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Output B.2: Report on the statistical analysis of pilot data and recommendations for the implementation of a new, empirically tested methodology for comprehensive individual functioning and needs assessment

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Abbreviations

- DG REFORM -European Commission's Directorate General for Structural Reform Support –
- ICD- World Health Organization's International Classification of Diseases
- ICF -International Classification of Functioning Disability and Health
- INA-Comprehensive assessment of individual needs of persons with disabilities
- MACs- Medical Assessment Commissions
- MOH-Ministry of Health
- MLSP- Ministry of Labor and Social Policy
- NFAMA -National Framework Agreement for Medical Activities
- NAM- Needs Assessment Methodology or
- NMEC- National Medical Expert Commission
- OME- Council of Ministers' Ordinance on Medical Expertise
- PDA- Persons with Disabilities Act of Bulgaria
- RSO- the Rules on the structure and organization of work of the bodies of the medical expertise and of the regional filing cabinets of the medical expertise
- SAA- Social Assistance Agency
- SAD- Social Assistance directorate
- TMECs Territorial Medical Expertise Commissions
- UNCRPD-United Nations' Convention on The Rights of Persons with Disabilities
- WHO-World Health Organization
- WHODAS- World Health Organization's Disability Assessment Schedule

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Executive summary

Introduction

This Report presents findings and recommendations on how to strengthen the individual comprehensive assessment of functioning and needs of adults with disabilities in Bulgaria. It is Output B.2 of the project "Strengthening Disability System in Bulgaria" implemented by the World Bank with funding from, and in collaboration with, the European Commission's Directorate General for Structural Reform Support (DG REFORM) and the Ministry of Labor and Social Policy (MLSP) of the Republic of Bulgaria. The specific objective of the project is to support the MLSP to strengthen and further develop its disability system, including through strengthening of the individual comprehensive assessment of functioning and needs of adults with disabilities and related administrative processes.

To accomplish the project objective, several interrelated activities were implemented. The project commenced with a comprehensive review of the disability system and policies in Bulgaria.[1] Among its key findings are: (i) the disability status assessment methodology in Bulgaria does not include functioning, i.e., it is entirely based on medical criteria, and (ii) the comprehensive individual needs assessment, while it includes functioning, still significantly reflects a medical approach to disability. The needs assessment is mostly used as an eligibility screening tool for financial support and to determine the "dependency" level on support from others and corresponding number of hours of personal assistance. The Review was followed by two pilots: (i) the pilot on how to include functioning into disability assessment; and (ii) the pilot testing of the revised individual needs assessment tool. Their results and recommendations based on them are presented in parts One and Two of this Report.

The project focuses on adults with disabilities. Including children in the project, would have significantly expanded its scope, timeframe and needed funding. Hence, the decision was made to focus on adult population only. While conceptionally the approach to disability of children is the same as that of adults, assessing and measuring it requires different methodology and tools. Children develop and early childhood development (up to 5 years of age) should be measured relative to age specific developmental milestones.[2] For children 5-18, activities and participation categories, albeit similar to those of adults are different at different ages and that must be taken into account when disability and needs assessment tools are developed. Moreover, labeling children as having a disability early on has lifelong adverse consequences and countries increasingly focus on early identification of developmental delays and an assessment of needs for support, instead of formally declaring and labelling children as having a disability.[3]

Finalization of this Report included extensive consultations with stakeholders. The results of the pilots and their recommendations have been extensively discussed with the Government counterparts, DG Reform, and at an international knowledge exchange event with participation of policymakers and policy practitioners in disability system and policy from Bulgaria, Romania, Latvia, Lithuania, France, and Azerbaijan, World Bank staff and international experts from OECD and World Health Organization. The discussions contributed to the finalization of this Report.

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[1] See: Posarac, A. et al. 2022, *Bulgaria: Disability System and Policy, A Comprehensive Revie*w. © World Bank. Chapters 3 and 4 are on disability status and needs assessment, respectively.

[2] See, for example: https://www.who.int/tools/child-growth-standards/standards/motor-development-milestones/, https://childmind.org/guide/parents-guide-to-developmental-milestones/, https://www.unicef.org/parenting/child-development/your-babys-developmental-milestones/.

[3] For further discussion see: Jerome Bickenbach and Aleksandra Posarac. 2022. *Assessing disability of children, a five-country mapping (Armenia, Georgia, Moldova, North Macedonia, and Serbia)*. UNICEF, Geneva.

Key concepts

Approach to disability

This Report adopts a contemporary and consensus view that disability is a complex phenomenon that is the outcome of an interaction of biomedical features of a person's body or mind (the person's state of health) and the impact of all aspects of his or her physical, human-built, interpersonal, social, cultural, and political world – the so-called bio-psycho-social model of disability. This view, originally presented as a theoretical underpinning for the World Health Organization's (WHO) International Classification of Functioning Disability and Health (ICF) was adopted unanimously by the World Health Assembly in 2001. It is also stated in the United Nations' Convention on The Rights of Persons with Disabilities (UNCRPD). The Bulgarian legislation also adopts this approach to disability, as stated in the Persons with Disabilities Act and other related legislation.

Disability status assessment

Disability status assessment is an official, authoritative, legally sanctioned, administrative process. It provides the entry for eligibility for some form of support, service, or assistance to individuals. The assessment procedure identifies the type and/or degree, of disability that a person experiences. The results of an assessment may be expressed as a percentage, type, and/or degree that forms the basis for an administrative decision and a certification or statement of disability.

The contemporary bio-psycho-social (or interactional) model of disability affects the processes by which disability is assessed. First, it is necessary to identify the underlying health state of individuals and impairments that result from the health conditions. This provides an assessment of the ***intrinsic health capacity*** of the person. But intrinsic health capacity is not the same as disability. Disability is a matter of how the intrinsic health capacity impacts people's daily life in the environment in which they live. Disabilities describe what people can, or cannot, do in their actual environment. As a result, assessing disability requires a description and assessment of what people do in their home, school, work, and community, shaped by environmental conditions that may help or hinder them. ***In ICF terms, disability assessment is a matter of assessing performance***: the actual, observable, execution of actions – simple or complex – in the person's actual world. Thus, the working definition of disability assessment for this Report is: *Disability assessment is a summary statement and measure of the overall status of disability as a determined summary level of a person's performance of ordinary, everyday behaviors and actions, simple to complex, in his or her actual or usual environment, in light of the person's state of health.*

Disability needs assessment

In a growing number of countries, the process of disability status assessment and determination is followed by a set of procedures sometimes involving several sectors, that seek to identify the individual's disability-related needs. These needs may be medical in nature, and if so, can only be assessed by medical professionals in the usual fashion. A person experiencing disability may also have medical rehabilitation needs to optimize her or his capacity to perform actions. A considerable broader set of needs are associated with fundamental areas of life that are constitutive of the experience of disability – family and relationships, housing, transportation, education and training, work and employment, community and social participation, and others. In a well-functioning system, these needs and requirements are matched to available support interventions provided by legally mandated authorities, agencies, public and private organizations, and others.

A note on Bulgarian legal definitions of disability and terminology used in this Report. The Persons with Disabilities Act of Bulgaria (PDA) defines *'people with disabilities'* as "persons with physical,

mental, intellectual and sensory disability, which in interaction with the surrounding environment could hinder these persons' full and effective participation in public life" and *'persons with permanent disabilities'* as "persons with permanent physical, mental, intellectual and sensory deficits which in interaction with the surrounding environment could hinder their full and effective participation in public life, and for whom a medical expertise has established the type and degree of disability or permanently reduced work capacity of 50 or more percent".[4] In Article 101, The Health Act stipulates that *medical expertise* is conducted to establish "temporary work incapacity, type and degree of disability of children up to 16 years of age and of persons who have acquired the right to a social insurance pension based on age and length of work history covered by social insurance contributions according to Article 68 of the Social Insurance Code, and to establish a degree of permanently reduced of working age adults, as well as to confirm the presence of professional disease".[5] For simplicity and clarity, whenever we refer to persons certified as having permanent disabilities, we use *persons with disabilities* or *a person with a disability.*

Introducing functioning into disability assessment in Bulgaria

The assessment of disability should be aligned with the country's approach to disability. Definitions from the PDA cited above show that Bulgarian legislation explicitly states that disability is the outcome of interactions between the health status and the surrounding environment (the ICF conception of disability).

