THE JAMAICA GAZETTE SUPPLEMENT

PROCLAMATIONS, RULES AND REGULATIONS

1582F[1]

Vol. CXLIV **THURSDAY, NOVEMBER 18, 2021** **No. 154B**

No. 190B

Extract from the Minutes of the meeting of the House of Representatives held on Tuesday, October 6, 2021:

PUBLIC BUSINESS

The Honourable Karl Samuda, OJ, CD, MP, Minister of Labour and Social Security, moved the following motion:

THE DISABILITIES ACT, 2014

THE DISABILITIES REGULATIONS, 2021, RESOLUTION

WHEREAS by virtue of section 46(1) of the Disabilities Act, 2014 (hereinafter referred to as the Act), the Minister may make regulations to give effect to the purposes of the Act:

AND WHEREAS section 46(3) of the Act provides that regulations made under the Act shall be subject to affirmative resolution:

AND WHEREAS on the 21st day of July, 2021, the Minister made the Disabilities Regulations, 2021:

NOW, THEREFORE, BE IT RESOLVED by this Honourable House as follows:

1. This Resolution may be cited as the Disabilities Regulations, 2021, Resolution.

2. The Disabilities Regulations, 2021, which were laid on the Table of the House on the 21st day of July, 2021, are hereby affirmed.

Mr. Mark Golding also spoke on the motion.

Seconded by: Mr. Robert Miller.

Agreed to.

I certify that the above is a true extract from the Minutes.

VALRIE A. CURTIS, CD, BH(M), JP
Clerk to the Houses.

No. 190C
Extract from the Minutes of the meeting of the Honourable Senate on the 22nd day of October, 2021:

PUBLIC BUSINESS

Senator the Honourable Kamina Johnson Smith, Minister of Foreign Affairs and Foreign Trade and Leader of Government Business, moved:

THE DISABILITIES ACT, 2014

THE DISABILITIES REGULATIONS, 2021, RESOLUTION

WHEREAS by virtue of section 46(1) of the Disabilities Act, 2014 (hereinafter referred to as the Act), the Minister may make regulations to give effect to the purposes of the Act:

AND WHEREAS section 46(3) of the Act provides that regulations made under the Act shall be subject to affirmative resolution:

AND WHEREAS on the 21st day of July, 2021, the Minister made the Disabilities Regulations, 2021:

NOW, THEREFORE, BE IT RESOLVED by this Honourable House as follows:

1. This Resolution may be cited as the Disabilities Regulations, 2021, Resolution.

2. The Disabilities Regulations, 2021, which were laid on the Table of the Senate on the 8th day of October, 2021, are hereby affirmed.

Senator Lambert Brown, Seantor Kavan Gayle and Senator Floyd Morris also spoke on the motion.

Seconded by: Senator Kavan Gayle.

Agreed to.

I certify that the above is a true extract from the Minutes.

VALRIE A. CURTIS, CD, BH(M), JP
Clerk to the Houses.

THE DISABILITIES ACT, 2014

THE DISABILITIES REGULATIONS, 2021, RESOLUTION

WHEREAS by virtue of section 46(1) of the Disabilities Act, 2014 (hereinafter referred to as the Act), the Minister may make regulations to give effect to the purposes of the Act:

AND WHEREAS section 46(3) of the Act provides that regulations made under the Act shall be subject to affirmative resolution:

AND WHEREAS on the 21st day of July, 2021, the Minister made the Disabilities Regulations, 2021:

NOW, THEREFORE, BE IT RESOLVED by this Honourable House as follows:

1. This Resolution may be cited as the Disabilities Regulations, 2021, Resolution.

2. The Disabilities Regulations, 2021, are hereby affirmed.

THE DISABILITIES ACT

THE DISABILITIES REGULATIONS, 2021

In exercise of the power conferred on the Minister by section 46 of the Disabilities Act, the following Regulations are hereby made:—

Citation.

1. These Regulations may be cited as the Disabilities Regulations, 2021.

Interpretation.

2. In these Regulations—

"applicant" means a person with a disability or a caregiver, who submits an application to be entered in the Register kept under regulation 9;

"Certificate" means a Certificate of Registration issued pursuant to regulation 3(2) or (4);

"Register" means the Confidential Register kept under regulation 9.

Application for registration.

Schedule, Form 1.

3.—(1) For the purposes of section 14 of the Act, an application for registration of a person with a disability shall be made in the form set out as Form 1 of the Schedule, accompanied by such charge in respect thereof as may be imposed under the Act.

(2) A person with a disability who, prior to the appointed day, was registered with the Jamaica Council for Persons with Disabilities (as

unincorporated) shall submit an application in the form prescribed as Form 2 of the Schedule and on receipt of the application the Council shall—

Form 2.

(a) issue a Certificate of Registration in the name of the person with a disability, in the form set out as Form 3 of the Schedule; and

Form 3.

(b) enter the particulars, of the person with a disability, in the Register kept pursuant to regulation 9.

(3) An application made under paragraph (1) shall be submitted to the Council, accompanied by a report completed in all relevant respects in the form set out as Form 4 of the Schedule and signed by a registered medical practitioner or a specialist trained in diagnosing or treating the disability concerned.

Form 4.

(4) The Council shall review the application submitted under paragraph (1) within thirty days after the date of submission (or if such review cannot practicably be completed within that time, then within such time as is reasonably practicable), and where satisfied that the person in whose name the application is made is a person with a disability—

Schedule, Form 3.

(a) issue a Certificate of Registration in the name of the person, in the form set out as Form 3 of the Schedule; and

(b) enter, in respect of the person, the particulars prescribed under regulation 9(3), in the Register.

(5) Where upon the review of an application made under this regulation, the Council is not satisfied that the person in whose name the application is made is a person with a disability, the Council shall refuse to approve the application.

(6) Where the Council decides to refuse approval of an application under paragraph (1), the Council shall inform the applicant, by notice in writing, and in appropriately accessible format if the case so requires, including the reason for the refusal.

(7) The Council shall send the notice referred to in paragraph (6) to the applicant, within fourteen days after the decision.

Review of decision of Council.

4.—(1) The applicant concerned may apply to the Minister for review of a decision of the Council—

(a) to refuse approval of an application under regulation 3(1);

(b) not to renew a Certificate on an application under regulation 6; or

(c) under regulation 8, to revoke a Certificate.

(2) An application under paragraph (1) shall—

(a) be supported by reasons as to why, as the case may require—

(i) the person with a disability in whose name the application was made shall be so registered;

(ii) the Certificate should be renewed; or

(iii) the Certificate should not be revoked; and

(b) be made within twenty-one days after the date of the service, on the applicant, of the notice of the decision.

(3) A review for the purposes of paragraph (1) shall be conducted by a panel appointed by the Minister, comprising the following members—

(a) a representative of an organization relating to the disability concerned;

(b) a registered medical practitioner, or a specialist trained in diagnosing and treating the disability concerned; and

(c) a representative of the Ministry with responsibility for health, nominated by the Permanent Secretary in that Ministry.

(4) The review upon an application under paragraph (1) shall be completed within sixty days after the Minister receives the application (or if the review cannot practicably be completed within that time, within such longer time as is reasonably practicable), and—

(a) the panel shall forthwith communicate its decision in writing to the Council; and

(b) the Council shall within ten days after receiving the panel's decision (excluding Saturdays, Sundays and public holidays) serve a copy of the decision upon the applicant.

(5) Where the decision communicated under paragraph (4)(a) is that-

(a) the application for registration should be approved, the Council shall enter the particulars of the person with a disability in the Register and issue a Certificate, in accordance with regulation 3(4);

(b) the Certificate should be renewed, the Council shall renew the Certificate, in accordance with regulation 6; or

(c) the Certificate should not be revoked, the Council shall restore the Certificate (and, for the avoidance of doubt, the period of validity of a restored Certificate shall be five years from the date on which the Certificate was originally issued).

Validity of Certificate.

