Estonian Unemployment Insurance Fund
Social Insurance Board

Application form for the assessment of work ability, for the determination of the degree ofseverity of a disability and for obtaining benefits

Mai 2021

Content

Before submitting an application, you must have had an appointment during last six months with your general practicioner, occupational physician or the medical doctor who has primarily been treating you. If the extent of your work ability cannot be determined by the available health information, the Estonian Unemployment Insurance Fund has the right to call you for an appointment with a medical expert for visit-based assessment.

If your work ability has been determined as partial, you must comply atleast one of the activity requirements (e.g. be working, studying or registered as unemployed) in order to receive the work ability allowance.

Please mark the appropriate response with an X for all multiple-choice questions.

I GENERAL

APPLICANT'S DETAILS

First name:	Surname: .....
Personal identification code: __ __ __ __ __ __ __ __ __ __ __	
If you do not have an Estonian personal identification code, please provide your date of birth: ____.____._____ and gender: ☐ M ☐ F	
Foreign personal identification code (if applicable): ..... Country of issue of personal identification code:	
Postal address (to receive a work ability card and disabled person's card): …….....	
E-mail address:	Phone: .....
If you have a speech or hearing difficulties or any other problems making communication by phone impossible, please specify who is the person you wish us to contact (first name and surname and contact details):	

If you are a resident of both Estonia and another country, provide the name of the foreign country and the address of your residence in the foreign country:

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Data of living / working abroad

If you live/work or have lived/worked in a foreign country, provide the name of the country and the periods during which you lived/worked there (full dates).

Country	**Period**	**If you worked in named country during the last five years,please indicate your profession (take into account all forms of work when answering this question)**

DETAILS OF APPLICANT'S REPRESENTATIVE

Please name the representative (authorized representative, parent or guardian) if the applicant is under 18 years of age or is under guardianship or has determined other person by proxy as authorizedrepresentative.

Parent/guardian ☐
Authorized representative ☐

First name:	Surname: .....
Personal identification code: _____	
E-mail address:	Phone: .....
Postal address:	

If the authorized representative of the applicant is a legal entity, please provide the name of the legal entity:

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If the application is submitted by a person holding the proxy, please provide the proxy identifying the right of representation as an annex to the application.

APPLYING FOR:

☐	Work ability assessment
☐	Work ability allowance
☐	Determination of degree of severity of disability
☐	Disability allowance for person of working age
☐	Disabled parent's allowance (paid to one disabled parent or toa disabled parent, guardian or foster parent who is raising a child on their own)

Which office of the Estonian Unemployment Insurance Fund do you wish to contact in case you have any questions?

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Agreement for the processing of your health data held in the health information system

I agree that Estonian Unemployment Insurance Fund and Social Insurance Board processing the following data for the purpose of assessing my work ability and the degree of severity of my disability:

☐	my/person`s on my guardianship health data in the healthinformation system (regarding the doctors who inscribed your medical records, incl. visits, hospital stays and medication). The data mentioned above will only be processed by medical doctors who have gone through medical training and the healthcare professionals involved in assessing work ability. The name of the doctor who inscribed medical record and the time the medical record was made are processed by authorized employees.

I am aware that this agreement also extends to the personal health data in the health information system that I have or **doctor treating me has forbidden to other health care providers to access.**

I am aware that I have the right to withdraw my agreement at any time by submitting the appropriate request to the Estonian Unemployment Insurance Fund or Social Insurance Board. **Withdrawing my agreement does not influence legality of decisions made before withdrawal and have made by my previous agreement, eg agreement is not possible to withdraw retroactively.**

The criteria of processing personal data are available on the Unemployment Insurance Fund website at **www.tootukassa.ee** or theSocial Insurance Board website at **www.sotsiaalkindlustusamet.ee**.

THE METHOD OF OBTAINING DECISIONS OF WORK ABILITY ASSESSMENT AND ALLOWANCE,NOTICE OF DETERMINATION OF DEGREE OF SEVERITY OF DISABILITY AND BENEFITS

Please issue the DECISIONS/NOTICE to the:			
Applicant ☐ **Parent/guardian** ☐ **Representative with proxy** ☐			
Please mark only **one** way to receive decisions and notices with an X.			
I wish to receive the DECISIONS OF MY WORK ABILITY ASSESSMENT AND WORK ABILITY ALLOWANCE*:			
☐	**By e-mail**	☐	**As a standard letter**
☐	**From an office of the Estonian Unemployment Insurance Fund** I wish to be notified when the decision becomes available: **By e-mail** ☐ **Over the phone** ☐		
DECISIONS FOR DETERMINATION OF THE SEVERITY OF DISABILITY AND GRANTING SOCIAL BENEFITS FOR PEOPLE WITH DISABILITIES are available from the self-service portal of the Social Insurance Board at iseteenindus.sotsiaalkindlustusamet.ee and a notification letter will be sent to the e-mail address. **In the absence of an e-mail, I would like an answer:**			
☐	**As a standard letter**	☐	**By registered mail**

** The decision of your work ability assessment and work ability allowance and the opinion of an expert are available via the Estonian Unemployment Insurance Fund's self-service portal at www.tootukassa.ee. The expert's opinion is also available via the patientportal at www.digilugu.ee.*