It is also important that disability status and needs assessment follow the same approach to disability. All persons with disabilities certified in Bulgaria are required to undergo an individual needs assessment to access financial support measures targeted at persons with disabilities. These interventions aim to compensate the costs related to living with a disability. The certificate of disability issued by medical expertise commissions serves as a basis on which the needs assessment is conducted. It is therefore very important that these two processes are harmonized in their respective approaches to disability.

To advise on the further development of the assessment of functioning and needs of persons with disability, the disability assessment system was extensively reviewed. Based on the findings, to provide empirically based recommendations for inclusion of functioning into disability assessment, the WHO's tool for measurement of disability – Disability Assessment Schedule – WHODAS was piloted (see description below).

Current state of disability assessment in Bulgaria

The current disability assessment system in Bulgaria does not assess disability, in the modern sense established by the ICF and endorsed in UNCRPD. The assessment is based on the medical model of disability. It is conducted by medical professionals through a *medical expertise process* and is founded entirely on evidence from medical documentation. The medical assessment instrument is a Baremic-style table that links health conditions and impairments of body functions and structures to levels of pre-determined degree of disability, represented as percentage of 'whole person' disability (as compared to a healthy person). This is a traditional application of the so-called Medical Model of Disability, which has been replaced by the bio-psycho-social approach found in both ICF and UNCRPD. To qualify for benefits and services, the person should have a degree of permanent disability of at least 50 percent.

[4] Approved in December 2018; effective January 2019. https://www.lex.bg/bg/laws/ldoc/2137189213/.
[5] The Health Act. https://www.lex.bg/laws/ldoc%20/2135489147/.

In its current form, the disability assessment methodology is not consistent with the approach to disability from PDA. It is based on medical evidence and criteria and does not take the environment into account.

Administratively, the assessments of temporary and permanent disability are organized in Bulgaria differently from many other countries. In Bulgaria, organization and conduct of these functions that are important both for affected persons and the state is delegated to medical establishments (mostly hospitals), engaging thousands of medical doctors. This is different from most countries in EU where the assessment is usually conducted by a dedicated public agency. As evidenced by high numbers of inspections of disability assessment commissions' decisions and appeals, the current system is not fully trusted by the public and Government administration. The outcome is a need for increased layers of checks and rechecks of the commissions' decisions (Medical Assessment Commissions - MACs for temporary disability and Territorial Medical Expertise Commissions – TMECs for disability).

An applicant's journey through the system of temporary and permanent disability assessment commissions appears complex and lengthy. To an outsider looking at the system from the regulatory documents, it appears that there is a constant demand for medical documents, additional diagnostic procedures, multiple applications, and multiple commissions.

Recommendations

Concerning the inclusion of functioning into disability assessment and thus aligning the status assessment methodology with the understanding of disability adopted in Bulgaria, the Government of Bulgaria may consider the following:

- Revise the disability assessment methodology by explicitly including functioning through a psychometrically valid and reliable measurement of functioning.
- Create specific disability assessment methodologies that are adapted to specific situations of children, the working age population, and retired people.
- Consider changing the way how disability assessment is organized to increase its technical robustness and consistency, efficiency, and transparency. Bulgaria may explore options applied in other EU countries.
- Use significant available IT resources and information management capacity to fully automate the disability assessment process.[6]

Empirically based options for including functioning into disability assessment

The WHODAS pilot

Based on the key finding from the review of the disability assessment system, options for the inclusion of functioning into the assessment were investigated. To acquire empirical evidence, the WHO's Disability Assessment Schedule (WHODAS) was piloted. Here, we summarize the results of the pilot. (A report detailing the pilot and statistical analysis was prepared separately and is available upon request.)

WHODAS is an extensively tested disability measurement tool based on ICF. The WHO developed, tested and has consistently recommended the WHODAS as an instrument that can validly and reliably capture ***the performance of activities*** by an individual in his or her daily life and actual environment.

[6] Chapter 7 of the above-mentioned World Bank report discusses disability information systems in Bulgaria.

WHODAS 36-question version was implemented in Bulgaria on a sample of 3,118 individuals who applied for disability (re)assessment in late 2021 and early 2022. The pilot sample included only persons who were assessed as having a disability of at least 50.0 percent. The survey was conducted in collaboration with the Social Assistance Agency of MLSP.

Statistical tests confirmed WHODAS psychometric properties of validity and reliability. It is important to keep in mind that the *WHO developed WHODAS explicitly to statistically capture the construct of functioning from the perspective of performance – namely the experience of performing activities by a person with an underlying health problem in their actual everyday life environment.*

Based on satisfactory psychometric properties, we conclude that information collected with the WHODAS is robust, viable, and relevant and that it validly represents the construct of disability as understood by ICF UNCRPD. Including WHODAS into the disability status assessment in Bulgaria would:

- Significantly strengthen the method of assessment currently in use (a medical assessment mostly based on impairments) and align it with Bulgaria's approach to disability.
- Bring it closer to the ICF and UNCRPD understanding of disability.
- Harmonize the approach to assessment with the ICF functioning based approach used in the individual needs assessment.

Comparing WHODAS and medically determined disability in Bulgaria

Including functioning into disability assessment will improve the accuracy of the assessment. One of the objectives of our analysis of the WHODAS data collected in Bulgaria is to show that the inclusion of functioning into the current medically based disability assessment method will improve its capacity to assess the experience of disability more accurately and to allow for better assessment of needs of persons with disabilities subsequently.

Looking at the WHODAS functioning score by current Bulgarian disability severity ranking groups, it is observed that the medical assessment does not differentiate well between moderate and severe disability, suggesting low reliability and precision. The discrimination is better for cases with very severe disability. The comparison also suggests the presence of false positives (high disability percentage and low WHODAS score) and false negatives (lower disability percentage and high WHODAS score), indicating that the medical information may misrepresent the true extent of disability as experienced in daily life.

To conclude

The empirical evidence collected through the WHODAS pilot shows that:

- Data from the Bulgarian WHODAS pilot corroborates empirical evidence from other international research studies that WHODAS performs well in capturing the disability experience, and it does so with strong psychometric properties of validity and reliability. It performs well in measuring whole-person disability, provides a summary score, and an objective and accurate assessment of functioning based on core functioning domains of the ICF. The scores are interval-scaled with values ranging from 0 to 100.
- The current system that determines disability raises well-known scientific concerns about the validity of an assessment based on medical criteria and whether it assesses the real extent of disability an individual experiences or can accurately differentiate degrees of disability. The percentage continuum of disability degree in Bulgaria – from 0 percent (no disability) to 100 percent (very severe disability) is poorly populated and polarizes on a few values, i.e., it does

not differentiate well disability degrees in the middle of the range (moderate and severe disability).

- ***In light of these results from the pilot, we conclude that including functioning through the WHODAS into the determination of disability already in place in Bulgaria will significantly improve its accuracy, resulting in a more refined methodology that adds information on the lived experience of the disability in addition to the medical diagnosis.***

Options for including functioning into disability assessment in Bulgaria

We are not suggesting that medical information, or even assessment of type and degree of disability based on medical information, should not play a role in disability assessment in Bulgaria. The ICF itself makes it clear that without an underlying health condition and associated impairments, disability does not exist, so medical information is essential to disability assessment. It also provides essential guidance on the medium- and long-term trajectory of disability.