5.—(1) Subject to paragraph (2), the Certificate issued under regulation 3, shall be valid for the period of five years after the date of issue, unless revoked in accordance with regulation 8.

(2) A certificate issued to a person with disability under these Regulations shall cease to be valid on the date of death of the person with a disability.

Renewal of Certificate.

6.—(1) An application for renewal of a Certificate shall be—

Schedule, Forms 2 and 4.

(a) made to the Council, not less than sixty days before the expiration of the Certificate and not more than six months after the date of expiration of the Certificate, in the form set out as Form 2 of the Schedule; and

(b) accompanied by such charge in respect thereof as may be imposed under the Act.

(2) Where an application is made for the renewal of a Certificate and the person—

(a) remains a person with a disability; and

(b) has been diagnosed, with a new disability,

the applicant shall give details of the new disability in the application for renewal and submit in respect thereof a report in the form set out as Form 4 of the Schedule, signed by a registered medical practitioner or a specialist trained in diagnosing or treating the disability concerned.

(3) The Council shall, within thirty days after receiving an application made under this regulation for renewal of the Certificate, review the application and if the Council—

(a) is satisfied that the person who was issued the Certificate remains a person with a disability or has acquired a new disability, the Council shall—

(i) approve the application in the name of the person with the disability;

(ii) issue a new Certificate, in the Form set out as Form 3 of the Schedule; and

(iii) in the case of the acquisition of a new disability, shall ensure that the Certificate reflects the new disability; or

(b) is not satisfied that the person who was issued the Certificate is a person with a disability (whether the same disability which formed the basis for the issue of the Certificate or a new disability), the Council shall—

(i) refuse the application; and

(ii) within fourteen days after the date of that refusal, inform the applicant of the refusal, in writing, and in an appropriately accessible format if the case so requires, giving the reason for the refusal.

(4) Where an application for renewal is not made within the time referred to in paragraph (1) and the person in whose name the Certificate is issued requires a new Certificate, the person shall make a new application in accordance with regulation 3(1).

Notification of secondary or subsequent disability.

7. A person with a disability who is registered under this Act, or that person's caregiver, shall notify the Council in writing of any secondary or subsequent disability acquired by that person, or confirmed in respect of that person, after the date of registration or renewal of the Certificate, and the person with a disability or the caregiver (as the case may be) shall provide information as to—

(a) the date or approximate date the second or subsequent disability was acquired or confirmed (whichever applies);

(b) the nature of the disability; and

(c) the type of disability.

Revocation of Certificate.

8.—(1) A Certificate shall be revoked by the Council if the Council reasonably believes that the application for registration, or any information submitted to the Council in support thereof, is false or misleading in any material particular.

(2) Within fourteen days after deciding to revoke a Certificate, the Council shall notify the applicant in writing in an appropriately accessible format, of the decision, and such notice shall state the reason for the revocation.

Confidential Register.

9.—(1) There shall be kept a Register to be known as the Confidential Register in which shall be entered the particulars in relation to a person with a disability issued a certificate under these Regulations.

(2) Subject to the provisions of this regulation, the Register shall be kept in the form determined by the Council (which may include electronic form), and the contents thereof shall be kept confidential and shall be accessible only by—

(a) the Executive Director; and

(b) such other persons employed by the Council in the administration of the Disabilities Act and authorised by the Executive Director to access the Register.

(3) The particulars referred to in paragraph (1) in relation to a person with a disability shall include—

(a) name;

(b) address;

(c) date of birth;

(d) nationality;

(e) sex;

(f) marital status;

(g) the date or approximate date the disability was acquired;

(h) the type of disability including—

(i) blindness;

(ii) deafness;

(iii) hard of hearing;

(iv) physical disability;

(v) mental illness;

(vi) intellectual disability

(vii) developmental disability;

(viii) speech; and

(ix) visual impairment;

(i) the nature of the disability;

(j) the date or approximate date of any secondary or subsequent disability acquired or confirmed after the date of registration;

(k) the nature of the secondary or subsequent disability;

(l) the type of the secondary or subsequent disability;

(m) information relating to the current education level or the education level which has been attained by the person with a disability;

(n) information relating to any changes to the education level of the person with a disability;

(o) the employment history of the person with a disability;

(p) the name and other particulars of the caregiver including the caregiver's address, the caregiver's relationship to the person with a disability, training of the caregiver if applicable;

(q) any changes to the particulars provided in respect of the person who is the caregiver of the person with a disability;

(r) the date of registration under this Act;

(s) the date of migration of a person with a disability who is registered under this Act to another jurisdiction.

(4) In this regulation, the nature of a disability refers to—

(a) in the case of a congenital disability, a condition present at birth; or

(b) in the case of an acquired disability, a condition developed during the lifetime of the person with a disability.

(5) In this regulation, "developmental disability" means a group of conditions occurring during the developmental period of childhood, which lasts throughout the person's life, and manifests in one or more of the following impairments—

(a) physical;

(b) learning;

(c) language; or

(d) behavioural.

(6) A person who is or has been employed by the Council shall not disclose any matter contained in the Register, except as required under, or for the due administration of, the Disabilities Act or as provided for under any other law.

(7) A person who contravenes paragraph (6) commits an offence and shall be liable, on conviction therefor before a Judge of a Parish Court, to a fine not exceeding one million dollars or to imprisonment for a term not exceeding twelve months.

Alteration and correction to Register.

10. The Council may alter or correct any entry in the Register—

(a) where the Council verifies that the entry was incorrectly made; or

(b) in circumstances where information is received from the person with a disability or the caregiver as to the status of the person with a disability, subsequent to the particulars being entered in the Register.

Council shall implement procedures to keep Register up-to-date.

11.—(1) The Council shall implement appropriate procedures for ensuring the information contained in the Register is up-to-date.

(2) Where the Council is satisfied that a person with a disability has acquired a new disability, the Council shall update the Register accordingly.

(3) The Council shall remove from the Register the particulars of a person with a disability—

(a) where a decision has been made—

(i) to revoke the Certificate; or

(ii) not to renew the Certificate;

(b) who is deceased; or

(c) for any other reason determined by the Council.

Certificate lost, stolen or destroyed.

12.—(1) Where a person with a disability who was issued a Certificate proves to the satisfaction of the Council that the Certificate so issued ("the original certificate") was lost, stolen or destroyed, the Council shall issue a new Certificate upon the payment of the charge imposed under section 6(2)(c) of the Act.

(2) A certificate issued under paragraph (1) shall be valid from the date of issue of the original certificate.

Lessee may request permission to alter premises. Schedule, Part A, Form 5.

13.—(1) A lessee of premises, who intends to make alterations to those premises, shall make a request to the lessor in accordance with section 38(1) of the Act, and shall do so in the form prescribed as Part A of Form 5 of the Schedule.

(2) In support of a request under paragraph (1), the lessee shall submit a drawing, plan, diagram, specification or other document, which delineates the proposed alterations to the leased premises.

(3) The drawing, plan, diagram, specification or other document submitted in support of a request under paragraph (1), shall be prepared and signed by a building practitioner approved under the Building Act, or any other person duly registered, licensed or otherwise authorised to prepare the same under any other law or enactment.

Part B, Form 5.

(4) Where the lessor of premises receives a written request in accordance with this regulation, the lessor shall communicate consent or refusal, of the request, in the form set out as Part B of Form 5 of the Schedule.

Service of documents.

14.—(1) A notice served pursuant to section 42 of the Act shall be transmitted—

(a) by post to the person's last known place of business or abode;

(b) by facsimile or any other mode of electronic transmission to, respectively, the person's last known facsimile number or electronic mailing address;

(c) in the case of a body or association of persons, to that body or association at its registered or principal office.

(2) Service under this regulation shall be deemed effected—

(a) within twenty-four hours after transmission by facsimile or other electronic mode; or

(b) within five days after the date of posting.

Fees.

15. Before imposing any charges pursuant to section 6(2)(c) of the Act, the Council shall cause a notice of the charges to be published in the *Gazette*.