Please transfer the ALLOWANCES to:	
The applicant's Estonian bank account:	☐
Bank account number: _____	
A foreign bank account at the applicant's expense:	☐
Bank account number: _____	
SWIFT/BIC:	
Bank:	
The bank account of another person in Estonia incl. a localgovernment or other establishment: (applicable only if thisapplication is signed in an office of the Unemployment insurance Fund or Social Insurance Board, submitted with adigital signature or authenticated by a notary public)	☐
First and family name of other person/ name of local government or other institution:	
Personal identification code of other person: _____	
Bank account number: _____	
Reference number:	
The applicant's home address by mail at the applicant's expense: provide the applicant's home address:	☐

The applicant's home address by mail at the expense of the Unemployment Insurance Fund/Social Insurance Board, because I am severely disabled and: - my mobility is restricted; - I live in a sparsely populated area and have limited access to bank services. Provide grounds for your request: .... **If you are applying for mail delivery to your home address at the expense of the Unemployment Insurance Fund/Social Insurance Board, please mark an alternative method of payment in case mail delivery is not approved.**	☐ ☐

If you wish to receive the work ability allowance paid by the Estonian Unemployment Insurance Fund in a different way or to different account from the one in which you receive your disability allowance, please specify which way you would wish to receive your work ability allowance:

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If you receive an allowance, a pension or other cash benefits that serve the same purpose as the work ability allowance from a foreign country, indicate:	
the country that pays you the allowance, pension or other benefits	
the type, amount and payment period of the allowance, pension or other benefits you receive from the foreign country (attach a document to the application for proof, e.g. the decision to grant the allowance, pension or benefit)	

MEDICAL DOCTORS AND HEALTH CARE PROFESSIONALS

Have you been on the medical doctor's appointment during the last six months?

YES ☐ NO ☐

If you live or work abroad and have been there on the medical doctor`s appointment during the last six months, please indicate the country in which you attended the appointment:

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Name the medical doctors who have described your health data regarding disorders in order to assess your work ability. Provide only the names of those medical doctors who have diagnosed or treated your chronic and ongoing illnesses.

MEDICAL DOCTOR	
First and last name	
Specialty	
Institution	
Last appointment with MD (date and year)	
MEDICAL DOCTOR	
First and last name	
Specialty	
Institution	
Last appointment with MD (date and year)	

MEDICAL DOCTOR	
First and last name	
Specialty	
Institution	
Last appointment with MD (date and year)	
MEDICAL DOCTOR	
First and last name	
Specialty	
Institution	
Last appointment with MD (date and year)	

You may also provide the names of other health care professionals (therapists) who could provide additional information about your limitations.

SOCIAL WORKER	
First and last name	
Institution	
PSYCHOLOGIST	
First and last name	
Institution	
SOCIAL SERVICE PROVIDER (incl. personal assistants and caregivers)	
First and last name	
Institution	
OTHER (e.g. physiotherapist, occupational therapist, special education specialist or speech therapist)	
First and last name	
Institution	

II HEALTH CONDITIONS EXCLUDING WORK ABILITY

Particularly serious and unchanging health conditions are listed below, and in general, there is no ability to work in the presence of such health impairment.

Please, read carefully the following list of conditions and select YES only if you are sure that an exclusionary condition is present.

2.1. Do you have any of the conditions mentioned below?

- alleviating ailments associated with a malignant tumor or hospice care when oncospecific treatment is not available and only the best supportive care is provided with a malignant tumor
- dialysis treatment;
- artificial ventilation or constant oxygen therapy for respiratory insufficiency;
- dementia;
- a moderate, severe or total intellectual disability;
- permanently bedridden (requiring 24-hour personal assistance)

YES ☐ **NO ☐**

I undertake to immediately notify the Estonian Unemployment Insurance Fund of any circumstances affecting my right to receive the work ability allowance and its amount, including moving to and commencing employment in a foreign country and any remuneration, unemployment insurance benefits, parental benefits, benefits for temporary incapacity for work and pensions and allowances, pensions or other cash benefits that serve the same purpose as the work ability allowance received in a foreign country.

I undertake to immediately notify the Social Insurance Board of any circumstances affecting my right to receive social benefits for disabled persons, including stopping a child's studies (disabled parent's allowance), moving to a foreign country and any allowances or othercash benefits that serve the same purpose as social benefits for disabled persons received in a foreign country.

I am aware that the Estonian Unemployment Insurance Fund/Social Insurance Board can demand the repayment of benefits/allowances granted and paid without a legal basis.

2.2. If you ticked YES to the exclusion status in point 2.1, it is possible to fill in a short application form, sign the application form.

If you are unsure about the exclusion status, please continue to complete the application.

_____	_____	_____
(date)	(name of applicant)	(signature)

_____	_____	_____
(date)	(name of applicant's representative)	(signature)

III PERSONAL ASSISTANCE, REHABILITATION AND SOCIAL SERVICES

Personal Assistance

Do you use the assistance of other people in your daily activities?

YES ☐ NO ☐

The assistance of other people must be described in the body of the application for each activity that cannot be carried out independently.

Rehabilitation

Have you participated in the social rehabilitation services provided by theSocial Insurance Board during the last three years?

YES ☐ NO ☐

If possible, please attach an assessment composed by therapists within the social rehabilitation service to the application. (Information regarding vocational rehabilitation is accessible to the EstonianUnemployment Insurance Fund.)

Social Services

Social services can be: general care service, social transport service, support person service, personal assistant service, adult care service, asylum service, shelter home service, housing security service, debt counseling service, child care service, substitute care service, aftercare service, etc.

Social services are also educational support services: SEN counselor, services of support specialists (special teacher, social pedagogue, psychologist, speech language therapist) in an educational institution.

If you use social services, please specify which services you use.