Several possible options for combining medical and functioning information in the assessment of disability in Bulgaria were tested.

Option A: Discretionary combination of medical and functioning components: This is the option in which an individual or committee reviews medical scores and the WHODAS scores and makes a judgment about the extent of disability as the individual or committee sees fit. This option does not meet disability assessment credibility criteria (reliability, transparency, validity, etc.), and we do not recommend it.

Options B: Using an averaging algorithm. This is a quantitative method that averages the disability percentages with the WHODAS score. Four weighting schemes were tested: (i) 75.0 percent disability percentage & 25.0 percent WHODAS score; (ii) 50.0 percent disability percentage & 50.0 percent WHODAS score; 25.0 percent disability percentage & 75.0 percent WHODAS score; and 0.0 percent disability percentage & 100.0 percent WHODAS score. *Advantages of Option B*: (i) Functioning plays a significant role in the determination of disability and thus eligibility for disability. (ii) Minimalizes the impact of the inherent psychometric problems with the disability percentage based on the Baremic medical assessment. (iii) The assessment of the level of functioning is empirically and statistically verified. (iv) Valid and reliable. (v) Merging the results of two assessments scaled by means of 'weighted averaging' is objective, transparent, and non-discretionary. (vi) Not sample dependent. *Disadvantages of Option B*: (i) There are, potentially, an infinite number of combinations of weighting schemes, each of which affects the set of eligible applicants differently and has different budgetary and political consequences. (ii) Any strategy selected will be objectionable to individuals who, under that strategy, will not be certified as disabled and thus not eligible for any benefits.

Option C: Using the flagging algorithm. This method identifies persons whose WHODAS severity grouping differs from the medically determined severity grouping and flags these individuals to request from them additional information or reassessment. Administratively, it needs a two-step procedure. *Advantages of Option C:* (i) Scientifically robust and based on actual data. (ii) High levels of validity and reliability. *Disadvantages of Option C*: (i) The WHODAS cut-offs for different degrees of functioning problems were determined based on past WHODAS pilots and some evidence from the scientific literature. (ii) Technically robust methodological and procedural instructions will have to be developed to guide the reassessment process to ensure transparency.

Implementation considerations

Bulgaria has administrative capacity to introduce functioning successfully and smoothly into disability assessment.

First, Bulgaria has an advanced information system that could accommodate the collection and use of the information on functioning.

Second, Bulgaria has a cadre of experienced social workers in the Social Assistance Agency that could be engaged in the WHODAS administration. While administrative process will have to be designed and details worked out, it could possibly flow in the following way: a person applying for/referred to the assessment of disability would have two meetings scheduled: one with the social worker to administer WHODAS and subsequently one with the TMEC. The WHODAS information would be sent to the National Medical Expert Commission (NMEC) electronically where the form would be checked, and the raw score transformed into the 0-100 scale (the Rasch based score). TMEC will proceed with the assessment as per the current criteria.

How the two scores will then be combined depends on the choice made by the Government. If the averaging method is chosen, say with 50.0 percent weight given to the TMEC determined degree of disability and 50.0 percent to the WHODAS score, the two scores will automatically be combined at the NMEC, and the final score sent to TMEC to issue the certificate. The certificate can also be issued by NMEC. If the flagging method is chosen, then in cases where the TMEC determined percentage of disability and the WHODAS score fall in the same disability grouping (no, moderate, severe, and very severe), NMEC will instruct the TMEC to issue the certificate with the proposed disability severity grouping. If they do not coincide, then a secondary assessment is undertaken either by a different TMEC or a NMEC.

Finally, it should also be noted that any new method adopted should be applied to new applicants only. To smooth the transition, disability recertification may be staged over several years.

Recommendations

(i) ***Include functioning into disability assessment using WHODAS to collect relevant information***. While the choice is political, either averaging or the flagging approach can comfortably be implemented based on the existing information systems and human resources (a cadre of social workers).

Including functioning into disability assessment will:

- ***Make the assessment of disability more precise, accurate and reliable, reflecting the real-life experience of disability,***
- ***Bring the assessment closer to a modern understanding of disability as formulated by ICF and mandated by UNCRPD, and adopted by Bulgaria, and***
- ***Align it with the individual needs assessment by providing valuable information input into it. A status assessment that includes functioning will provide a better profile of disability that the person experiences to identify needs that, once addressed, will improve the experience of disability by optimize the person's functioning.***

(ii) We also recommend that a separate WHODAS like assessment tool is developed for children, because the tools used for adults are not suitable for children. (WHO does not recommend

that WHODAS is used for children and is currently working on a WHODAS instrument for children).

Strengthening Individual comprehensive assessment of needs of persons with disabilities

The review of the system

Comprehensive assessment of individual needs of persons with disabilities (INA) was introduced into Bulgaria by the Persons with Disabilities Act (PDA). The PDA created the legal right of persons with disabilities to a complex and individual assessment of needs that examines "the functioning difficulties of a person with a disability, related to her/his health condition and the presence of barriers in the performance of daily and other activities, as well as the type of support needed." This statement reflects the concepts of functioning and disability found in ICF, as well as the UNCRPD characterization of 'persons with disabilities'.

PDA identifies domains of support for persons with disabilities and details the corresponding means of support. Not all support measures require an INA; those that do are specified in PDA and accordingly included in the Needs Assessment Methodology. They are financial support for the purchase of a private motor vehicle, for housing adjustment, for balneotherapy and/or rehabilitation services, for the municipal dwelling rent, and monthly financial support; personal assistance; social care services and other support. To receive these support measures, a person who has received from TMEC/NMEC a disability certificate must apply for an INA.

INA is conducted by a specialized municipal unit of SAA called the Social Assistance Directorate (SAD). The primary functions of the SAD are to conduct INA and provide benefits and supports to persons with disabilities as approved by the needs assessment process.

The INA process is demand-based and thus assumes that a person knows which services she/he needs. This may not necessarily be correct, and it is not consistent with the purpose of the needs assessment: to assess the state of functioning of a person with a disability in her/his environment and determine the needs for available support that would improve it. While a person may list the services that she/he wishes to receive, it is the needs assessment that should determine the needs. Moreover, currently, persons with disabilities are eligible to receive most benefits irrespective of the needs assessment. Even for personal assistance, it is the number of service hours that is determined, not the right per se. The right is guaranteed to all adults for whom a disability assessment commission has determined a permanent disability of over 90 percent or 80 percent, when one or more comorbidities, which cause more than 50 percent degree of disability, and a need for assistance by others.

Key findings and recommendations from the review

The introduction in 2019 of the individual needs assessment of persons with work incapacity and type and degree of disability is an important step in the implementation of UNCRPD in Bulgaria. UNCRPD mandates that persons with disabilities have the right to the provision of health and social services "based on the multidisciplinary assessment of individual needs and strengths".

Within the current context of medical certification of disability and eligibility rules for support measures to persons with disabilities, INA plays a limited role. Decisions on the needs for support measures, such as personal assistance or the need for technical aids are *de facto* made by medical commissions. Thus, INA serves as an instrument to determine the level of dependence on support from others and a corresponding number of hours of personal assistance per month and as an eligibility screening tool for measures administered by SAA or a referral tool for measures implemented by other government bodies (where, such as the case of social services, additional needs assessment may be conducted).