SCHEDULE

FORM I **(Regulation 3(1))**

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

APPLICATION FORM

(Pursuant to section 14 of the Disabilities Act)

INSTRUCTIONS:

- I. This application is to be completed in BLOCK CAPITALS using black or blue ink pen;
- II. Tick (✓) boxes where applicable;
- III. Where the information is not applicable to you, indicate by writing N/A

1. National Insurance Number.. 2. TRN..

3. Birth Certificate Number.. 4. National Identification Number ....

5. Name ☐ Mr. ☐ Miss ☐ Mrs.

....

(Last Name) *(First Name)* *(Middle Name(s))*

6. State all other names (including maiden name) that you have been known by.

....

7. Marital Status

☐ Single ☐ Common-Law ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

8. Sex ☐ Male ☐ Female

9. Date of Birth ..../........../.......... *Year* *Month* *Day*

10. Nationality ....

11. Parish, Country of Birth ....

12. Home Address

....

....

....

13. Mailing Address (*if different from Home Address*)

....

....

....

14. E-mail Address:

....

15. Contact Number(s): ....
(Home) *(Work)* *(Mobile)*

16. Name and Address of Next of Kin ....
(Name) (Address)

17. Next of Kin Contact Number(s).. ....
(Home) *(Work)* *(Mobile)*

18. Are you the head of your household? Yes ☐ No ☐

SCHEDULE, *contd.*

FORM I, *contd.*

☐ Mother/Wife ☐ Father/Husband ☐ Daughter/Son

SECTION A continued

19. Indicate the Number of Dependents: .... **20.** Age(s) From .... To........................
(Youngest Age) *(Eldest Age)*

21. Indicate the Type of Disability, if the applicant has more than one Disability please indicate:

☐ Blind ☐ Deaf ☐ Hard of Hearing ☐ Physical ☐ Mental Illness

☐ Visual Impairment ☐ Speech ☐ Intellectual ☐ Developmental Disability

☐ Multiple (tick them) ☐ Other (specify): ....

22. Approximate Date of Disablement: ..../............/............
Year *Month* *Day*

23. Nature of Disability: ☐ Congenital ☐ Acquired

24. Persons to be notified in case of emergency:

Name	Address	Telephone	Relationship

25. EDUCATIONAL BACKGROUND

Indicate last school completed:

☐ Early Childhood ☐ Primary ☐ Secondary

☐ Tertiary ☐ Vocational Training ☐ None

26. Indicate Employment Status:

☐ Employed ☐ Unemployed ☐ Self Employed ☐ Seasonal Employment

☐ Unemployable (unable to get paid employment because of a lack of skills or qualification) ☐ Student

SECTION B

CAREGIVER INFORMATION

27. National Insurance Number: .... **28.** TRN: .... **29.** National Identification Number. ....

30. Name of Caregiver ☐ Mr. ☐ Miss ☐ Mrs.

....
(Last Name) *(First Name)* *(Middle Name(s))*

31. State all other names (including maiden name) that you have been known by.

....

32. Sex **33.** Date of Birth **34.** Nationality

Male ☐ Female ☐ ..../............/............ ....
Year *Month* *Day* *Country*

SCHEDULE, *contd.*

FORM I, *contd.*

35. Home Address of Caregiver

....

....

....

36. Mailing Address (*if different from Home Address*)

....

....

....

37. E-mail Address: ....

38. Contact Number(s): .... (*Home*) .... (*Work*) .... (*Mobile*)

39. Relationship to the person with disability: ....

40. Training Attained, if any:

DECLARATION AND CERTIFICATION
To be completed by all Applicants/Caregiver

APPLICANT'S DECLARATION AND SIGNATURE

I hereby declare that the information given in this application is true and correct to the best of my knowledge and belief. It is understood that my application may be refused in the event I give any information that is false or misleading.

Signature or Mark of Person with a Disability ....

Date .... /............/............
Year Month Day

Signature or Mark of Caregiver ....

Date .... /............/............
Year Month Day

WITNESS' CERTIFICATE AND SIGNATURE

INSTRUCTIONS: To be completed by an applicant who is unable to read and write due to illness, disability or illiteracy.

I hereby certify that the applicant made the necessary mark to the Declaration in my presence after same was first explained to him/her and he/she indicated that he/she fully understood.

Name of Witness .... Occupation ....

Qualification .... Address ....

....

Name & Signature of Witness .... Contact Number .... Date........./............/............
Year Month Day

N.B. This form can be witnessed by any of the named persons: A Justice of the Peace, a Medical Doctor, a Principal/Senior Teacher, a Minister of Religion, a Senior Social Worker, an Attorney-at-Law, or a Parish Manager for the Ministry of Labour and Social Security.

SCHEDULE, *contd.*

FORM 1, *contd.*

FOR OFFICIAL USE ONLY

National Insurance. № ____________________

DATE RECEIVED

Documents received from Applicant/Caregiver:

- ☐ Driver's License № ____________________
- ☐ Electoral ID № ____________________
- ☐ Passport № ____________________
- ☐ Birth Certificate № ____________________
- ☐ Taxpayer Reg. № ____________________
- ☐ Marriage Certificate № ____________________
- ☐ Other ____________________

Checked by: Name ____________________

Signature ____________________ Date __________

Verified by: Name: ____________________

Signature ____________________ Date __________

SCHEDULE, *contd.*

FORM 2 **(Regulations 3(2) and 6(1))**

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

Application to be entered on the Confidential Register
(Pursuant to section 14 of the Disabilities Act)

PART A **PARTICULARS OF PERSONS WITH DISABILITIES**		
National Insurance Number	2. TRN	
1 Name:		
Surname:	Christian Name:	Middle Name:
2. Home Address:		
Street:	Town/District:	Parish:
3. Mailing Address if different from Home Address:		
Street:	Town/District:	Parish:
4. Date of Birth: (dd/mm/yyyy)	5. Nationality:	6. Sex: Male ☐ Female ☐
7. Marital Status: Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Married ☐ Common-Law Union ☐		
8. Date Disability Acquired		
Exact Date: (dd/mm/yyyy)	Approximate Date: (dd/mm/yyyy)	
9. Type of Disability: (indicate with a tick)	Blindness ☐ Deafness ☐ Hard of Hearing ☐ Physical Disability ☐ Mental Illness ☐ Intellectual Disability ☐ Speech Impairment ☐ Visual Impairment ☐ Developmental Disability ☐ ☐ Other...	
10. Nature of Disability:		
Congenital ☐	Acquired ☐	
11. Date of Secondary/Subsequent Disability:		
Date Acquired: (dd/mm/yyyy)	Date confirmed: (dd/mm/yyyy)	

SCHEDULE, *contd.*

FORM 2, *contd.*

12. Type of Secondary/ Subsequent Disability: (indicate with a tick):	Blindness ☐ Deafness ☐ Hard of Hearing ☐ Physical Disability ☐ Mental Illness ☐ Intellectual Disability ☐ Speech Impairment ☐ Visual Impairment ☐ Developmental Disability☐ ☐ Other...
13. Current Education Level:	
Early Childhood ☐ Primary ☐ High School ☐ Vocational Training ☐ Tertiary ☐ None ☐	
14. Employment Status: (Specify)	☐ Student ☐ Employed ☐ Seasonal employment ☐Self-employed ☐ Unemployed ☐ Unemployable (unable to get paid employment because of a lack of skill or qualification)

PART B

PARTICULARS OF CAREGIVER

15. Name:		
Surname:	Christian Name:	Middle Name:
16. Relationship to the person with disability: (Please state)		
17. Home Address:		
Street:	Town/District:	Parish:
18. Mailing Address if different from above:		
Street:	Town/District:	Parish:
Training Attained, if any		

I hereby declare that the information given in this application is true and correct to the best of my knowledge and belief. It is understood that my application may be refused in the event I give any information that is false or misleading.