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IV PHYSICAL AND MENTAL ABILITIES

Please assess how you can perform different activities, taking into account your physical and mental abilities. Your own opinion regarding the limitations of activity is very important in the ASSESSMENT of your work ability. Please describethe occurrences, frequency and extent of your limitations asaccurately as possible.

Performing an activity without difficulties means that you are able toengage in the activity safely and repeatedly without excessive effort.

Select the option 'My ability varies' if you are sometimes able to perform the specified activity and sometimes unable to do so (e.g. if your illness is periodically more severe). Please describe 'good' and 'bad' days as accurately as possible, specifying the frequency of occurrence of your limitations.

Before starting to fill out the questionnaire, please read the entire application form. This will make application easier to understand and more precise the areas in which you describing your limitations.

Do you have the will to engage in daily activities?

YES ☐ NO ☐

Please think about whether you have the vitality to carry out daily activities, whether you feel the urge to act, whether you have the will to live family life, to communicate with friends and acquaintances, whether you feel good on a daily basis.

If you selected NO, please describe how often and with regard to which daily activities you struggle with your will.

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PHYSICAL ABILITIES

1. Mobility

In this section you will be asked about how easily you are able to move around, climbing the stairs, exceed the obstacles, maintaining standing and sitting positions and changing the body positions.

If you use assistive technology aids or the assistance of another person to move around, stand up or sit down, indicate this under the corresponding activity.

Mobility aids include: lower limb prosthetic(s); manual and electric wheelchairs; crutches, walking sticks and walkers; adapted cars; two-and three-wheeled scooters and adapted bicycles (incl. motorised ones); aids for transferring and relocating the body (transfer boards, lifts and ramps); and white sticks, guide dogs and arm, leg, back or neck orthoses. If you are unable to use the prescribed or recommended mobility aid, please describe the reason.

1.1. Moving on different surfaces

Moving around means that a certain distance is covered on one surface at an ordinary speed.

Moving on different surfaces means walking on an uneven surface, exceed the obstacles and climbing the stairs. Please compare yourself to a friend, family member or colleague who has no limitations.

- Can you keep upwith them?
- Has it ever happened that your companion has had to stop and wait for you?

Your moving ability is without difficulties if you do not experience any pain, weakness, fatigue, gasping, imbalance, etc.

I am able to move around and climb the stairs without difficulty.

YES ☐ NO ☐

If you selected YES, please proceed to question 1.2 (page 22). If you selected NO, please continue answering the questions below.

1.1.1. What distance are you able to cover without pain, weakness, fatigue, vertigo, gasping or imbalance?

- ☐ More than 200 meters
- ☐ 200 meters
- ☐ 100 meters (roughly the length of a football pitch)
- ☐ 50 meters (roughly the length of five buses)
- ☐ I am not able to move independently at all
- ☐ My ability to move varies

Please specify the answer you selected. Describe how you move and what limits or interferes you in moving around freely. Add the frequency of occurrence of your limitations (in a day, a week, etc.) and the severity of your pain if you experience it. If you use any assistive technology aids, please name them and describe for what and how the device or aid helps you.

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1.1.2. Are you able to climb the stairs and exceed the obstacles (the thresholds of doors, pavement curb stones, etc.) if needed?

- ☐ Yes
- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ No
- ☐ My ability to move up and down stairs varies

Please specify the answer you selected. Do youexperience any pain, imbalance, gasping, palpitation or falls while exceeding the obstacles or climbing stairs, and how often any of theseoccur? If you use any assistive technology aids, please name them and describe how they help you.

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1.2. Moving around safely

Moving around safely means reaching the desired place in a reasonable amount of time, without difficulty and safely (e.g. without loss of balance or falling over and on different surfaces). Here, safe moving around applies in terms of musculoskeletal diseases and sight or hearing difficulties. Difficulties caused by fear or anxiety are not covered here.

I am able to move around safely both indoors and outdoors.

YES ☐ NO ☐

If you selected YES, please proceed to question 1.3 (page 24). If you selected NO, please continue answering the questions below.

1.2.1. Are you able to move around on the street safely, incl. inplaces you have not been before?

- ☐ Yes
- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ No
- ☐ My ability to move safely varies

Please specify the answer you selected. Describe the difficulties that inhibit you from moving around safely. If you use any assistive technology aids (incl. seeing, hearingand mobility aids), please name them and describe how they help you.

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1.2.2. Are you able to move around safely indoors, incl. in rooms that you have not been in before?

- ☐ Yes
- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ No
- ☐ My ability to move safely indoors varies

Please specify the answer you selected. Describe the difficulties what inhibit you going to new placesand moving around safely. If you use any assistive technology aids, please name them and describe how they help you.

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1.3. Standing and sitting

Standing is defined as staying in one place using an aid or leaning on something (e.g. a table or a chair) if necessary. Another person's help cannot be taken into account here.

Sitting is defined as staying in a seated position on a chair without armrests. You can change sitting and standing positions, which means you can sit for two to three minutes between periods of standing and vice versa.

I am able to maintain and change positions without difficulty or feeling any pain.

YES ☐ NO ☐

If you selected YES, please proceed to question 1.4 (page 26). If you selected NO, please continue answering the questions below.

1.3.1. Are you able to remain in one place standing or sitting without experiencing pain or fatigue?

- ☐ Yes
- ☐ With mild difficulty
- ☐ I am able to for up to three hours
- ☐ I am able to for less than an hour
- ☐ No
- ☐ My ability to remain in one place while sitting, standing or changing positions varies

Please specify the answer you selected. Describe your ability to maintain position and the difficulties that occur while you are doing so. Ifyou use any assistive technology aids, please name them and describe how they help you.