While legal provision stipulates that needs assessment should focus on functioning, the tools used for INA are focused on disability as a medical issue. First, the disability certification which feeds into disability assessment and pre-determines eligibility for personal assistance, is medically based. In addition, INA in the social worker form introduces the notion of "functional insufficiency" in a "yes"/"no" answer format, which has nothing to do with functioning, but seems to pertain to medical diagnosis. Information on functioning is collected only in the case when a person requests personal assistance. Thus, it is difficult to understand how the needs are assessed without first assessing problems in functioning experienced by a person with a disability.

Administrative process to apply for the individual needs assessment is demanding. The applicants are required to submit documents most of which should commonly be available in other government information management systems, and an applicant should not be asked to provide them, save for an application, identity document and a self-assessment form. Even an application submission could be eliminated and each person who has gotten a certificate from TMEC/NMEC (or a referral from MAC) could automatically be referred to SAD for a needs assessment. A referral could also include (agreed) documents in electronic format. A person with a disability could then be invited to submit a self-assessment and indicate which services and benefits she/he would wish to receive. Many parts of the needs assessment templates should be populated automatically, including personal information, TMEC/NMEC certificate information, etc.

Existing guidelines, methodological explanations, and instructions on how to conduct INA need to be strengthened by detailed explanation of what is meant by description of each qualifier in each domain, use of vignettes, how to observe cross dependency across domains and spot inconsistencies that require further probing. Instructions on how to assess the environment need expansion too. Collecting information on functioning necessitates deep understanding of functioning and a modern concept of disability as conceptualized by ICF.

Recommendations

Considering that the needs assessment is new, and that the implementation thus far could be considered as trial and a learning period, based on the above observations, we **recommend**:

- ***Revise the needs assessment tools*** to collect information on problems in functioning, identify the needs the fulfillment of which within the existing support measures can improve functioning and the experience of persons with disabilities in their everyday life, and, considering wishes of persons with disabilities, link them to the support measures and institutions that provide them. Make appropriate changes in the TMEC/NMEC decision-making process, including eliminating medical information from the needs assessment tools.
- ***Apply the needs assessment as legislated: to determine the needs for support measures, including for personal assistance.*** In other words, consider having TMEC/NMEC/MACs recommending (not deciding on) support measures and make decisions only after a full functioning and needs assessment has been completed.
- ***Apply a full needs assessment to all persons with disabilities***. This might be time and effort-consuming, but it is consistent with legal requirements and the rollout could be gradual.
- ***Simplify administrative process*** by introducing an automatic referral to INA, minimizing document requirements, and using available information systems to automatically pull out needed data and documents.
- ***Modify the self-assessment form to focus on environmental questions*** and include a selection of ICF categories with ordinal rating scale, rather than the current YES and NO response options. Prepare guide to make it easier for applicants to fill it out.

- ***Prepare expanded and strengthened technical guidelines and methodological instructions for INA and regularly (re)train*** staff in their implementation.
- ***Establish a technical and methodological individual needs assessment unit in SAA*** (or the Disability Policy Directorate of MLSP) that would conduct statistical analysis of the INA data and monitor the trends.
- ***Use available significant IT resources to fully automate INA administrative process; use information exchange with available databases to pre-populate INA instrument.***
- ***Develop a separate INA instrument for children.***

Pilot testing of the revised needs assessment tool

Based on the INA review findings and recommendations, in collaboration with the Social Assistance Agency and after a study of similar instruments used in England, France, Germany, and Serbia, the INA tool was revised, and pilot tested. The revised tool was designed to serve as a needs assessment tool that among other needs, also identifies the need for personal assistance and its extent (number of hours). In this way, the tool more closely reflects the intent of the Persons with Disabilities Act regarding INA. The objective of the revised tool pilot testing was to explore how it relates to disability as determined by TMEC/NMEC, as well as to the functioning assessment WHODAS score, as well as how the social workers and persons with disabilities found the instrument – its usefulness for the purpose of determining the needs and ease and comfort of its implementation. Below we present the pilot-testing results.

A sample of 561 persons was randomly selected from the WHODAS pilot sample of 3,118 individuals, to participate in the pilot testing of the revised INA instrument. All of them had previously undergone INA, as part of the administrative procedure to establish their eligibility for the requested support measures. The fieldwork was implemented in June 2022.

The pilot testing of the revised INA instrument showed that significantly more people with disabilities need help from others than decided on by the disability assessment system. The application of the revised instrument suggested that 250 persons from the pilot test sample of 561 persons need some assistance from others. This is significantly higher than 185 persons in the sample who requested personal assistance based on their certified disability degree of 90 percent or over and determined need for personal assistance by a disability assessment commission.

Most of these persons in need of personal assistance were from the group of persons with severe disability (90 percent and over) for whom the disability assessment commissions did not determine the need for personal assistance. This signals that the assessment of needs, including for personal assistance should be a responsibility of the INA process, not pre-determined by medical expertise commissions.

The disability assessment based on functioning (WHODAS) and the individual needs assessment were more consistent than INA and the disability status assessment based on medical expertise. Hence, disability status assessment and the needs assessment approach to disability should be harmonized. To that end, a disability status assessment should include functioning as well.

Qualitative feedback from persons with disabilities and the social workers who participated in the pilot test of the revised INA tool was overwhelmingly positive. Both groups agreed that the tool reflects difficulties that a person faces in everyday life and that the revised tool was more appropriate to evaluate individual needs than the current one. However, the social workers also noted that the tool took longer to complete, and some questions needed to be explained to the interviewees.

Technical and methodological guide, training, and pre-populating of the tool with personal and demographic information, and standardizing response options would help shorten the time needed to fill out the instrument. Many social workers made a point that the revised tool should be accompanied by a technical and methodological guide and that the social workers should be trained on how to use it. The SAA has an automated exchange of information with most of the government information systems. It should, thus, be able to prepopulate most of the INA tool, except for the part that pertains to the activities and participation information that should be collected in a face-to-face interview at the person's residence. Also, standardization of the response options will not only lead to a faster assessment but will also reduce the fatigue of the interviewer and the interviewee.

Based on the revised INA instrument pilot test and feedback from the persons with disabilities and the social workers, the INA tool, as well as the self-assessment form, were revised. As SAA moves ahead with the tool implementation, we recommend that

- Persons with disabilities and social workers are involved in all further steps.
- A methodological guide is developed.
- All social workers are trained (with regular refresher courses) in topics related to disability, functioning and the needs of persons with disabilities, interviewing techniques and in general the INA tool administration.

Report on the statistical analysis of pilot data and recommendations for the implementation of a new, empirically tested methodology for comprehensive individual functioning and needs assessment

Introduction & Conceptual Framework

Introduction

This Report is Output B.2 of the project "Strengthening Disability System in Bulgaria". This project has been implemented since 2019 by the World Bank with funding from, and in collaboration with, the European Commission's Directorate General for Structural Reform Support (DG REFORM) and the Ministry of Labor and Social Policy (MLSP) of the Republic of Bulgaria. The specific objective of the project is to support the MLSP to strengthen and further develop its disability system with two main streams of activities.

One stream of project activities was to provide technical advice to MLSP regarding the establishment of the State Agency for Persons with Disabilities and included an institutional review of the disability system in Bulgaria, France, Czech Republic and Slovenia, a technical proposal for the institutional, functional, and human resources set up of the Agency and a related international knowledge exchange event. The technical proposal was delivered to MLSP as a separate report.

The second stream of activities pertained to supporting the MLSP in strengthening the individual comprehensive assessment of functioning and needs of adults with disabilities and related administrative processes. Within this stream, we first prepared a comprehensive review of the disability system and policies in Bulgaria with special focus on the systems of disability status certification and individual needs determination for adults certified as having a disability. This review is presented in the Report *Bulgaria: Disability System and Policy, A Comprehensive Review*.[7] Among the key findings of the Review are: (i) disability status assessment methodology in Bulgaria does not include functioning, i.e., it is entirely based on medical criteria, and (ii) the comprehensive individual needs assessment, while it includes functioning, is still permeated by a medical approach to disability. Moreover, the needs assessment tool is mostly used as an eligibility screening tool for financial support interventions and to determine the "dependency" level and a corresponding number of hours of personal assistance.