____________________________ ________________
Signature or Mark of Person with Disability Date

____________________________ ________________
Signature or Mark of Caregiver (where applicable) Date

FOR OFFICIAL USE ONLY

Received By: ____________________________
(Print name)

Signature: ____________________________

Date Received ____________________________

Approved By: ____________________________

SCHEDULE, *contd.*

FORM 2, *contd.*

(Print name)

Signature: ______________________________

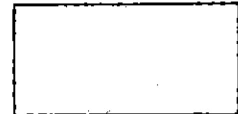
Date Approved: ______________________________

FORM 3 **(Regulation 3(2) and (4))**

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

Certificate of Registration
(Pursuant to section 13(4) of the Disabilities Act)

Photograph



This is to certify that ______________________________
(Full name in Block Letters)

has been registered as a person with ______________________________ disability
(Type of Disability)

pursuant to the section 13 of the Act as at ______________________________.
(Date)

This Certificate of Registration is valid for five years with effect from ______________________________, unless revoked.
(Date)

Dated this ________ day of ______________________________, 20______.

Signed by: ______________________________
Executive Director
Jamaica Council for Persons with Disabilities

SCHEDULE, *contd.*

If this certificate is found please return to the Jamaica Council for Persons with Disabilities at

____

FORM 4 **(Regulations 3(3) and 6(2))**

GOVERNMENT OF JAMAICA
MINISTRY OF LABOUR & SOCIAL SECURITY

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

ELIGIBILITY REPORT- ADULT
FUNCTIONAL ASSESSMENT

The purpose of this report is to provide verification of disability (ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in BLOCK letters

Title: Mr. ☐ Miss ☐ Dr. ☐ Professor ☐

Name: ______________ ______________ ______________ Male ☐
Last Name First Name Middle Name Female ☐

Address: ______________________________

____

Contact Number: ______________________________

E-mail Address: ______________________________

Usual or Previous Occupation: ______________ **TRN #:** ______________

Current Occupation (if any) : ______________________________

Functional Assessment- to be completed by General Practitioner/Orthopedic Specialist

Indicate ability, in words, e.g. "moderate," "weak," "poor," "nil" and percentages

Use of Upper Limb

Shoulder		Arms		Hands		Fingers		Reaching Overhead	
LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT

Reaching Away from Body		Use of Limb	
LEFT	RIGHT	RIGHT	LEFT

Use of Lower Limbs

SCHEDULE, *contd.*

FORM 4, *contd.*

Walking (Distance/ Frequency)		Standing Tolerance (Time)		Balance		Kneeling	
LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT

Not able to use Limb	
LEFT	RIGHT

Ability to

Stoop/Bend	Push/Pull (Kgs/distance)	Lift/Carry (max.kgs/ distance)	Repetitive Lift/Carry (max.kgs/ distance)	Climb	Travel to work	Sit	Stand

Description of work: Physical Effort

Much	Little

Description of Work: Work Tolerance

Full-time	Part- time	Shift Work

Specific Limitations/ Restrictions:

Summary/ Overview:

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Doctor: ____________________

Signature of Doctor: ________________

Date: _____/_____/_______
Day Month Year

Official Stamp

SCHEDULE, *contd.*

FORM 4, *contd.*

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

ELIGIBILITY REPORT- ADULT
HEARING ASSESSMENT

The purpose of this report is to provide verification of disability (ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in BLOCK letters

Title: Mr. ☐ Miss ☐ Dr. ☐ Professor ☐

Name: ____________________ ____________________ ____________________ Male ☐
Last Name First Name Middle Name Female ☐

Address: ____
____

Contact Number: ____

E-mail Address: ____

Usual or Previous Occupation: ____________________ **TRN #:** ____________________

Current Occupation (if any) ____

Hearing Assessment – to be completed by an Audiologist/ Approved Clinician

Hearing: Left ☐ ____

Right ☐ ____

Both ☐ ____

Degree of hearing loss: dB=decibels

☐ **Mild** Sounds softer than 25 dB to 40 dB are not detected
☐ **Moderate** Sounds softer that 40 dB to 65 dB are not detected
☐ **Severe** Sound softer than 65 dB to 90 dB are not detected
☐ **Profound** Sounds softer than 90 dB are not detected

Cause of Disability/ Etiology:

Summary:

SCHEDULE, *contd.*

FORM 4, *contd.*

MAIN MEDICAL PROBLEM(S) *In order of priority:*

RECOMMENDATION(S) *Who will implement them:*

CRITERIA for IMPROVEMENT:

I hereby certify that the information provided by me is true to the best of my knowledge.

____
NAME AND SIGNATURE OF DOCTOR

____/____/____
Day Month Year

____
SIGNATURE OR MARK OF APPLICANT

____/____/____
Day Month Year

Official Stamp

SCHEDULE, *contd.*

FORM 4, *contd.*

GOVERNMENT OF JAMAICA
MINISTRY OF LABOUR & SOCIAL SECURITY

Jamaica Council for Persons with Disabilities

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

ELIGIBILITY REPORT- ADULT
MULTIPLE DISABILITY

The purpose of this report is to provide verification of disability(ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.
Form is to be completed in BLOCK letters

Title: Mr. ☐ Miss ☐ Dr. ☐ Professor ☐

Name:__________ __________ __________ Male ☐
Last Name First Name Middle Name Female ☐

Address: ______________________________

____

Contact Number: ____________________

E-mail Address: ____________________

Usual or Previous Occupation: __________ **TRN #:** __________

Current Occupation (if any) ____________________

Psycho-educational/Psychological Assessment - to be completed by Registered Psychologist (e.g. Educational or Clinical)

Primary Disability (what function is affected):

____

Date of Initial Diagnosis: _____/_____/_____ **Age at Diagnosis:** __________
Day Month Year

Secondary/ Associated Disabilities (specify): ____________________

Nature of Disability: Congenital ☐ Acquired ☐

Levels of Intellectual Disabilities & Support Required:

☐ Mild: Intermittent ☐ Moderate: Limited ☐ Severe: Extensive ☐ Profound: Pervasive
☐ Unspecified Intellectual Disability (Adults who are untestable)

Name of Clinician/Doctor: ____________________

SCHEDULE, *contd.*

FORM 4, *contd.*

Address: ______________________________

Telephone: ______________________________

Date of last Psychological Evaluation: ______/______/______
Day Month Year

Medical/ Health Conditions: ______________________________

____

____

(Please attach proof of evaluation to this form)

Medical/ Health Problems: ______________________________

____

____

Name of Person Completing Form: ______________________________

Address: ______________________________

Telephone #: ______________________ **Cell:** ______________________

I hereby certify that the information provided by me is true to the best of my knowledge.

Signature: ______________________ **Date:** ______________________

Official Stamp

______________________________ ______/______/______
SIGNATURE/ SPECIAL STAMPS/ MARK OF APPLICANT Day Month Year

Complete this section if person has Physical Disabilities

Functional Assessment - to be completed by General Practitioner/Orthopedic Specialist

Indicate ability, in words, e.g. **"moderate," "weak," "poor," "nil"** and percentages

Use of Upper Limb

Shoulder		Arms		Hands		Fingers		Reaching Overhead	
LEFT	**RIGHT**	**LEFT**	**RIGHT**	**LEFT**	**RIGHT**	**LEFT**	**RIGHT**	**LEFT**	**RIGHT**

SCHEDULE, *contd.*

FORM 4, *contd.*

Reaching Away from Body		Use of Limb	
LEFT	RIGHT	RIGHT	LEFT

Use of Lower Limbs

Walking (Distance/ Frequency)		Standing Tolerance (Time)		Balance		Kneeling	
LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT

Not able to use Limb	
LEFT	RIGHT

Ability to

Stoop/Bend	Push/Pull (kgs: distance)	Lift/Carry (max.kgs: distance)	Repetitive Lift/Carry (max.kgs: distance)	Climb	Travel to work	Sit	Stand

Description of work: Physical Effort

Much	Little

Description of Work: Work Tolerance

Full-time	Part-time	Shift Work

SCHEDULE, *contd.*

FORM 4, *contd.*

Specific Limitations/Restrictions:

Summary/Overview:

