please clarify the answer you chose. Please describe how often do you have disturbances of consciousness and for what cause; also how they are expressed.

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4.2. Controlling bowel movement and bladder

Controlling bowel movement and bladder means voluntary holding in and vacation of the content of your bowel and bladder.

I am able to control my bowel movement and bladder without difficulties, including by using collection devices or a bladder catheter.

YES ☐ NO ☐

If you checked YES, please proceed to question 4.3. If you checked NO, please continue answering to the questions below.

Do you have to wash or change your clothes because they are soiled due to difficulties in controlling the bladder, bowel movement or collection devices?

(collection devices means the ileostomy bag and bladder catheter)

☐ Yes, in single cases

☐ Yes, each time that I cannot make it to the toilet rapidly

☐ Yes, at least once a month

☐ My control of bladder and bowel movement varies

Please clarify the answer you chose. Please describe your coping with controlling your bowel movement and bladder, or using the collection device, and how often you need to wash or change clothes dues to soiling, wetting or leakage.

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4.3. Eating and drinking

Eating and drinking means independent eating the served food and drinking using, if necessary, (technical) aids.

I am able to eat and drink without difficulties.

YES ☐ NO ☐

If you checked YES, please proceed to question 4.4. If you checked NO, please continue answering to the questions below.

Are you able to put food and drink in your mouth without another person's assistance?

☐ Yes

☐ With mild difficulties

☐ With moderate difficulties

☐ With big difficulties, almost impossible

☐ No

☐ My ability to eat and drink varies

Please clarify the answer you chose. Write which of activities you have problems with and why.

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Are you able to freely chew and swallow?

- ☐ Yes
- ☐ With mild difficulties
- ☐ With moderate difficulties
- ☐ With big difficulties, almost impossible
- ☐ No
- ☐ My ability to chew and swallow varies

Please clarify the answer you chose. Please describe how you eat and drink and what obstacles you may have when chewing and swallowing.

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4.4. Other problems related to staying conscious and safe-care

If you have difficulties with remaining conscious, eating and drinking or self-care but the questions above did not enable to describe them, please describe them here.

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5. Learning and completing activities

In this part you are asked about how freely you are able to acquire new skills and then use them repeatedly and whether you are able to plan and complete your activities, taking into account your mental state. Generally, this does not include activity difficulties due to the physical condition.

5.1. Learning activities

Learning activities means learning simple and complicated activities encountered in normal life. A simple activity may be deemed to be an activity involving one or two steps, for instance, switching on the TV from the button, taking a broom and sweeping the floor, setting the table, cleaning. More complicated are activities that involve several consecutive steps, for instance, preparing a meal using various utensils, learning to play a board game, shopping for food.

I am able to learn daily life activities without difficulties and use them.

YES ☐ NO ☐

If you checked YES, please proceed to question 5.2. If you checked NO, please continue answering to the questions below.

Are you able to learn a simple activity, such as making a phone call or use a cash machine?

☐ Yes
☐ With mild difficulties
☐ With moderate difficulties
☐ With big difficulties, almost impossible
☐ No
☐ My ability to learn simple activities varies

Please clarify the answer you chose. Write which of the activities you have problems learning with and why.

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Are you able to learn a more difficult activity, such as the use of a washing machine or preparing a hot meal for yourself?

☐ Yes

☐ With mild difficulties

☐ With moderate difficulties

☐ With big difficulties, almost impossible

☐ No

☐ My ability to learn more complicated activities varies

Please clarify the answer you chose. Please describe difficulties you experience when learning activities as well as why they arise.

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5.2. Starting and ending activities

Starting and ending activities means the ability to start and complete daily routine activities, such as getting out of the bed in the morning, washing and clothing, preparing meals, going shopping. When answering, please also take into account how much will and energy you have for this. Here activity difficulties due to your physical condition are not described.

I am able to cope with daily activities without difficulties.

YES ☐ NO ☐

If you checked YES, please proceed to question 5.3. If you checked NO, please continue answering to the questions below.