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1.3.2. Are you able to change positions, e.g. stand up, sit on a chair, bend over, etc.?

- ☐ Yes
- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ No
- ☐ My ability to change positions varies

Please specify the answer you selected. Indicate whether you have difficulty changing positions and how this difficulty expresses itself. If you use any assistive technology aids, please name them and describe how they help you.

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1.4. Other limitations related to mobility

Please consider whether all difficulties in moving, maintaining or changing your posture are described above. If you have additional limitation which was not described in the questions, mention it here. If all the limitations are described above, leave the question unanswered.

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2. Hand and arm use

In this part you will be asked if you are able to stretch your arms, hold and move large objects and make precise movements with your fingers without excessive effort. You can perform hand activities without difficulty if you do not experience pain, weakness or trembling, movement restrictions, etc.

If you use assistive technology aids or the help of another person, describe this under the corresponding activity. If you are unable to use the prescribed or recommended aid, please describe the reason.

Aids for hand activity include upper limb or hand prosthetics, robot arms, grabbers, upper limb, hand or finger orthoses and special keyboards and/or mice for computers.

I am:

- ☐ Left-handed
- ☐ Right-handed

2.1. Stretching arms

Stretching arms is defined as extending your arms forward or to the sides to shoulder level or higher, bending the arms at the shoulder or elbow joints, for example reaching for and throwing items.

I am able to raise my arms without difficulty.

YES ☐ NO ☐

If you selected YES, please proceed to question 2.2 (page 28). If you selected NO, please continue answering the questions below.

2.1.1. Are you able to raise your arms enough to, for example, reach an object on a shelf?

- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ No
- ☐ My ability to lift and bend my arms to perform activities varies

Please specify the answer you selected. If you cannot raise your arms, give the reason for this and whether it affects both of your arms. If you use any assistive technology aids, please name them and describe how they help you.

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2.2. Moving objects

Moving objects is defined as grabbing them with two hands and shifting them from one place to another at waist level (for example, moving a plate on the table from your left side to the right).

I am able to move objects with my hands without difficulty.

YES ☐ NO ☐

If you selected YES, please proceed to question 2.3 (page 29). If you selected NO, please continue answering the questions below.

2.2.1. Are you able to lift and move a container filled with one litre of liquid?

- ☐ Yes
- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ I can lift a container filled with up to half a litre of liquid
- ☐ I cannot lift any object regardless to its weight
- ☐ My ability to lift and move such containers varies

Please specify the answer you selected. If you cannot move a container filled with one litre of liquid, describe how the difficulty expresses (e.g. if instability or shaking of your hands causes the liquid to spill orif you need to use two hands because your hands are clumsy or you need to support one hand with another). If you use any assistive technology aids, please name them and describe how they help you.

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2.2.2. Are you able to lift and move a large but lightweight object such as a pillow or empty cardboard box without difficulty?

- ☐ Yes
- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ No
- ☐ My ability to lift and move such an object varies

Please specify the answer you selected. If you are not able to lift objects, please indicate why. It is not intended to lift heavy objects or lift them from the floor to the table.

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2.3. Fine hand use

Fine hand use is defined as the mobility and strength of your fingers and wrists, the ability to turn your wrists inwards and outwards and the precise movement of your hands and fingers (grabbing, holding and handling small objects).

I am able to use my hands and fingers without difficulty.

YES ☐ NO ☐

If you selected YES, please proceed to question 2.4 (page 30). If you selected NO, please continue answering the questions below.

2.3.1. How well are you able to use your hands and fingers?

- ☐ With mild difficulty when performing certain activities
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ I cannot
- ☐ My ability to use my hands and fingers varies

Please specify the answer you selected. List the activities you experience difficulty with and why. If you use any assistive technology aids, please name them and describe how they help you.

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2.4. Other limitations related to hand and arm use

Please consider whether all difficulties in hand and arm use are described above. If you have additional limitation which was not described in the questions, mention it here. If all the limitations are described above, leave the question unanswered.

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3. Transmitting and receiving the information

In this part you will be asked if you are able to communicate taking into account your ability to see, hear, speak for transmission and receiving information.

If you use assistive technology aids or the help of another person to communicate, describe this under the corresponding activity. If you are unable to use the prescribed or recommended aid, please describe the reason.

Communication aids include glasses, a magnifying glass, reading TVs, video magnifying or other systems, materials written with a tactile writing system, hearing aids, hearing aids used with implants, hearing glasses, audio amplifiers, electronic devices for close communication (dialogue devices) and alternative communication aids (communicators).

3.1. Transmitting the information

Transmission of information is described as communicating through speech and writing. Information can be transmitted among other ways by signing, typing, etc.

I am able to communicate with other people without difficulty by speaking and writing.

YES ☐ NO ☐

If you selected YES, please proceed to question 3.2 (page 32). If you selected NO, please continue answering the questions below.

3.1.1. Are you able to transmit a simple message to another person? (A simple message could be defined as, for example, a warning or information about the time or a location)

- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ I am not able
- ☐ My ability to transmit a simple message varies

Please specify the answer you selected. Describe how you communicate with other people. How your difficulty in transmitting messages to other people is expressed? If you use any assistive technology aids, please name them and describe how they help you.

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3.2. Receiving information

In this part you will be asked whether you are able to receive information using hearing or seeing.

I am able to hear what has been said and read what has been written down without difficulty.