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Doctor: ____________________

Signature of Doctor: ____________________

Official Stamp

Date: ______/______/______
Day Month Year

To be completed if client has psychiatric disorder or mental illness

Psychiatric Evaluation (Ages 18 and over)- to be completed by Psychiatrist

Name: ____________________________

Date of Birth: ______________________

Age: ________

Sex: ________

Marital Status: ________________

Place of Birth: ______________________

Diagnosis(es): ____

____

Age at which diagnosis was first made: ________________________________

Progress of Illness

Improving ☐ Improved Stable ☐ Deteriorating ☐ Fluctuating ☐ Other State ☐

**Prescribed treatment: Medication/Psychotherapy/Occupational Therapy/
Other** ________________________ **(State)**

Level of compliance with treatment: Very Good/Good/Fair/Poor

(Explain) ____

____

____

____

Level of Functioning

Normal	Mildly Improving	Moderately Impaired	Severely Impaired
☐	☐	☐	☐

SCHEDULE, *contd.*

FORM 4, *contd.*

Level of social and family support:

Very Good ☐ Good ☐ Fair ☐ Poor ☐

(Explain): ______________________________

____

____

Lives independently: Y/N

If no, explain with whom: ______________________________

Is disorder likely to be?

Short Term ☐

Permanent ☐

Other (explain): ______________________________

Recommended time for review of this form: ______________________________

____

Additional Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Psychiatrist: ______________________________

Signature of Psychiatrist: ______________________________

Date of Completion: ______________________________

Official Stamp

To be completed if client has hearing disabilities

Hearing Assessment – to be completed by an Audiologist/ Approved Clinician

Hearing: Left ☐ ______________________________

Right ☐ ______________________________

Both ☐ ______________________________

Degree of hearing loss: dB=decibels

☐ **Mild**	Sounds softer than 25 dB to 40 dB are not detected
☐ **Moderate**	Sounds softer that 40 dB to 65 dB are not detected
☐ **Severe**	Sound softer than 65 dB to 90 dB are not detected
☐ **Profound**	Sounds softer than 90 dB are not detected

SCHEDULE, *contd.*

FORM 4, *contd.*

Cause of Disability/ Etiology:

Summary:

MAIN MEDICAL PROBLEM(S) *In order of priority:*

RECOMMENDATION(S) *Who will implement them:*

CRITERIA for IMPROVEMENT:

I hereby certify that the information provided by me is true to the best of my knowledge.

NAME AND SIGNATURE OF DOCTOR ______/______/______ Day Month Year

SIGNATURE OR MARK OF APPLICANT ______/______/______ Day Month Year

Official Stamp

To be completed if person has a visual disability

Visual Assessment- to be completed by Ophthalmologist

Vision: **Left** ☐ **Right** ☐ **Both** ☐

Vision: (Correct if glasses worn). The following is suggested:

☐ **Good:** not less than 6/9 (Snellen) ☐ **Moderate:** less than 6/9 and more than 6/24

☐ **Bad:** less than 6/24

Treatment/ intervention: Is adult in any intervention programme? ☐ **YES** ☐ **NO**

Specify the intervention programme:

Cause of Disability/ Etiology:

SCHEDULE, *contd.*

FORM 4, *contd.*

Any Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

NAME AND SIGNATURE OF DOCTOR ______/______/______ **Day Month Year**

SIGNATURE OR MARK OF APPLICANT ______/______/______ **Day Month Year**

Official Stamp

SCHEDULE, *contd.*

FORM 4, *contd.*

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

ELIGIBILITY REPORT- ADULT PSYCHIATRIC EVALUATION

The purpose of this report is to provide verification of disability(ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in BLOCK letters

Title: Mr. ☐ Miss ☐ Dr. ☐ Professor ☐

Name: _______________ _______________ _______________ Male ☐
Last Name First Name Middle Name Female ☐

Address: ____

____

Contact Number: ________________________________

E-mail Address: ________________________________

Usual or Previous Occupation: ________________ TRN #: ____________

Current Occupation (if any) ________________________________

Psychiatric Evaluation (Ages 18 and over) - to be completed by Psychiatrist

Name: ______________________

Date of Birth: __________________

Age: ______

Sex: ______

Marital Status: ______________

Place of Birth: _____________________

Diagnosis (es): ____

Age at which diagnosis was first made: ____________________________

Progress of Illness

Improving ☐ Improved Stable ☐ Deteriorating ☐ Fluctuating ☐ Other State ☐

Prescribed treatment: Medication/Psychotherapy/Occupational Therapy/
Other ______________________ (State)

Level of compliance with treatment: Very Good/Good/Fair/Poor

SCHEDULE, *contd.*

FORM 4, *contd.*

(Explain) ____________________

____

____

____

Level of Functioning

Normal ☐ Mildly Improving ☐ Moderately Impaired ☐ Severely Impaired ☐

Level of social and family support:

Very Good ☐ Good ☐ Fair ☐ Poor ☐

(Explain): ____________________

____

____

Lives independently: Y/N

If no, explain with whom: ____________________

Is disorder likely to be?

Short Term ☐

Permanent ☐

Other (explain): ____________________

Recommended time for review of this form: ____________________

____

Additional Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Psychiatrist: ____________________

Signature of Psychiatrist: ____________________

Date of Completion: ____________________

Official Stamp

SCHEDULE, *contd.*

FORM 4, *contd.*

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

ELIGIBILITY REPORT- ADULT
INTELLIGENCE/COGNITIVE ASSESSMENT

The purpose of this report is to provide verification of disability (ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in BLOCK letters

Title: Mr. ☐ Miss ☐ Dr. ☐ Professor ☐

Name:________________ ________________ ________________ Male ☐
Last Name First Name Middle Name Female ☐

Address: ____

____

Contact Number: ____________________________________

E-mail Address: ____________________________________

Usual or Previous Occupation: ________________ **TRN #:** ________________

Current Occupation (if any) ________________________________

Psycho-educational/Psychological Assessment- to be completed by Registered Psychologist (e.g. Educational or Clinical)

Primary Disability (what function is affected):

____

Date of Initial Diagnosis: _____/_____/_____ **Age at Diagnosis:** __________
Day Month Year

Secondary/ Associated Disabilities (specify): ____________________________
Nature of Disability: Congenital ☐ Acquired ☐

Levels of Intellectual Disabilities & Support Required:

☐ Mild: Intermittent ☐ Moderate: Limited ☐ Severe: Extensive ☐ Profound: Pervasive
☐ Unspecified Intellectual Disability (Adults who are untestable)

Name of Clinician/Doctor: ________________________________

Address: ____

Telephone: ____

Date of last Psychological Evaluation: _____/_____/_____
Day Month Year

SCHEDULE, *contd.*

FORM 4, *contd.*

Medical/ Health Conditions:

____

____

____

(Please attach proof of evaluation to this form)

Medical/ Health Problems: ____

____

____

Name of Person Completing Form: ___________________________________

Address: ____

Telephone #: ________________________ **Cell:** _______________________

I hereby certify that the information provided by me is true to the best of my knowledge.

