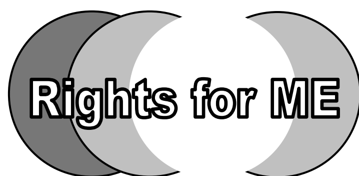

EMPLOYMENT AND SUPPORT ALLOWANCE CHECK LIST FOR PEOPLE WITH ME

benefits service for people with me/cfs

NOTES for filling in these sheets.
These checklists are based on the first stage health criteria for Employment and Support Allowance (ESA) benefit. This first stage is part of the Work Capability Assessment (WCA). (The next health stages assess whether you can be treated as being too ill to consider work – the details for this assessment are not included here.)This checklist will give an indication of how your day to day life is affected by illness. This information can be very helpful when applying for this benefit and useful to doctors and others if they are asked to write reports in support of your benefit claim.
The assessment for Work Capability Assessment assesses physical and mental/cognitive functions.
The assessment should take the following matters into account: the **length of time taken to complete** an activity; whether it will result in **discomfort or fatigue, or cause fatigue** to a point where the activity **cannot be repeated in a reasonable space of time**; whether you need somebody to help with an activity; if you have difficulty in **motivating yourself to start or complete an activity.**
If one or more of the above factors affects your ability to complete a particular activity, for **most of the time** (even though for a minority of the time you might be able to do it) then you should consider that that you "cannot do" that activity.

Please remember that the statements of what you are able and not able to do should be based on how you are most of the time. This is an important idea when applying for benefits, because you will be assessed on how you are on the basis of a "typical day", or usual day, so you need to state confidently what you usually are able to do and not do. Do not consider your good days unless they are occur for most of the time.
When you have completed the tables, covering both your physical and mental health symptoms as appropriate, could you please copy the sheets, before handing them to your GP or anybody else.

PLEASE RECORD EFFECTS OF ALL THE ILLNESSES YOU HAVE, NOT JUST ME/CFS

NAME	**d.o.b.:**	Date:

PHYSICAL FUNCTIONS

FUNCTIONS		**REASONS** for any difficulties or restrictions you have with this activity, most of the time, and any help you need or actually receive.
1) How far can you **WALK** ON LEVEL GROUND without stopping or severe discomfort? Can you walk **up** / **down two steps?**	a few steps 50 metres (55 yards) 100 metres (110 yards) 200 metres (220 yards) yes/no (delete as appropriate)	
2) Are you restricted in **STANDING** AND **SITTING**, and do you have difficulties in **RISING** from a chair?	yes / no (delete as appropriate)	

3) Do you have difficulty **BENDING** AND/OR **KNEELING** as if to pick something up from a low table or the floor?	yes / no (delete as appropriate)	
4) Do you have difficulty **REACHING**, for example, putting either arm behind your back, above shoulders, or to your head?	yes / no (delete as appropriate)	
5) Do you have difficulty **LIFTING AND MOVING,** (using arms) with either hand, things like carton of milk?	yes / no (delete as appropriate)	
6) Do you have difficulty USING YOUR **HANDS**, for example gripping things, holding, or picking up coins, using keyboard, small buttons?	yes / no (delete as appropriate)	.
7) Are you restricted in **SPEAKING,** so that strangers cannot understand you?	yes / no (delete as appropriate)	
8) Do you have difficulty with **HEARING,** (using a hearing aid if necessary)?	yes / no (delete as appropriate)	
9) Are you restricted in **SEEING,** and if so, how much?	yes / no (delete as appropriate)	
10) Are you affected by **INCONTINENCE,** and if so how frequently?	yes / no (delete as appropriate)	
11) Do you have any involuntary episodes of lost or altered **CONSCIOUSNESS**?	yes / no (delete as appropriate)	

MENTAL, COGNITIVE AND INTELLECTUAL FUNCTIONS

12) Do you have difficulty in **LEARNING** / **COMPREHENDING** tasks and how tasks completed?	yes / no (delete as appropriate)	

NAME		Date of birth
13) Is your awareness of **HAZARD** so reduced that injury or damage to property likely to occur?	yes / no (delete as appropriate)	
14) Do you struggle with **MEMORY** and **CONCENTRATION** that you need for example, somebody to prompt you?	yes / no (delete as appropriate)	
15) Do you struggle to **COMPLETE TASKS**, and take much longer than a well person – such as cooking a meal?	yes / no (delete as appropriate)	
16) Is it difficult to **START**, and **SUSTAIN PERSONAL ACTION** because of severe mood or behaviour?	yes / no (delete as appropriate)	
17) Can you **COPE** with unplanned **CHANGES** or expected **CHANGES IN ROUTINE**?	yes / no (delete as appropriate)	
18) Can you **GET TO FAMILIAR PLACES** without being accompanied by somebody?	yes / no (delete as appropriate)	
19) Are you subject to overwhelming **FEAR OR ANXIETY** at prospect of new places or social contact?	yes / no (delete as appropriate)	
20) Are you subject to **STRONG REACTIONS TO OTHERS** or to criticism?	yes / no (delete as appropriate)	
21) Are you unaware of the **EFFECT OF YOUR BEHAVIOUR** on others?	yes / no (delete as appropriate)	

Please make a copy of the completed checklist and keep one for yourself. A copy should be sent to your GP, Occupational Therapist, Social Worker, and consultant, if you are applying or renewing a benefit claim. They may be approached by the Department for Work and Pensions for evidence.

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