YES ☐ NO ☐

If you selected YES, please proceed to question 3.3 (page 34). If you selected NO, please continue answering the questions below.

3.2.1. Are you able to hear and/or lip-read another person's simple message?

(A simple message could be defined as, for example, a warning or information about the time or a location). Only answer about reading from your lips if your hearing does not allow you to get information.

- ☐ Yes
- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ I am not able
- ☐ My ability to receive verbally forwarded message varies

Please specify the answer you selected. List the activities you experience difficulty with and why. If you use any assistive technology aids, please name them and describe how they help you.

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3.2.2. Are you able to see and read a message printed in a large font?

(A large font can be defined as a text that is in a font larger than used for regular newspaper and book texts, i.e. at least 14 p).

- ☐ Yes
- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ I am not able
- ☐ My ability to read written messages varies

Please specify the answer you selected. Describe how you are able to see and receive messages. If you use any assistive technology aids, please name them and describe how hey help you.

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3.3. Other limitations related to transmitting and receiving information

Please consider whether all difficulties in transmitting and receiving information are described above. If you have additional limitation which was not described in the questions, mention it here. If all the limitations are described above, leave the question unanswered.

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4. Staying conscious and self-care

In this part you will be asked:

1) whether and how often you experience consciousness impairments or loss of consciousness;
2) whether you have any difficulty controlling your bowels and/or bladder;
3) whether you are able to eat and drink without difficulty;
4) whether you are able to wash and take care of your hygiene.

If you use any assistive technology aids or **the help of another person** to control your bowels and/or bladder or to eat and drink, please describe this under the corresponding activities. If you are unable to use the prescribed or recommended aid, please describe the reason.

Aids that help control your bowels and bladder include urine and fecal collection devices, urine-directing devices, skin protection and cleaning products, urine-absorbing single-use inserts, diapers etc.

Aids for eating and drinking include special-purpose cutlery, drinking straws and special-purpose mugs, plates, bowls etc.

Aids related to self-care include armrests for toilet seats, commode seats and chairs, shower and bath seats and chairs, toilet paper grabbers, tracheostomy care products etc.

4.1 Staying conscious

State of consciousness is defined as usual wakefulness and the abilityto make contact while awake. This does not include dizziness caused by ailment, drowsiness due to medication or insomnia, vertigo or tension headaches.

I am able to stay conscious without difficulty.

YES ☐ NO ☐

If you selected YES, please proceed to question 4.2 (page 36). If you selected NO, please continue answering the questions below.

4.1.1. How often do you experience consciousness-related disorders?

(This includes fainting, epileptic seizures and consciousness impairments related to diabetes).

- ☐ Once every couple of years
- ☐ A couple of times a year
- ☐ Monthly
- ☐ At least once a week

Please specify the answer you selected. Describe why and how these disorders occur.

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4.2. Toileting

Toileting can be defined as the ability to control your bladder and bowels, incl. difficulties like frequent soiling of clothesand the need to change them.

When answering, take into account any use of special undergarments or collection devices (ostomy bags and bladder catheters), small leaks (i.e. controllable with single-use inserts or diapers) that do not require a change of clothes and limitations related to bowel or bladder constipation.

I am able to control my bowels and bladder without difficulty.

YES ☐ NO ☐

If you selected YES, please proceed to question 4.3 (page 37). If you selected NO, please continue answering the questions below.

4.2.1. Do you have difficulties with controlling your bladder or bowels or other such difficulties?

- ☐ Yes, at random times throughout the year
- ☐ Yes, monthly
- ☐ Yes, daily
- ☐ My bladder or bowel control varies

Please specify the answer you selected. Describe your bowel and bladder control, how often you have to wash or change your clothes because of soiling, wetting or leaks. If you use any assistive technology aids, please name them and describe how hey help you.

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4.3. Eating and drinking

Eating and drinking is defined as independently eating and drinking the given food and beverages, using the special cutlery if needed. Decreased or loss of appetite, the need for diets and food allergies are not meant here.

I am able to eat and drink without difficulty.

YES ☐ NO ☐

If you selected YES, please proceed to question 4.4 (page 39). If you selected NO, please continue answering the questions below.

4.3.1. Are you able to put food and drink to your mouth without being helped by another person?

- ☐ Yes
- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ I am not able
- ☐ My ability to eat and drink varies

Please specify the answer you selected. List the activities you experience difficulty with and why.

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4.3.2. Are you able to chew and swallow freely?

- ☐ Yes
- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ I am not able
- ☐ My ability to chew and swallow varies

Please specify the answer you selected. Describe how you eat and drink and what kind of difficulties can occur when you chew and swallow. If you use any assistive technology aids, please name them and describe how hey help you.

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4.4. Other limitations related to staying conscious and self-care

Please describe any limitations in your **clothing, washing** and **care of body parts**, as well as skin problems such as inflammation, etc. that make self-care difficult. If you use aids or the help of another person in self-care activities, please describe in which activities and why you need help.

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MENTAL ABILITIES

In the domains of mental abilities, you can describe your memory disorders, behavioral disorders, time, place and personal orientation disorders, sleep disorders, attention disorders, emotional control disorders, thinking disorders, motivation and energy loss, and mood disorders. **No physical difficulties are meant here to describe.**

5. Learning and performing activities

In this part you will be asked how freely you are able to acquire and use new skills and plan and perform activities. When answering, take into account your motivation and energy, your ability to control your emotions, mood drop, your ability to understand the time, place and personality, your ability to focus and maintain your attention, etc. If you use the help of another person, describe this under the corresponding activity.