Signature: ____________________

Date: _______________________

Official Stamp

______________________________________ ______/______/______

SIGNATURE/ SPECIAL STAMPS/ MARK OF APPLICANT **Day Month Year**

SCHEDULE, *contd.*

FORM 4, *contd.*

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

ELIGIBILITY REPORT- ADULT
VISUAL ASSESSMENT

The purpose of this report is to provide verification of disability(ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in BLOCK letters

Title: Mr. ☐ Miss ☐ Dr. ☐ Professor ☐

Name: ________________ ________________ ________________ Male ☐
Last Name First Name Middle Name Female ☐

Address: ____

____

Contact Number: ____

E-mail Address: ____

Usual or Previous Occupation: ____________________ **TRN #:** ____________________

Current Occupation (if any) ____

Visual Assessment- to be completed by Ophthalmologist

Vision: Left ☐ **Right** ☐ **Both** ☐

Vision: (Correct if glasses worn). The following is suggested:

☐ **Good:** not less than 6/9 (Snellen) ☐ **Moderate:** less than 6/9 and more than 6/24

☐ **Bad:** less than 6/24

Treatment/ Intervention: Is adult in any intervention programme? ☐ **YES** ☐ **NO**

Specify the intervention programme:

Cause of Disability/ Etiology:

SCHEDULE, *contd.*

FORM 4, *contd.*

Any Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

__________________________________ ______/______/______

NAME AND SIGNATURE OF DOCTOR **Day Month Year**

__________________________________ ______/______/______

SIGNATURE OR MARK OF APPLICANT **Day Month Year**

Official Stamp

SCHEDULE, *contd.*

FORM 4, *contd.*

GOVERNMENT OF JAMAICA'S MINISTRY OF LABOUR & SOCIAL SECURITY

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

ELIGIBILITY REPORT FORM- CHILDREN MULTIPLE DISABILITIES

The purpose of this report is to provide verification of disability (ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in BLOCK letters

Name: __________ __________ __________ **Male** ☐
Last Name **First Name** **Middle Name** **Female** ☐

Age: ______ **Date of Birth:** ____/____/____ (**Day Month Year**) **Nationality:** ________

Address: ____________________

____

Telephone (Home): __________ **Cell:** __________

Name of Parent/Guardian: __________ **Occupation:** __________

Address ***(if different from above):*** ____________________

Telephone (Home): __________ **Cell:** __________

E-mail Address: ____________________

Date of Disablement: ____/____/____ (**Day Month Year**) **Date of Diagnosis:** ____/____/____ (**Day Month Year**)

Nature of Disability: Congenital ☐ Acquired ☐

Degree of Disablement:

☐ Mild: Intermittent ☐ Moderate: Limited ☐ Severe: Extensive ☐ Profound: Pervasive

Other Disablement (if any): ____________________

Treatment/ Assistive Devices/ Prosthetic Appliance Required (Specify):

____

Medical Diagnosis (cause): ____________________

____

Name of Person Completing Form: ____________________

Address: ____________________

Telephone #: __________ **Cell:** __________

SCHEDULE, *contd.*

FORM 4, *contd.*

Signature: ______________________________ **Date:** ________________________

Complete this section if child has physical disability. For guidelines on the completion of Form see attached criteria. The purpose of this report is to identify challenges that would mitigate against schoolin or other integrated childhood activities.

Functional Assessment- To be completed by General Practitioner/ Orthopedic Specialist

Indicate ability in words and percentages e.g. '**moderate**', '**weak**', '**poor**', '**nil**'

☐ **Use of Hands** Seizing, holding, grasping, or otherwise working with the hand or arm;
☐ **Use of Fingers** Pickup, pinching, gripping between thumb and fingers, or otherwise working with the fingers;
☐ **Balancing** Maintain position whether sitting, standing, or bending forward without holding on or being held.
☐ **Walking**
☐ **Travel to school by public transportation**

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Clinician/Doctor: ____

Address: ____

Telephone: ____

Signature of Doctor: ________________________ _____/_____/_____
Day Month Year

Official Stamp

Complete this section if person has an Intellectual or Developmental Disability

Psycho- Educational/Psychological Assessment- to be completed by Registered Psychologist (e.g. Educational or Clinical)

Primary Disability (what function is affected): ________________________

Date of Initial Diagnosis: _____/_____/_____ **Age at Diagnosis:** ____________
Day Month Year

Secondary/ Associated Disabilities (specify): ________________________

Nature of Disability: Congenital ☐ Acquired ☐

Levels of Intellectual Disabilities & Support Required:

☐ Global Developmental Delay (Children 0-5 years, but untestable)
☐ Mild: Intermittent ☐ Moderate: Limited ☐ Severe: Extensive ☐ Profound: Pervasive
☐ Unspecified Intellectual Disability (Children >5 years, but untestable; reassess in 5 years)

Name of Clinician/Doctor: ____

Address: ____

Telephone: ____

SCHEDULE, *contd.*

FORM 4, *contd.*

Date of last Psychological Evaluation: ______/______/______
Day Month Year

Medical/ Health Conditions: ______

______

______

(Please attach proof of evaluation to this form)

Medical/ Health Problems: ______

______

______

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Person Completing Form: ______

Address: ______

Telephone #: ______ **Cell:** ______

Signature: ______ **Date:** ______

Official Stamp

______ ______/______/______
SIGNATURE/ SPECIAL STAMPS/ MARK OF APPLICANT Day Month Year

To be completed for children with mental disorders or mental illness

Psychiatric Evaluation for Children (less than 18 years) - to be completed by Psychiatrist

Name: ______

Date of Birth: ______

Age: ______

Sex: ______

Name of Parent/ Guardian: ______

Is child attending school: ☐ **YES** ☐ **NO**

If so, current grade:

Diagnosis(es): ______

Age at which diagnosis was first made: ______

Level of functioning at school: ______

Level of functioning at home: ______

☐ ☐ ☐

SCHEDULE, *contd.*

FORM 4, *contd.*

Level of impairment: **Mild** **Moderate** **Severe**

Prescribed Treatment: Medication/ Psychotherapy/ Other (specify): ____________________

Level of compliance with treatment: Very Good/Good/Fair/Poor

(Explain) ____________________

____

____

Progress of Illness:

Improving ☐ Improved Stable ☐ Deteriorating ☐ Fluctuating ☐ Other State ☐

Prescribed treatment: Medication/Psychotherapy/Occupational Therapy/ Other ____________________ **(State)**

Likely Progress

Expected to improve ☐
Mildly Improving ☐
Moderately Impaired ☐
Other (specify): ____________________

Recommended Time for Review of this form: ____________________

Additional Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Psychiatrist: ____________________

Signature of Psychiatrist: ____________________

Date of Completion: ____________________

Official Stamp

SCHEDULE, *contd.*

FORM 4, *contd.*

To be completed if client has visual or hearing disabilities

Hearing Assessment – to be completed by an Audiologist/ Approved Clinician

Remarks and General Appraisal

Hearing: Left ☐ ____________________

Right ☐ ____________________

Both ☐ ____________________

Degree of hearing loss: dB=decibels

☐ **Mild**	Sounds softer than 25 dB to 40 dB are not detected
☐ **Moderate**	Sounds softer that 40 dB to 65 dB are not detected
☐ **Severe**	Sound softer than 65 dB to 90 dB are not detected
☐ **Profound**	Sounds softer than 90 dB are not detected

Treatment/ Intervention: *Is child in any intervention programme?* ☐ **YES** ☐ **NO**

Specify:

Cause of Disability/ Etiology:

Any Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

____
NAME AND SIGNATURE OF DOCTOR ______/______/______ **Day Month Year**

____
NAME AND SIGNATURE OF APPLICANT ______/______/______ **Day Month Year**

Official Stamp

SCHEDULE, *contd.*

To be completed if person has a visual disability

Visual Assessment- to be completed by Ophthalmologist/ Approved Clinician

Vision: **Left** ☐ **Right** ☐ **Both** ☐

Vision: (Correct if glasses worn). The following is suggested:

☐ **Good:** not less than 6/9 (Snellen) ☐ **Moderate:** less than 6/9 and more than 6/24

☐ **Bad:** less than 6/24

Treatment/ intervention: Is child in any intervention programme? ☐ **YES** ☐ **NO**

Specify the intervention programme:

Cause of Disability/ Etiology:

Any Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

____
NAME AND SIGNATURE OF DOCTOR ______/______/______ **Day Month Year**

____
NAME AND SIGNATURE OF APPLICANT ______/______/______ **Day Month Year**

Official Stamp

SCHEDULE, *contd.*

FORM 4, *contd.*

GOVERNMENT OF JAMAICA MINISTRY OF LABOUR & SOCIAL SECURITY

Jamaica Council for Persons with Disabilities

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

ELIGIBILITY REPORT FORM- CHILDREN
EPILEPSY

The purpose of this report is to provide verification of disability (ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in BLOCK letters