Based on the findings of the comprehensive disability system and policy review, we conducted two pilots that included extensive data collection. First, to harmonize the meaning of disability between the disability status assessment and the individualized needs assessment methodologies, and to strongly embed into both the concept of functioning (as defined in WHO's *International Classification of Functioning, Disability and Health* (ICF)),[8] we investigated options for systematic inclusion of functioning into disability status assessment. To derive these options from empirical evidence, we

[7] Posarac, A. et al. 2022, *Bulgaria: Disability System and Policy, A Comprehensive Revie*w. © World Bank. Chapters 3 and 4 are on disability status and needs assessment, respectively.

[8] World Health Organization. 2001. *International Classification of Functioning, Disability and Health (ICF)*. https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health.

piloted WHO's functioning assessment instrument, the Disability Assessment Schedule (WHODAS).[9] The summary of the results of the statistical analysis of the WHODAS pilot data and recommendations are presented in Part One of the current Report.[10] Secondly, we pilot-tested the implementation of the revised version of the individual needs assessment tool. The results of this pilot test and a final version of the revised needs assessment tool are presented in Part Two of this Report.

Finalization of this Report included extensive consultations with stakeholders. The results of the pilots and their recommendations have been extensively discussed with the Government counterparts, DG Reform and at an international knowledge exchange event with participation of policymakers and policy practitioners in disability system and policy from Bulgaria, Romania, Latvia, Lithuania, France and Azerbaijan, World Bank staff and international experts from OECD and World Health Organization. The discussions contributed to the finalization of this Report.

This Report is organized in the following way. We begin with description of the project and the conceptual framework underlying the Report. Part One of the Report focuses on functioning and disability status assessment. Part Two focuses on comprehensive individual needs assessment. Each part concludes with recommendations. Additional material is provided in Annexes to the Report.

Conceptual framework

Approach to disability

This Report adopts a contemporary and consensus view that disability is a complex phenomenon that is the outcome of an interaction of biomedical features of a person's body or mind (the person's state of health) and the impact of all aspects of his or her physical, human-built, interpersonal, social, cultural, and political world, i.e., the context in which the person acts, works and participation in all aspects of personal and social life. This view, originally presented as a theoretical underpinning for the ICF, was adopted unanimously by the World Health Assembly in 2001 and is also stated in the United Nations' Convention on The Rights of Persons with Disabilities (UNCRPD).[11]

This bio-psycho-social model of disability is the dominant one today. Disability is not simply about how a person's body functions, since two people can have exactly the same problem of bodily functioning—or impairment as it is typically termed—while one experiences a severe disability and the other little or no disability because they live in very different contexts that make very different demands on them: the fact that a person has lost the first digit of her/his index finger in an accident will mean the person cannot be a concert pianists; but that same accident may be irrelevant if the person sells clothing. If a person's eyesight weakens with age, that may have little impact on being able to read or see friends across the street if the person has access to corrective glasses, but major impact if the person does not. In short, the context in which we live – how products, buildings, and cities are laid out, the attitudes and values of other people, and economic conditions – makes a difference in how a disability is experienced.

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[9] Ustun, T. B, Kostanjesek, N, Chatterji, S, Rehm, J. Editors. 2010. Measuring health and disability: manual for WHO Disability Assessment Schedule (WHODAS 2.0) https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health/who-disability-assessment-schedule/

[10] The full description of the pilot and presentation of the statical analysis with recommendation are available in a separate Note prepared under this project: Fellinghauer, C., Posarac, A., Bickenbach, J., Marijana, J. 2022, *Bulgaria: Options for Introducing Functioning into Disability Status Assessment*. © World Bank.

[11] https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html//.

On the other hand, the body and how it functions makes a difference as well. Disability is not just about environmentally or socially created disadvantages -- the body and how it functions makes a difference as well. If a person has chronic pain, a missing limb, or severe depression, it does not matter much how the community or society at large is organized as it will have little effect on pain levels, the missing leg or schizophrenia It also makes a difference whether the health problem a person experiences is temporary or long term, or whether it is stable or will progressively get worse. The body, in other words, will always make a difference in the type and severity of disability that is experienced.

The bio-psycho-social (also called "interactional") conceptualization of disability is at the heart of the ICF (and UNCRPD). The ICF arose from a consensus that formed in the late 1990s that an interactional approach moves beyond an unhelpful deadlock between the Medical and Social models and was moreover supported by evidence of the experience of persons with disabilities. As an international standard classification, ICF formalized and operationalized this approach to disability to provide the scientific basis for practical application – transforming the bio-psycho-social model into a working framework for epidemiology, clinical practice, research, and other domains.

Although the bio-psycho-social model of disability is the consensus view today, the old Medical Approach to disability – in which disability is only linked to the health state of a person – still has a powerful hold over policy in many countries. This has led to the peculiar situation in which, although no one would deny that disability depends both on the state of one's body and the condition of one's environment, the way disability is assessed ignores the impact of the environment.

Disability status assessment and determination and disability needs assessment

Disability status assessment

Disability status assessment is an authoritative, legally sanctioned administrative process. This process often involves several steps and official actors and occurs once or several times. It provides the entry for eligibility for some form of support, service, or assistance to individuals. The assessment procedure identifies the type or degree of disability that a person experiences. The results of an assessment may be expressed as a percentage, grade, or level, that forms the basis for an administrative decision sometimes referred to as determination of disability that can take the form of a certification or statement of disability. Disability assessment is a technical issue whereas disability determination is a political issue, one in which the country decides who it will support.[12]

The contemporary bio-psycho-social model of disability affects the processes by which disability is assessed. First, it is necessary to identify the underlying health state of individuals, both in terms of the health conditions (diseases, injuries, syndromes) they experience and, more specifically, in terms of problems in body functions and structures, or impairments, that result from the health conditions. This provides an assessment of the *intrinsic health capacity* of the person. *But intrinsic health capacity is not the same as disability.* Disability is a matter of how intrinsic health capacity (determined by health conditions and impairments) impact people's daily life in the environment in which they live. Disabilities describe what people can, or cannot, do in their actual environment. As a result, assessing disability requires a description and assessment of what people do in their home, school, work, and community, shaped by environmental conditions that may help or hinder them. In ICF terms, disability assessment is a matter of assessing *performance*: the actual, observable execution of actions – simple or complex – in the person's actual world. Disabilities range from problems performing simple actions – grasping, walking, communicating, self-care – or more complex and socially-constructed activities –

[12] Bickenbach J, Posarac A, Cieza A, Kostanjsek N. Assessing Disability in Working Age Population - A Paradigm Shift: from Impairment and Functional Limitation to the Disability Approach. Washington DC: The World Bank; 2015. Available at: https://openknowledge.worldbank.org/handle/10986/22353//.

interpersonal relationships, keeping a household, education, employment, and community participation.

Disability assessment should thus be about the overall, or summary level or extent of disability that a person experiences. This experience can be disaggregated into separate, discrete disabilities (e.g., mobility, visual, hearing, communication, mental, learning, work, etc., disability) , but the overall experience of disability is more than the sum of the experience of these distinct disabilities: the impact of disabilities on people's lives cannot be simply added together to arrive at a summary score. Distinct disabilities interact among themselves, often leading to greater performance problems than each individual disability causes on its own. Therefore, it is important to view disability as an overall experience that is holistic, emergent, and not merely the sum of separate disabilities. To emphasize this holistic approach, in this Report we refer to **disability 'status' assessment**, to highlight that the administrative significance of disability assessment is that it provides the basis for a determination of the status of being a person with disability.