If you do not or have not attended a regular school, please write down information about your special educational needs.

This includes activity-related difficulties caused by mental and psychological limitations.

5.1. Learning activities

Learning activities are defined as the ability to learn and complete both simple and complex activities in daily life.

A simple activity can be defined as an activity involving one or two parts, which does not require longer thinking beforehand.

A complex activity involves several consecutive parts, which requires prior thinking.

I am able to learn and perform both simple and complex daily activities without difficulty.

YES ☐ NO ☐

If you selected YES, please proceed to question 5.2 (page 41). If you selected NO, please continue answering the questions below.

5.1.1. Are you able to learn how to perform simple activities?

- ☐ Yes
- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ I am not able
- ☐ My ability to learn how to perform simple activities varies

Please specify the answer you selected. Describe which activities you have difficulty to learn and which skills you have difficulty using and why.

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5.1.2. Are you able to learn doing complex activities?

- ☐ Yes
- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ I am not able
- ☐ My ability to learn how to do complex activities varies

Please specify the answer you selected. List which activities you have difficulty to learn and which skills you have difficulty using and why.

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5.2. Starting and completing activities

Starting and completing activities is defined as the ability to plan and perform daily activities. When answering, take into account whether you experience any difficulty with memory and the ability to concentrate and how much will, energy and motivation you have to start and complete activities.

Only activity-related difficulties caused by mental and psychological limitations are described here.

I am able to handle daily activities without difficulty.

YES ☐ NO ☐

If you selected YES, please proceed to question 5.3 (page 42). If you selected NO, please continue answering the questions below.

5.2.1. Do you recognize the need for daily activities and are you capable of planning, starting and completing these on your own?

- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ I am not able
- ☐ My ability to start and complete activities varies

Please specify the answer you selected. Describe how you manage in terms of remembering, planning and organizing activities. Indicate what can make this difficult for you and how often and with what things you need other people's help.

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5.3. Other limitations related to learning and performing activities

Please consider whether all of the difficulties in your learning and performing activities are described above. If you have additional limitation which was described in the questions, please mention it here. If all limitations are described above, leave the question unanswered.

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6. Adapting to changes and recognizing threat

In this part you will be asked whether you are able to move around outside of your home without becoming agitated or feeling excessive anxiety and whether you can assess dangerous situations and adapt to changes in your daily life. If you use the **help of another person**, please describe this under the corresponding activity.

Only activity-related difficulties caused by **mental and psychological** limitations are described here.

6.1. Going outside

Emotional and mental tension related to going outside is defined as feeling anxious, uncomfortable or afraid when moving around outside of your home. These difficulties can be connected to understanding the time and place and to memory or delusions.

I am able to go outside without emotional or mental tension.

YES ☐ NO ☐

If you selected YES, please proceed to question 6.2 (page 44). If you selected NO, please continue answering the questions below.

6.1.1. Are you able to go to the familiar places without experiencing emotional or mental tension and anxiety?

- ☐ Yes
- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ I am not able
- ☐ My ability to go to the familiar places varies

Please specify the answer you selected. Describe whether you need someone to go with you and why.

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6.1.2. Are you able to go to the unknown places without experiencing emotional or mental tension and anxiety?

- ☐ Yes
- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ I am not able
- ☐ My ability to go to the unknown places varies

Please specify the answer you selected. Describe whether you need someone to go with you and why.

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6.2. Recognizing risks or threat

Recognizing threat is defined as understanding which daily activities could be dangerous to your or others health and safety and acting in a way that avoids causing dangerous situations.

I am able to perform daily activities safely and understand threats related to traffic.

YES ☐ NO ☐

If you selected YES, please proceed to question 6.3 (page 45). If you selected NO, please continue answering the questions below.

6.2.1. Do you need someone with you to avoid danger?

- ☐ No
- ☐ For some activities, but not every day
- ☐ Yes, always, during the day
- ☐ Yes, around the clock
- ☐ My need to have someone with me varies

Please specify the answer you selected. Describe what kind of dangerous situations can occur and how you deal with them. If you need the help of another person, please describe why.

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6.3. Adapting to changes

Coping with change is defined as adapting to unexpected situations that interfere your daily routine.

I am able to adapt to changes in my daily life without difficulty.

YES ☐ NO ☐

If you selected YES, please proceed to question 6.4 (page 46). If you selected NO, please continue answering the questions below.

6.3.1. Are you able to adapt to changes in your daily life?

For example, if your mealtime shifts to an earlier or later time, if a bus or train arrives at a different time than expected or if a friend or caretaker arrives earlier or later than planned.

- ☐ With mild difficulty
- ☐ Yes, if I know in advance about change
- ☐ No, if the change is unexpected
- ☐ I am not able to adapt to changes at all
- ☐ My ability to adapt to changes varies

Please specify the answer you selected. Describe how you cope with change and what your difficulties are related to. If you need the help of another person, please describe why.

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6.4. Other limitations related to adapting to changes and recognizing threat

Please consider whether all the difficulties in adapting to changes and recognizing the threat are described above. If you have additional limitation which was not described in the questions, mention it here. If all the limitations are described above, leave the question unanswered.

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7. Interpersonal interactions

In this part you will be asked whether you have any difficulty interacting with people you know or do not know and how you manage in situations that require communication. If you use the help of another person, describe this under the corresponding activity.

7.1. Coping with interpersonal interaction

Interpersonal communication is defined as being prepared to meet people and to interact with people you know and do not know.

I am able to handle interacting with people without feeling too anxious or afraid.