Are you able to independently plan, start and complete daily activities, for instance, decide when to go shopping for food and bring the necessary products from the shop and prepare a meal; or plan to watch a TV show and watch it at the right time?

☐ With mild difficulties
☐ With moderate difficulties
☐ With big difficulties, almost impossible
☐ No
☐ My ability to start and end activities varies

Please clarify the answer you chose. Please describe how you manage to remember, plan and organise activities. Write what may complicate this for you and how often you need help from others.

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5.3. Other problems related to learning and completing activities

If you have difficulties with learning new skills or competing activities but the questions above did not enable to describe them, please explain them here. Please also describe problems where you are not able to learn or perform activities due to lack of will or energy

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6. Adaptation to changes and perception of safety

In this part you are asked about how freely your emotional and mental state allows your movement outside the home. You are asked whether you can assess unsafe situations in daily life and how easily you adapt to changes that may interfere with daily routine. Here activity difficulties due to your physical condition are not described.

6.1. Going out

Going out means movement outside the home without emotional or mental stress and coping with stressful situations (for instance, when you are lost).

I am able to go out on my own, without mental or emotional hindrance.

YES ☐ NO ☐

If you checked YES, please proceed to question 6.2. If you checked NO, please continue answering to the questions below.

Can you leave the house and go to places known to you?

☐ Yes

☐ With mild difficulties

☐ With moderate difficulties

☐ With big difficulties, almost impossible

☐ No

☐ My ability to leave home for places known to me varies

Please clarify the answer you chose. Please describe why you cannot always go to a place. Do you need somebody to come with you? Please explain your problems and give examples.

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Can you leave the house and go to places unknown to you?

☐ Yes

☐ With mild difficulties

☐ With moderate difficulties

☐ With big difficulties, almost impossible

☐ No

☐ My ability to leave home for places unknown to me varies

Please clarify the answer you chose. Please describe why you cannot always go to a place. Do you need somebody to come with you? Please explain your problems and give examples.

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6.2. Perception of risk or danger

Perception of safety means understanding which daily activities may be dangerous to your own health of that of others, and behaving in a way that no dangerous situations are created.

I am able to complete safely daily activities: preparing meals, using house appliances, moving at home and near home.

YES ☐ NO ☐

If you checked YES, please proceed to question 6.3. If you checked NO, please continue answering to the questions below.

Do you need, for most of the time, someone to stay with you so as to be safe?

☐ No

☐ For a few activities, not every day

☐ Yes, always during the daytime

☐ Yes, 24 hours a day

☐ My need for a supervisor varies

Please clarify the answer you chose. Please describe which unsafe situations you encounter and how you address them. Please provide examples of problems that prevent you from doing things safely.

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6.3. Coping with change

Coping with change means adaptation to small changes and unexpected situations that interfere with daily routine.

I am able to cope with changes in daily routine without difficulties.

YES ☐ NO ☐

If you checked YES, please proceed to question 6.4. If you checked NO, please continue answering to the questions below.

Are you able to cope with minor changes in your daily routine?

(for instance, the dinner time is before or after the routine time, a bus or a train arrives at a time not expected, a friend or caregiver comes to your place earlier or later than planned)

☐ With mild difficulties

☐ Yes, if I know of the change in advance

☐ No, if the change is unexpected

☐ No

☐ My ability to cope with changes communicated in advance varies

Please clarify the answer you chose. Please describe how you cope with changes. Please explain your problems and give examples.

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6.4. Other problems related to adoption to changes and perception of safety

If you have difficulties with adaptation to changes or perception of safety but the questions above did not enable to describe them, please describe them here.

Please also describe problems where you are not able to adopt to a change due to lack of will or energy.

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7. Interpersonal interaction and relationships

In this part you are asked about how freely you communicate with people you know and don't know and how you cope in situations requiring conventional communication and in conflict situations, taking into account your mental and emotional state.