To conclude, the working definition of disability assessment for this Report is therefore: ***Disability assessment is a summary statement and measure of the overall status of disability as a determined summary level of a person's performance of ordinary, everyday behaviors and actions, simple to complex, in his or her actual or usual environment, in light of the person's state of health.***

Disability assessment and disability determination

Disability assessment is different from disability determination: one is a technical assessment, the second is an administrative decision that is based on prior political choices (e.g., a cut-off point for disability percentage). Nonetheless, it is rarely put into practice. In most countries, the individual assessor, multi-disciplinary assessment team, or assessment agency that carries out the disability status assessment also makes the determination of the status.

Disability assessment and disability needs assessment

In many countries, a certified status of disability (often including a degree of disability) is one of eligibility criteria for benefits and services. Others may include number of children or income level. By including disability among eligibility criteria, some level of need is presumed, and may be administratively predetermined. For example, if a person has a severe disability and meets income and family criteria, he or she may automatically qualify for income support, while a person having disability status and not capable of working may immediately qualify for a disability pension. In short, disability status assessment and determination may directly entail eligibility for benefits and services.

However, in a growing number of countries, the process of disability status assessment is followed by a more complex and detailed needs assessment procedures. These needs may be medical in nature, e.g., surgery, therapeutic treatment, medical rehabilitation, and if so, can only be assessed by medical professionals in the normal fashion. A considerable broader set of needs are associated with fundamental areas of life that are constitutive of the experience of disability – family and relationships, housing, transportation, education and training, work and employment, community and social participation, and others. In a well-functioning system, these needs and requirements are matched to available supports, services, or benefits, provided by legally mandated authorities, agencies, public and private organizations, and others.

***The process by which these needs are assessed is often called an 'individual' (or 'comprehensive') needs assessment*.** This is an administrative process that identifies the needs and requirements of persons based on evidence of the person's discrete problems in functioning (e.g., mobility, self-care, seeing, hearing, communicating, etc.). Needs assessments may be generic or specialized (e.g., special educational needs assessment); but all are individualized in the sense that to be effective and relevant

they must focus on the actions a person has difficulties performing because of her or his underlying health conditions or the environmental barriers she or he confronts in daily life (for example, sensitivities to air pollution or obstacles to mobility).

There are many examples of needs assessment instruments: forms, clinical tests, performance tests, and questionnaires. The better tools collect a full range of information that contextualizes the individual, his or her short and long-term goals and aspirations, family and social circumstances, a survey of impairments and their severity, a review of experienced disabilities, environmental barriers faced or facilitators that might improve performance, and so on. These instruments can be long or short, conducted at the same time as the disability assessment or later, and can be focused on specific areas or more general.

Individual needs assessment is not the same as disability (status) assessment. The differences between the two cover a range of content, administrative and practical issues. (Table 1 summarizes the key differences in aim, purpose, uses, information requirements and scope between disability assessment and needs assessment for persons with disabilities.) Disability assessment serves the limited function of dividing population into essentially two categories, those who will qualify by virtue of disability for social benefits and supports and those who do not. Needs assessment, by contrast, is a highly detailed, individualized, and contextualized process of identifying and quantifying needs and requirements of persons with disabilities and matching these with services. Disability status assessment is the basis for a clear-cut administrative decision to allow the applicant to enter the disability system; needs assessment is the basis for an on-going negotiation between the individual and providers of supports and services.[13] This is an important distinction. Because it provides a summary assessment of whole-person disability, disability status assessment requires a summarizing algorithm that has scientific validity and is psychometrically sound. By contrast, needs assessment does not require a summarizing methodology as it is purely descriptive of salient features of the individual's life relevant to her or his needs and the context for the provision of needs. However, since disability status assessment precedes ("feeds into") the needs assessment it is extremely important that they follow a synchronized approach to disability.

[13] Sometimes the merging of disability and needs assessment is unintentional: "In line with the principles and vision of the CRDP, disability assessment mechanisms must concentrate on participation restriction and on support needs of the disabled person more than on her/his impairment or functional limitations. This implies also that these mechanisms take the environment into account, most often overlooked in assessments." But disability status assessment does not identify support needs, that is only accomplished by means of a needs assessment. See: Carlyne A, Barral C, Eddy B, Castelein P, Chiriacescu D, Cote A. Disability Assessment Mechanisms: Challenges and Issues at Stakes for the Development of Social Policies in Light of the United Nations Convention for the Rights of Persons with Disabilities. Summary Report of Fondation Internationale de la Recherche Appliquée sur le Handicap (FIRA), 2012.

Table 1: Disability status assessment and disability needs assessment

	Disability status assessment	Disability needs assessment
Aim	Whole person, summary assessment of the overall experience of disability by an individual	Discrete needs and requirement created by specific functioning difficulties experienced in daily life
Purpose	Basis for determining eligibility for social benefits, services and supports	Basis for determining needs that might be met by available social benefits, services and supports
Varieties	Generic (although specific disabilities may be used for summary)	Generic or specialized by participation domain (e.g., education, work)
Uses	Used as an entryway into disability system	Used for individualized plans or case management and for monitoring progress
Information required	Information about limitations in performance in actual environment	Wide variety of information relevant to the identification of needs and the context of provision of supports
Scope	Restricted to disability domain	May not be restricted to the disability domain but include needs more generally

This Report focuses on adults only. Strengthening disability status and needs assessment of children in Bulgaria would have required an entirely separate project. At the project inception, it was agreed to focus on adults first and then seek a separate, possibly multi-EU country project for children with disabilities.

Part One: The Assessment of functioning and disability status assessment and certification in Bulgaria

The assessment of disability should be aligned with the country's approach to disability. Definitions of disability and permanent disability in PDA explicitly state that disability is the outcome of interactions between health status and the surrounding environment (this is both the ICF and UNCRPD conception of disability).

It is also important that disability status and needs assessment follow the same approach to disability. All persons with disabilities certified in Bulgaria are required to undergo individual needs assessment to access financial support targeted at persons with disabilities. The certificate of disability serves as a basis on which the needs assessment is conducted. It is therefore very important that these two processes are harmonized in their respective approaches to disability.

To advise on the further development of the assessment of functioning and needs of persons with disabilities, it was necessary to evaluate the disability status assessment from the perspective of functioning. To that end, we first carried out a review of the disability assessment system. Based on the findings from the review, to provide empirically based recommendations for inclusion of functioning into disability assessment, we piloted the ICF based WHO's tool for measurement of disability – Disability Assessment Schedule – WHODAS.

A review of the disability status assessment in Bulgaria

Below, we provide a short summary of the review of disability assessment system in Bulgaria. A full version of the review is presented in Chapter 3 of the abovementioned World Bank Report.