YES ☐ NO ☐

If you selected YES, please proceed to question 7.2 (page 48). If you selected NO, please continue answering the questions below.

7.1.1. Are you able to meet with people you know without feeling too anxious or afraid?

- ☐ Yes
- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ No
- ☐ My ability to meet people I know without feeling anxious or afraid varies

Please specify the answer you selected. Describe the difficulties in meeting and interacting with people.

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7.1.2. Are you able to meet with people you do not know without feeling too anxious or afraid?

- ☐ Yes
- ☐ With mild difficulty
- ☐ With moderate difficulty
- ☐ With severe difficulty (almost impossible)
- ☐ No
- ☐ My ability to meet people I do not know without feeling anxious or afraid varies

Please specify the answer you selected. Describe the difficulties in meeting and interacting with people.

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7.2. Appropriate behavior

Appropriate behavior is defined as controlling your emotions and acting in a way that is appropriate and corresponds to the situation – how you express your feelings and whether your behavior (be it intentional or unintentional) bothers other people.

I am able to control my emotions and behavior.

YES ☐ NO ☐

If you selected YES, please proceed to question 7.3 (page 49). If you selected NO, please continue answering the questions below.

7.2.1. How often do you lose control of your emotions and behavior?

- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Every day

Please specify the answer you selected. Describe how often, in which situations and how your behavior bothers other people.

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7.3. Other limitations related to interpersonal interaction

Please consider whether all the difficulties of your interpersonal interaction are described above. If you have additional limitation which was not described in the questions, mention it here. If all the limitations are described above, leave the question unanswered.

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8. Influence of addictive substances and adverse drug reactions

8.1. Do you have difficulties with activities due to consumption of alcohol or other addictive substances?

YES ☐ NO ☐

If you selected YES, please specify your answer. Describe the problems you have related to substance consumption, the frequency of their occurrence and how they affect your ability to perform activities.

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8.2. Do you experience adverse reactions related to taking medications (e.g. vomiting, nausea or light-headedness)?

YES ☐ NO ☐

If you selected YES, please specify your answer. Describe the problems you have related to taking medications, the frequency of their occurrence and how they affect your ability to perform activities.

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9. Other health problems

In this part you will be asked **only** the difficulties that could not be described in the above domains. It is **not necessary** to list the diagnoses or medicines of your diseases here, as this information is visible to the expert doctor in the applicant's health data. It is possible to describe, for example, sleep disorders (daytime hypersensitivity, sleep deprivation, strong urge to sleep at the wrong time or place; morning or night headache; apathy) or your headaches, their frequency and nature.

9.1. Do you have any activity-related difficulties that the questions above did not cover?

YES ☐ NO ☐

If you selected YES, describe the difficulties and specify how often they occur.

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V WORKING

If you have difficulty performing work tasks in your current job because of your health, please describe them:

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If any of your previous employment relationships ended because of the state of your health, please specify the reasons:

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_____	_____	_____
(date)	(name of applicant)	(signature)

_____	_____	_____
(date)	(name of applicant's representative)	(signature)

If you filled out the application form for the assessment of workability above, only fill out part two of the work ability allowance application (activity requirements) by marking which activityrequirement you fulfil.

If you filled out the application for the assessment of work ability above and indicated that you have a condition excluding work ability in question 2.1, you do not have to fill out the work ability allowance application below.

If your work ability has already been assessed and you wish to applyfor the work ability allowance, fill out every part of the work ability allowance application below.

APPLICATION FOR WORK ABILITY ALLOWANCE

1. DETAILS OF WORK ABILITY ALLOWANCE APPLICANT

First name:	Surname: .....
Personal identification code: _____	
If you do not have an Estonian personal identification code, please provide your date of birth: ....._____ and gender: ☐ M ☐ F	
Foreign personal identification code (if applicable): ..... Country of issue of personal identification code:	

Postal address:	
E-mail address:	Phone: .....

If you are a resident of more than one country, please provide the name of the foreign country and the address of your residence there:

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If you live/work or have lived/worked in a foreign country, write down the name of the country and the period for which you were living/working there with accurate dates

Country	**Period**

If you receive an allowance, a pension or other cash benefits that serve the same purpose as the work ability allowance from a foreign country, indicate:	
the country that pays you the allowance, pension or other cash benefits	
the type, amount and payment period of the allowance, pension or other benefits you receive from the foreign country (attach a document to the application for proof, e.g. the decision to grant the allowance, pension or benefit)	

DETAILS OF WORK ABILITY ALLOWANCE APPLICANT'S REPRESENTATIVE

Please fill in the details of the representative (authorized representative, parent or guardian) if the applicant is under 18 years of age or has a designated guardian or authorized representative.

Parent/guardian ☐
Authorized representative ☐

First name:	Surname: .....
Personal identification code: _____	
E-mail address:	
Phone:	
Postal address:	

If the representative of the applicant is a legal entity, please provide the name of the legal entity:

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If the application is being submitted by a person with power of attorney, please provide the power of attorney on which the right of representation is based as an annex to the application.

I wish to receive decisions related to my work ability allowance (mark one option): **at the applicant's address** ☐ **at the representative's address** ☐	
at my e-mail address:	☐
as a standard letter:	☐
from an office of the Estonian Unemployment Insurance Fund: Indicate the office of the Unemployment Insurance Fund from which you wish to collect the decisions ..... I wish to be notified when decisions become available: ☐ via e-mail ☐ over the phone	☐

Regardless of the option you selected, all decisions related to the granting of the work ability allowance can be viewed on the Estonian Unemployment Insurance Fund's self-service portal at www.tootukassa.ee.