7.1. Coping with social situations

Social situations mean meeting new people and going to meet new people, communication with people close to you and with strangers.

I cope with social situations without excessive anxiety or fear.

YES ☐ NO ☐

If you checked YES, please proceed to question 7.2. If you checked NO, please continue answering to the questions below.

Can you meet people you know without excessive anxiety or fear?

☐ Yes

☐ With mild difficulties

☐ With moderate difficulties

☐ With big difficulties, almost impossible

☐ No

☐ My ability to meet persons known to me without anxiety or fear varies

Can you meet people you do not know without excessive anxiety or fear?

☐ Yes

☐ With mild difficulties

☐ With moderate difficulties

☐ With big difficulties, almost impossible

☐ No

☐ My ability to meet persons unknown to me without anxiety or fear varies

Please clarify the answer you chose. Please describe why you are afraid of meeting people. What makes it difficult for you to meet other people? How often do you feel like this? Please explain your problems and give examples.

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7.2. Proper behaviour

Proper behaviour means behaviour appropriate for a situation, for instance, how you express your feelings and whether your (intentional or involuntary) behaviour may disturb other people.

My behaviour connected with my mental and emotional state disturbs other people.

YES ☐ NO ☐

If you checked NO, please proceed to question 7.3. If you checked NO, please continue answering to the questions below.

How often do you behave in a way that it disturbs other people? This may happen, for instance, because you do not perceive the conventional distance to be kept in communication, or you are aggressive or behave unusually.

☐ Rarely

☐ Sometimes

☐ Often

☐ Every day

Please clarify the answer you chose. Please describe why your behaviour disturbs others and how often this happens. Please explain your problems and give examples. If the situation varies, please describe.

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7.3. Other problems related to interpersonal interaction and relationships

If you have difficulties with interpersonal interaction and relationships but the questions above did not enable to describe them, please describe them here. Please also describe problems where your communication is hindered due to lack of will or energy.

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8. Effects of alcohol, narcotic, psychotropic and other addictive substances

Do you have coping difficulties due to the use of alcohol, addictive or psychotropic substances or other substances (drugs, glues, solvents, etc.)?

(this also includes addictive or psychotropic substances that your treating physician has prescribed to you for prolonged used)

YES ☐ NO ☐

If you checked YES, please clarify the answer you chose. Please describe problems related to the use of such substances and the frequency of their occurrence, also how they hinder your ability to be active.

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Do you have other problems due to the side effects caused by the use of medications (e.g., vomiting, nausea, dizziness, etc.)?

YES ☐ NO ☐

If you checked YES, please clarify the answer you chose. Please describe problems related to the use of such substances and the frequency of their occurrence, also how they hinder your ability to be active.

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9. Other disorders

In this part you are asked about the activity difficulties that you were not able to describe when answering previous questions. Here such activity difficulties that are caused by your disorder are meant.

Do you have coping difficulties due to a disorder not covered by the above questions?

YES ☐ NO ☐

If you checked YES, please describe the difficulties and how often they occur.

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10. Additional information

Additional information regarding extra costs incurred by medical appointments due to special needs

If, based on the available and submitted data, your work ability cannot be assessed, the Estonian Unemployment Insurance Fund may refer you to a health care provider carrying out expertise in order to obtain an opinion regarding your work ability. The Unemployment Insurance Fund will reimburse to you extra costs incurred by medical appointments due to special needs.

Medical appointments incur extra costs due to my special needs.

☐ YES ☐ NO

If you checked YES, please clarify.

☐ use of a sign language interpreter (you need help in communicating with a doctor)

☐ use of special transport (you need special transport to drive to the doctor's)

☐ use of a support person/personal assistant (you need help getting to a doctor due to a physical disability or in relation with organisational matters)

☐ other additional cost due to special needs (please describe):

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Justification of the need for extra costs

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ATTACHMENTS

Please specify the documents which you submit together with the application.

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(date) (name and signature of the applicant)

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(date) (name and signature of the representative of the applicant)