Disability Assessment is the primary decision-making factor for the determination and formal certification of disability. In practical terms, it determines temporary and permanent incapacity to work (for working age adults), eligibility for disability pension (under the *Social Security Act*), for determination of the occupational nature of a disease, and (for children under 16) the determination of the type and degree of disability. The medical expertise used for these determinations is carried out or overseen by either a general practitioner, an attending physician or a dentist, the Medical Advisory Commission (MAC), the Territorial Medical Expert Commission (TMEC) or (mainly for appeals) by the National Medical Expert Commission (NMEC). The circumstances under which one or another of these commissions are involved in the medical examination are described in the National Framework Agreement for Medical Activities (NFAMA), an agreement between the National Health Insurance Fund and the Bulgarian Medical Union.[14]

***Currently, in Bulgaria, disability assessment is based entirely on a 'medical expertise' assessment*.** The assessment methodology was developed and is managed by the Ministry of Health under the Health Act and is conducted by medical professionals. It is founded entirely on evidence from medical documentation. The medical assessment instrument, and procedures and criteria governing its use, are set out in the Council of Ministers' Ordinance on Medical Expertise (OME)[15] and the Rules on the structure and organization of work of the bodies of the medical expertise and of the regional filing cabinets of the medical expertise (RSO).[16] The medical expertise instrument itself (found in OME) is a

[14] National Framework Agreement for Medical Activities. https://www.nhif.bg/get_file?uuid=9CE5C398732226B9E05400144FFB42AE

[15] Ordinance on Medical Expertise adopted in a resolution of the Council of Ministers № 120/2017. https://www.lex.bg/bg/laws/ldoc/2137150573

[16] The Rules for the Structure and Organization of the Work of the Medical Examination Bodies and of the Medical Examinations' Regional Files. https://www.lex.bg/bg/laws/ldoc/2135677394

Baremic-style assessment instrument that links health conditions (diseases, disorders, injuries) and selected impairments of body function and structure to pre-determined levels of severity of disability, represented as percentage of 'whole person' disability.[17]

The Ordinance for Medical Expertise (OME) establishes the principles and criteria for a medical expertise. It provides, as an assessment methodology, a Baremic instrument that matches diseases and associated impairments with pre-determined percentages of disability (as compared to a healthy person) on the bases of which the degree of disability is determined. This is a classic application of the so-called Medical Model of disability, which, as we have said above, has been replaced by the bio-psycho-social approach found in both ICF and UNCRPD. To qualify for benefits and services, the person should have a degree of permanent disability of at least 50 percent. As noted above, the assessment of permanent disability is based on medical documentation, justifying the degree of impairments in diseased or injured body parts or structures, detailed relevant clinical history, in-depth clinical examination, and, in some cases, targeted laboratory and other examinations performed or ordered by TMEC. OME specifies that the expertise of permanent disability also includes: (i) an assessment of the need for care assistance from others and terms of such assistance, (ii) a decision on the duration of permanent disability and dates of its beginning and expiration, (iii) an opinion on the causal connection between the impairment and related disability in cases of a work accident, occupational disease, and military service-related disability, (iv) recommendations for further monitoring and rehabilitation, and (v) contraindicated working conditions (not applicable to persons of retirement age).

The current disability assessment system is limited by the fact that the Baremic medical expertise instrument and methodology used does not assess disability, in the modern sense established by the ICF and espoused by UNCRPD.[18] The medical expertise instrument used for disability assessment in Bulgaria is a standard Baremic instrument – that is, an organ system-based listing of diseases, traumas, and associated impairments (called 'functional limitations') that are directly linked to a pre-determined percentage of disability. As a standard Baremic instrument, the medical expertise assumes, without evidence, that a disease state, injury, or associated impairment constitutes an assessment of the overall state of disability of the person as a whole. This assumption does not consider the role of the person's environment on the actual experience of the person with the health condition on the person's actual level of disability. In short, the medical expertise equates disability with health condition or impairment, and as such is inconsistent with the understanding of disability found in ICF and UNCRPD. Moreover, the medical expertise is not uniformly based on the WHO's International Classification of Diseases (ICD) format but rather roughly arranged by diseases and injuries of organ systems (and associated impairments), but with two additional categories of 'internal diseases' and a somewhat random collection of diseases called 'surgical'.

In its current form, disability assessment does not align with the approach to disability from the Persons with Disabilities Act. Definitions of disability and permanent disability in PDA explicitly state that disability is the outcome of interactions between health status and the surrounding environment

[17] This method was introduced by the French mathematician François Barrême in late XVIII Century. Hence the name.

[18] It is significant that concerns about this method are widely held in both the scientific and policy making communities. A good and clear example of these concerns in the specific case of disability assessment is a Council of Europe's report on disability assessment in Europe, published in 2002.[18] In this report, the Baremic method is characterized as "an arbitrary ordinal scale which attaches progressive percentage values to define disabilities. The Council of Europe. 2002. *Assessing Disability in Europe – Similarities and Differences*. Council of Europe Publishing F-67075 Strasbourg Cedex. ISBN 92-871-4744-2. © Council of Europe. See also: Bickenbach J, Posarac A, Cieza A and Kostanjsek N. 2015. Assessing Disability in Working Age Population – A Paradigm Shift: from Impairment and Functional Limitation to the Disability Approach. Report No: ACS14124. Washington, DC.: The World Bank.

(the ICF conception of disability). However, the method currently used to assess disability is based on medical evidence and criteria and does not take the environment into account.

Several institutions are involved in the medical examination, decision-making, documentation collection, and certification of disability. In general, the Ministry of Health (MOH) and Regional Health Inspectorates (RHIs) are responsible for organizing and managing the medical examination, while the entities that carry out the assessment are called the 'bodies of medical examination', whose powers and responsibilities are stipulated in Chapter 3 of the RSO. The process is monitored and overseen by the National Medical Expert Commissions, the Minister of Health, the National' Health Insurance Fund, the National Social Security Institute, the Regional Health Inspectorate and by the Regional Health Councils.[19]

Administratively, the assessments of temporary and permanent disability are organized in Bulgaria differently from many other countries. In Bulgaria, organization and conduct of these functions that are important both for affected persons and the state is delegated to medical establishments (mostly hospitals), engaging thousands of medical doctors. As evidenced by high numbers of inspections of MACs and TMECs and appeals, the system is not fully trusted by the public and administration. While the current organization of assessment helps achieve better territorial coverage of services, it is difficult to ensure the absence of conflict of interest (in small towns where everyone knows everyone) or a strict and consistent application of the expertise methodology. The current system incurs increased cost to the national health budget by additional diagnostic procedures normally conducted at the medical institutions where the patient had been treated and is being assessed (which may or may not be needed), as well as increased cost to the Social Security Fund that pays for the sick leave. In addition, the way in which members of MACs and TMECs are paid for their work is not entirely transparent. The outcome is a need for increased layers of checks and rechecks of MACs and TMECs decisions.

An applicant's journey through the system of MACs and TMECs appears complex and lengthy. To an outsider looking at the system from the regulatory documents, it appears that there is a constant demand for medical documents, additional diagnostic procedures, multiple applications, and multiple commissions. The decisions take a long time (e.g., a MAC may take three months to issue a decision).

Recommendations:

Concerning the inclusion of functioning into disability assessment and thus aligning the status assessment methodology with the understanding of disability adopted in Bulgaria, the Government of Bulgaria may consider the following:[20]

- Revise the disability assessment system methodology by explicitly including functioning ("performance" in the ICF terms) through a psychometrically valid and reliable measurement of functioning. The change in methodology should be based on empirical evidence. This evidence can be statistically developed into an automated algorithm that would calculate degrees of disability in a scientifically sound, non-arbitrary or non-discretionary fashion.
- Create specific disability assessment methodologies that are adapted to specific situations of children, the working age population, and retired people.

[19] Art. 111 of the Health Act.
[20] For other recommendations, see the Review.

- Consider changing the way how disability assessment is organized to increase its technical robustness and consistency, efficiency, and transparency. Bulgaria may explore options applied in other EU countries.[21]
- Use significant available IT resources and information management capacity to fully automate the disability assessment process.[22]

Options for including functioning into disability assessment

Based on the key finding from the review of the disability assessment system that the assessment is entirely based on medical criteria and not aligned to Bulgaria's general approach to disability, which is consistent with ICF and UNCRPD, we investigated options for the inclusion of functioning into the assessment. To get empirical evidence, we piloted the ICF based WHO's Disability Assessment Schedule (WHODAS).