I would like to receive the work ability allowance.

2. ACTIVITY REQUIREMENT

A person with partial work ability will only be paid an allowance if they meet at least one of the following requirements: Mark which requirement you fulfil below.

☐	**I work under an employment contract, contracting agreement, authorisation agreement or other agreement under the law of obligations entered into in order to provide a service or sell goods under the Simplified Business Income Taxation Act or I work for the civil service**
☐	**I am a member of the Riigikogu, a member of the European Parliament, the President of the Republic, a member of the Government of the Republic, a judge, the Chancellor of Justice, the Auditor General, a Public Conciliator, a rural municipality or city district elder, the chairman or deputy chairman of a council of a local government working in a remunerative position, a member of a rural municipality or city government working in a remunerative position, including a rural municipality or city mayor**
☐	**I am engaged in a profession in public law as an independent person**
☐	**I am a member of the management or controllingbody of a legal entity**
☐	**I am registered as a sole proprietor**
☐	**I am listed in the register of taxable persons as a spouse participating in the activity of a sole proprietor's enterprise**
☐	**I am registered as unemployed**
☐	**I am acquiring level-based (primary, secondary or higher) or vocational education**
☐	**I am on academic leave for health reasons**
☐	**I am raising or caring for at least one child underthree years of age**

☐	**I am caring for a family member (child, parent or spouse) with a severe or profound disability who needs assistance**
name and personal identification code or, in the absence thereof, date of birth of the family member being cared for	
☐	**I am caring for a disabled person under paragraph 26of the Social Welfare Act**
☐	**I receive support from an artistic association**
☐	**I have been placed, without my consent, in a socialwelfare institution in order to receive 24-hour specialist care**
☐	**I am receiving treatment as an outpatient or inpatient or am subject to another alternative sentence or sanction provided by law that preventsme from fulfilling any of the other listed requirements**
medical facility	
☐	**I am participating in compulsory military service,**
☐	**I am fulfilling one of the requirements mentionedabove in a foreign country**
requirement ..... country ..... start date of requirement ..... **Please attach to your application a document provingthat you are fulfilling the requirement.**	

3. PAYMENT METHOD OF WORK ABILITY ALLOWANCE

Please transfer the work ability allowance to:

The applicant's Estonian bank account:	☐
Bank account number:	
A foreign bank account at the applicant's expense:	☐
Bank account number:	
SWIFT/BIC:	
Bank:	
To the bank account of **another person in Estonia incl. a local government or other establishment:** (applicable only if this application is signed in an office of the Estonian Unemployment insurance Fund, submitted with a digital signature or authenticated by a notary public)	☐
First and last name of other person/ name of local government orother institution:	
Bank account number:	
Reference number:	
The applicant's home address by mail at the applicant's expense: provide the applicant's home address:	☐

The applicant's home address by mail at the expense of the Estonian Unemployment Insurance Fund, because I am severely disabled and: - my movement is restricted; - I live in a low-density area and have limited access to bank services. Provide grounds for your request: .... **If you are applying for mail delivery to your home address at the expense of the Estonian Unemployment Insurance Fund, please mark an alternative method of payment in case mail delivery is not approved.**	☐ ☐

I undertake to immediately notify the Estonian Unemployment Insurance Fund of any circumstances affecting my right to receive the work ability allowance and its amount, including moving to and commencing employment in a foreign country and any remuneration, unemployment insurance benefits, parental benefits, benefits for temporary incapacity for work and pensions and allowances, pensions or other cash benefits that serve the same purpose as the work ability allowance received in a foreign country.

I am aware that if my work ability has been determined as partial, I must meet at least one of the activity requirements (e.g. be working, studying or registered as unemployed) to receive the work ability allowance.

I am aware that the Estonian Unemployment Insurance Fund can demand the repayment of a work ability allowance granted and paid without a legal basis.

_____	_____	_____
(date)	(name of applicant)	(signature)

_____	_____	_____
(date)	(name of applicant's representative)	(signature)

To the Estonian Unemployment insurance Fund
Lasnamäe 2, 11412
Tallinn
info@tootukassa.ee

PROXY

[Place and date of drafting document]

Hereby, I, *[PRINCIPAL'S first and last name*]....,
personal identification code *[personal identification code]*....,
residing at *[address of residence]*....,
authorise *[first and last name of AUTHORISED person]*....,
personal identification code *[personal identification code]*....,
with the contact details *[e-mail and/or phone number]* ....
and residing at *[address of residence]*....,
to represent me in the Estonian Unemployment Insurance Fund in the following activities (mark YES or NO):

1	☐	submitting an application for the assessment of my work ability/determination of the degree of severity of my disability and activities related to the processing of said application;
2	☐	submitting an application for the work ability allowance andactivities related to the processing of said application;
3	☐	submitting an application for social benefits for disabled persons;
4	☐	clarification applications related to fulfilling the decisions made inthe assessment of my work ability and work ability allowance;
5	☐	appealing decisions made in the assessment of my work ability and work ability allowance;
6	☐	appealing decisions made in the determination of the degree of severity of my disability and benefits for disabled persons.

This power of attorney is valid from the date of granting authority until *[the representative completes the activities for which the authority was granted (points 1-3 or 5)] / [the end of the term of validity of the decisions on work ability assessment and the work ability allowance (point 4)]*[1].

This power of attorney has been issued without the right of delegation.

[PRINCIPAL'S signature]

[1] *Choose one option and erase or cross out the other inapplicable option*