Name: ____________ ____________ ____________ **Male** ☐ **Female** ☐
Last Name **First Name** **Middle Name**

Age: ________ **Date of Birth:** ______/______/______ **Nationality:** ____________
Day Month Year

Address: ____

____

Telephone (Home): ____________ **Cell:** ____________

Name of Parent/Guardian: ____________ **Occupation:** ____________

Address *(if different from above)*: ____

Telephone (Home): ____________ **Cell:** ____________

E-mail Address: ____

Date of Disablement: ______/______/______ **Date of Diagnosis:** ______/______/______
Day Month Year **Day Month Year**

Nature of Disability: Congenital ☐ Acquired ☐

Degree of Disablement:

☐ Mild: Intermittent ☐ Moderate: Limited ☐ Severe: Extensive ☐ Profound: Pervasive

Other Disablement (if any): ____

Treatment/ Assistive Devices/ Prosthetic Appliance Required (Specify):

____

Medical Diagnosis (cause): ____

____

Name of Person Completing Form: ____

Address: ____

Telephone #: ____________ **Cell:** ____________

Signature: ____________ **Date:** ____________

SCHEDULE, *contd.*

FORM 4, *contd.*

Epilepsy Assessment – to be completed by an approved Clinician/ Doctor

What type of seizure(s) does child have?

☐ **Focal** ☐ **Generalized** ☐ **Combined**

Is an epilepsy syndrome identified? ☐ **Yes** ☐ **No**

If yes, please specify: ____________________________________

Age when diagnosis of epilepsy was made: ____________________________

Are seizures controlled? ☐ **Yes** ☐ **No**

If no, please specify the frequency of seizures:

☐ **Daily** ☐ **Weekly** ☐ **Monthly** ☐ **Yearly**

Is the child on Antiepileptic Drugs (AED's): ☐ **Yes** ☐ **No**

If yes, name and dose of AED(s):

1. ____
2. ____
3. ____

Has an EEG been performed? ☐ **Yes** ☐ **No**

If yes, please specify: ☐ **Normal** ☐ **Abnormal**

Any Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Clinician/ Doctor: ____________________________________

Address: ____

Registration #: ________________________

____________________________ ______/______/______

Signature of Clinician/ Doctor **Day** **Month** **Year**

Official Stamp

SCHEDULE, *contd.*

FORM 4, *contd.*

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

ELIGIBILITY REPORT FORM - CHILDREN
HEARING ASSESSMENT

The purpose of this report is to provide verification of disability (ies) for registration of the Jamaica Council for Persons wit Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in BLOCK letters

Name: ______________ ______________ ______________ **Male** ☐
Last Name **First Name** **Middle Name** **Female** ☐

Age: ________ **Date of Birth:** ______/______/______ **Nationality:** ____________
Day Month Year

Address: ____

____

Telephone (Home): ____________________ **Cell:** ____________________

Name of Parent/Guardian: ____________________ **Occupation:** ____________

Address ***(if different from above)***: ____________________________________

Telephone (Home): ____________________ **Cell:** ____________________

E-mail Address: ____

Date of Disablement: ______/______/______ **Date of Diagnosis:** ______/______/______
Day Month Year **Day Month Year**

Nature of Disability: Congenital ☐ Acquired ☐

Degree of Disablement:

☐ Mild: Intermittent ☐ Moderate: Limited ☐ Severe: Extensive ☐ Profound: Pervasive

Other Disablement (if any): ____

Treatment/ Assistive Devices/ Prosthetic Appliance Required (Specify):

____

Medical Diagnosis (cause): ____

____

Name of Person Completing Form: ____

Address: ____

Telephone #: ____________________ **Cell:** ____________________

SCHEDULE, *contd.*

FORM 4, *contd.*

GOVERNMENT OF JAMAICA
MINISTRY OF LABOUR & SOCIAL SECURITY

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

ELIGIBILITY REPORT FORM- CHILDREN PSYCHIATRIC DISORDERS

The purpose of this report is to provide verification of disability (ies) for registration of the Jamaica Council for Persons wit Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in BLOCK letters

Name: ______________________________ **Male** ☐
Last Name **First Name** **Middle Name** **Female** ☐

Age: __________ **Date of Birth:** ______/______/______ **Nationality:** ______________
Day **Month** **Year**

Address: ____

____

Telephone (Home): ______________________ **Cell:** ______________________

Name of Parent/Guardian: ______________________ **Occupation:** ______________

Address ***(if different from above)*****:** ______________________________

Telephone (Home): ______________________ **Cell:** ______________________

E-mail Address: ____

Date of Disablement: ______/______/______ **Date of Diagnosis:** ______/______/______
Day **Month** **Year** **Day** **Month** **Year**

Nature of Disability: Congenital ☐ Acquired ☐

Degree of Disablement:

☐ Mild: Intermittent ☐ Moderate: Limited ☐ Severe: Extensive ☐ Profound: Pervasive

Other Disablement (if any): ______________________________________

Treatment/ Assistive Devices/ Prosthetic Appliance Required (Specify):

____

Medical Diagnosis (cause): ______________________________________

____

Name of Person Completing Form: ______________________________

Address: ____

Telephone #: ______________________ **Cell:** ______________________

Signature: ______________________ **Date:** ______________________

SCHEDULE, *contd.*

FORM 4, *contd.*

Psychiatric Evaluation for Children (less than 18 years) - to be completed by Psychiatrist

Name: ____________________

Date of Birth: ____________________

Age: ________

Sex: ________

Name of Parent/ Guardian: ____________________

Is child attending school: ☐ **YES** ☐ **NO**

If so, current grade:

Diagnosis (es): ____________________

Age at which diagnosis was first made: ____________________

Level of functioning at school: ____________________

Level of functioning at home: ____________________

Level of impairment: ☐ **Mild** ☐ **Moderate** ☐ **Severe**

Prescribed Treatment: Medication/ Psychotherapy/ Other (specify):____________________

Level of compliance with treatment: Very Good/Good/Fair/Poor

(Explain) ____________________

____

____

Progress of Illness:

Improving ☐ Improved Stable ☐ Deteriorating ☐ Fluctuating ☐ Other State ☐

Prescribed treatment: Medication/Psychotherapy/Occupational Therapy/ Other ____________________ **(State)**

Likely Progress

Expected to improve ☐
Mildly Improving ☐
Moderately Impaired ☐
Other (specify): ____________________

Recommended Time for Review of this form: ____________________

Additional Comments:

SCHEDULE, *contd.*

FORM 4, *contd.*

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Psychiatrist: ______________________________

Signature of Psychiatrist: ______________________________

Date of Completion: ______________________________

Official Stamp

SCHEDULE, *contd.*

FORM 4, *contd.*

GOVERNMENT OF JAMAICA
MINISTRY OF LABOUR & SOCIAL SECURITY

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

ELIGIBILITY REPORT FORM - CHILDREN
INTELLECTUAL/ DEVELOPMENT DISABILITIES

The purpose of this report is to provide verification of disability (ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in BLOCK letters

Name:______________ ______________ ______________ **Male** ☐
Last Name **First Name** **Middle Name** **Female** ☐

Age: ______ **Date of Birth:** ____/____/____ **Nationality:** ________
Day Month Year

Address: ______________________________________

____

Telephone (Home): ______________ **Cell:** ______________

Name of Parent/Guardian: ______________ **Occupation:** ______________

Address *(if different from above)*: ____________________________

Telephone (Home): ______________ **Cell:** ______________

E-mail Address: ____________________________________

Date of Disablement: ____/____/____ **Date of Diagnosis:** ____/____/____
Day Month Year **Day Month Year**

Nature of Disability: Congenital ☐ **Acquired** ☐

Degree of Disablement:

☐ Mild: Intermittent ☐ Moderate: Limited ☐ Severe: Extensive ☐ Profound: Pervasive

Other Disablement (if any): ______________________________

Treatment/ Assistive Devices/ Prosthetic Appliance Required (Specify):

____

Medical Diagnosis (cause): ______________________________

____

Name of Person Completing Form: ________________________

Address: ______________________________________

Telephone #: __________________ **Cell:** ______________

Signature: __________________ **Date:** ______________

SCHEDULE, *contd.*

FORM 4, *contd.*

Psycho-educational/Psychological Assessment - to be completed by Registered Psychologist (e.g. Educational or Clinical)

Primary Disability (what function is affected): ____________________

Date of Initial Diagnosis: ______/______/______ **Age at Diagnosis:** __________
Day Month Year

Secondary/ Associated Disabilities (specify): ____________________

Levels of Intellectual Disabilities & Support Required:

☐ Global Developmental Delay (Children 0-5 years, but untestable)
☐ Mild: Intermittent ☐ Moderate: Limited ☐ Severe: Extensive ☐ Profound: Pervasive
☐ Unspecified Intellectual Disability (Children >5 years, but untestable; reassess in 5 years)

Name of Clinician/Doctor: ____________________

Address: ____________________

Telephone: ____________________

Date of last Psychological Evaluation: ______/______/______
Day Month Year

Medical/ Health Conditions: ____________________

____

____

(Please attach proof of evaluation to this form)

Medical/ Health Problems: ____________________

____

____

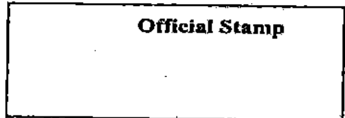
I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Person Completing Form: ____________________

Address: ____________________

Telephone: ____________________ **Cell:** ____________________

Signature: ____________________ **Date:** ____________________


Official Stamp

____
SIGNATURE/ SPECIAL STAMPS/MARK OF APPLICANT ______/______/______
Day Month Year

SCHEDULE, *contd.*

FORM 4, *contd.*

GOVERNMENT OF JAMAICA
MINISTRY OF LABOUR & SOCIAL SECURITY

Jamaica Council for Persons with Disabilities

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

ELIGIBILITY REPORT FORM- CHILDREN
VISUAL ASSESSMENT

The purpose of this report is to provide verification of disability (ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in BLOCK letters

Name: ____________ ____________ ____________ **Male** ☐ **Female** ☐
Last Name **First Name** **Middle Name**

Age: ________ **Date of Birth:** ______/______/______ (**Day** **Month** **Year**) **Nationality:** ____________

Address: ____

____

Telephone (Home): ____________________ **Cell:** ____________________

Name of Parent/Guardian: ____________________ **Occupation:** ____________________

Address *(if different from above)*: ____

Telephone (Home): ____________________ **Cell:** ____________________

E-mail Address: ____

Date of Disablement: ______/______/______ (**Day** **Month** **Year**) **Date of Diagnosis:** ______/______/______ (**Day** **Month** **Year**)

Nature of Disability: Congenital ☐ Acquired ☐

Degree of Disablement:

☐ Mild: Intermittent ☐ Moderate: Limited ☐ Severe: Extensive ☐ Profound: Pervasive

Other Disablement (if any): ____

Treatment/ Assistive Devices/ Prosthetic Appliance Required (Specify):

____

Medical Diagnosis (cause): ____

____

Name of Person Completing Form: ____

Address: ____

Telephone #: ____________________ **Cell:** ____________________

Signature: ____________________ **Date:** ____________________

SCHEDULE, *contd.*

FORM 4, *contd.*

Visual Assessment- to be completed by Ophthalmologist/ Approved Clinician

Vision: **Left** ☐ **Right** ☐ **Both** ☐

Vision: (Correct if glasses worn). The following is suggested:

☐ **Good:** not less than 6/9 (Snellen) ☐ **Moderate:** less than 6/9 and more than 6/24

☐ **Bad:** less than 6/24

Treatment/ intervention: Is child in any intervention programme? ☐ **YES** ☐ **NO**

Specify the intervention programme:

Cause of Disability/ Etiology:

Any Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

____________________ ____/____/____

NAME AND SIGNATURE OF DOCTOR **Day Month Year**

____________________ ____/____/____

NAME AND SIGNATURE OF APPLICANT **Day Month Year**

Official Stamp

SCHEDULE, *contd.*

FORM 4, *contd.*

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

ELIGIBILITY REPORT FORM- CHILDREN
FUNCTIONAL ASSESSMENT

The purpose of this report is to provide verification of disability (ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in BLOCK letters

Name: ____________ ____________ ____________ **Male** ☐
Last Name **First Name** **Middle Name** **Female** ☐

Age: ________ **Date of Birth:** ______/______/______ **Nationality:** ____________
Day **Month** **Year**

Address: ____

____

Telephone (Home): ____________________ **Cell:** ____________________

Name of Parent/Guardian: ____________________ **Occupation:** ____________

Address *(if different from above)*: ______________________________

Telephone (Home): ____________________ **Cell:** ____________________

E-mail Address: ____

Date of Disablement: ______/______/______ **Date of Diagnosis:** ______/______/______
Day **Month** **Year** **Day** **Month** **Year**

Nature of Disability: Congenital ☐ Acquired ☐

Degree of Disablement:

☐ Mild: Intermittent ☐ Moderate: Limited ☐ Severe: Extensive ☐ Profound: Pervasive

Other Disablement (if any): ____

Treatment/ Assistive Devices/ Prosthetic Appliance Required (Specify):

____

Medical Diagnosis (cause): ____

____

Name of Person Completing Form: ____

Address: ____

Telephone #: ____________________ **Cell:** ____________________

Signature: ____________________ **Date:** ____________________

SCHEDULE, *contd.*

FORM 4, *contd.*

Functional Assessment- To be completed by General Practitioner/ Orthopedic Specialist

Indicate ability in words and percentages e.g. **'moderate'**, **'weak'**, **'poor'**, **'nil'**

- ☐ **Use of Hands** Seizing, holding, gasping, or otherwise working with the hole hand or arm;
- ☐ **Use of Fingers** Pickup, pinching, gripping between thumb and fingers, or otherwise working with the fingers;
- ☐ **Balancing** Maintain position whether sitting, standing, or bending forward without holding on or being held.
- ☐ **Walking**
- ☐ **Travel to school by public transportation**

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Clinician/Doctor: ____________________________________

Address: ____________________________________

Telephone: ____________________________________

Signature of Doctor: ____________________ ______/______/______

Day Month Year

Official Stamp

SCHEDULE, *contd.*

FORM 5 **(Regulation 13(1) and (4))**

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

PART A

Request for Alteration to Leased Premises
(Pursuant to section 38 of the Disabilities Act)

To: ....
Name of Lessor

....
Address of Lessor

From: ....
Name of Lessee

....
Address of Lessee

I hereby apply for your permission to make alterations to the leased premises located at .... in the parish of .... to make same accessible to and usable by a person with a disability.

The following is a description of the alterations to be made to said premises
....
....
....
....
....

Please find attached a drawing, plan, diagram, specification or such other document showing the proposed alterations to the leased premises.

You are hereby notified that by virtue of section 38(2) and (3) of the Act, your written consent or refusal to the proposed alterations must be communicated to the Lessee within thirty days of receipt of this request and that your consent shall not be unreasonably withheld.

Dated this .... day of ...., 20......

....
Signature of Lessee

SCHEDULE, *contd.*

FORM 5, *contd.*

PART B

To: ....
Name of Lessee

....
Address of Lessee

From: ....
Name of Lessor

....
Address of Lessor

I acknowledge receipt of your request to make alterations to the leased premises dated the ...., day of.................................

I hereby ☐ consent ☐ refuse to consent (tick the appropriate response) to your request for permission to make alterations to the leased premises located at .... in the parish of .... to make same accessible to and usable by a person with a disability.

Where the consent is denied, state reason(s) below:

....
....
....
....
....

The Lessor is reminded that pursuant to section 38(3) of the Act consent cannot be unreasonably withheld.

Dated this ....day of ...., 21 ....

....
Signature of Lessor

Dated this 21st day of July, 2021.

KARL SAMUDA
Minister of Labour and Social Security

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