About the World Health Organization's Disability Assessment Schedule (WHODAS)

WHODAS is an extensively tested disability measurement tool based on ICF. A disability assessment is a summary measure of the level of a person's performance of an adequately representative set of behaviors and actions, simple to complex, in their actual environment, considering the person's state of health. In the ICF, information about categories of Activities and Participation can be collected either from the ***perspective of capacity*** (reflecting exclusively the expected ability of a person to perform activities considering their health conditions and impairments) or the ***perspective of performance*** (reflecting the actual performance of activities in the real-world environmental circumstances in which the person lives). Information about capacity typically represents the results of a clinical inference or judgment based on medical information, while performance is a true description of what occurs in a person's life. The two perspectives are therefore very different, although capacity constitutes a determinant of performance.

The WHO developed, tested, and has consistently recommended the WHODAS as an instrument that can validly and reliably capture the performance of activities by an individual in his or her daily life and actual environment. The 'actual environment' is represented in the ICF in terms of environmental factors that act either as environmental facilitators (e.g., assistive devices, supports, home modifications) or as environmental barriers (inaccessible houses, streets and public buildings, stigma, and discrimination). The WHODAS questionnaire, in short, is WHO's recommended, generic, performance-based disability assessment tool.

Implementing WHODAS in Bulgaria

WHODAS 36-question version was implemented in Bulgaria on a sample of 3,118 individuals who applied for disability (re)assessment in late 2021 and early 2022. The pilot sample included only persons who were assessed as having a disability of at least 50.0 percent. The survey was conducted in collaboration with the Social Assistance Agency of MLSP and more than 60 social workers participated as interviewers, while day-to-day pilot monitoring was conducted by the two pilot coordinators. Because of the social distancing restrictions in Bulgaria at the time of the pilot, only 66.7 percent of the interviews took place face-to-face, while 33.3 percent were phone interviews.

[21] Under this project, a comparative review of disability system and policy institutional set up, including disability assessment system, was conducted for Bulgaria, France, Czech Republic and Slovenia. See: Posarac, A. at all. 2021. Strengthening Disability System in Bulgaria: Review of EU relevant practices regarding creation and functioning of disability agencies. © World Bank.

[22] Chapter 7 of the above-mentioned World Bank report discusses disability information systems in Bulgaria.

Descriptive statistics of the WHODAS sample are as follows: The pilot sample included more female than male applicants (53.5 percent vs. 46.5 percent, respectively). The average age was 56.2 years. A little over half of the applicants were currently married (50.7 percent); 12.4 percent were widowed; 11.9 percent were divorced, and 4.7 percent were cohabiting. Most applicants were living independently in the community (99.3 percent). The applicants had an average of 11.7 years of education. Most applicants reported either being unemployed for health reasons (35.4 percent) or being retired (26.4 percent). Only 30.8 percent reported having a paid employment. All applicants reported one primary ICD-10 linked health condition with additional comorbidities. Neoplasms (23.9 percent) and diseases of the circulatory system (23.0 percent) were the most reported main diagnoses. Mental and behavioral disorders were reported by 11.3 percent of applicants. ICD chapter XIII (diseases of the musculoskeletal system and connective tissue) and ICD chapter IV (endocrine, nutritional, and metabolic diseases) were the primary diagnoses in 8.1 percent and 7.7 percent, respectively.

Data analysis

Below, we summarize the results of the pilot data set data analysis. First, we analyze metric and psychometric properties of the WHODAS pilot data and then we look at the current disability assessment methodology outcomes of the pilot participants as compared to the WHODAS assessment.

Psychometric properties of WHODAS 2.0 in Bulgaria

Statistical tests confirmed WHODAS validity and reliability. A statistical analysis of psychometric properties of WHODAS pilot that included seven essential statistical tests (described in detail in the full report mentioned above) show that the data collected with WHODAS, under the Rasch analysis, display robust psychometric properties of validity and reliability. It is important to keep in mind that the WHO developed WHODAS explicitly to statistically capture the construct of functioning from the perspective of performance – namely, the experience of performing activities by a person with an underlying health problem in their actual everyday life environment. There is an abundance of evidence from the scientific literature – supported by the results of this pilot – that WHODAS is a psychometrically sound instrument that reliably and validly collects information about levels of disability.

Based on satisfactory psychometric properties, we conclude that information collected with the WHODAS is robust, viable, and relevant and that it validly represents the construct of disability as understood in ICF and UNCRPD. Including WHODAS into disability status assessment in Bulgaria would (i) significantly strengthen the method of assessment currently in use (a medical assessment mostly based on impairments) and align it with Bulgaria's approach to disability; (ii) bring it closer to the ICF and UNCRPD understanding of disability; and (iii) harmonize the approach to assessment with the ICF functioning based approach used in the individual needs assessment.

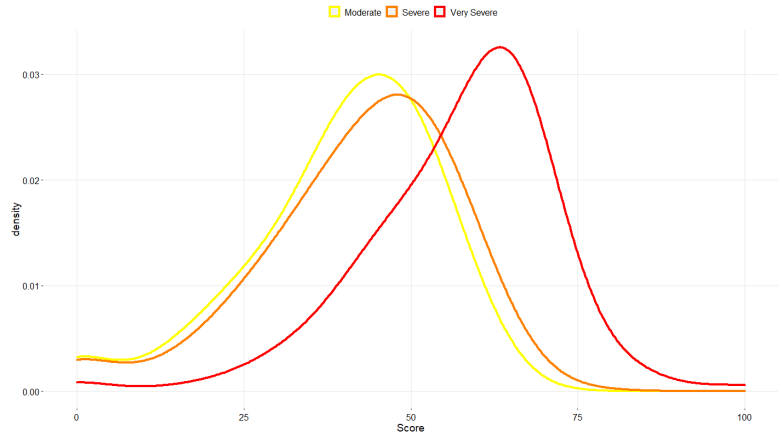
Comparing WHODAS and certified disability degree data

Including functioning into disability assessment will improve the accuracy of the assessment. One of the objectives of our analysis of the WHODAS data collected in Bulgaria is to show that the inclusion of functioning into the current medically based disability assessment method will significantly improve its capacity to assess the experience of disability more accurately and to allow for better assessment of needs of persons with disabilities subsequently. The WHODAS data set included not only WHODAS collected data, but also the certified disability degree as determined by TMECs/NMEC and associated ICD codes for each participant in the WHODAS survey. This allowed us to compare the two sets of data. As explained above, the current disability assessment method in Bulgaria is medically based and

uses an instrument of a Baremic type that matches diseases and associated impairments with pre-determined percentages of disability (as compared to a healthy person). Procedurally, the assessment is based on medical documentation, justifying the degree of impairments in diseased or injured body parts or structures, detailed relevant clinical history, in-depth clinical examination, and, in some cases, targeted laboratory and examinations performed by TMEC/NMEC. The current Bulgarian disability assessment system identifies disability degrees as percentages – with values < 50 percent designating mild/no disability, 50-70 percent moderate disability, 70-90 percent severe disability, and > 90 percent very severe disability. In what follows, we will call these here 'disability severity ranking groups'.

Looking at the WHODAS functioning score by current Bulgarian disability severity ranking groups, it is observed that the medical assessment does not differentiate well between moderate and severe disability, suggesting low reliability and precision. The match is stronger in the case of very severe disability. Figure 1 shows that while the WHODAS scores for very severe functioning restrictions stand out (red line), the difference between severe and moderate disability severity (the yellow and orange lines) is less obvious with a closer location to each other. The density lines in Figure 1 also suggest the presence of false positives (high disability percentage and low WHODAS score) and false negatives (lower disability percentage and high WHODAS score). A more accurate assessment would show the very severe WHODAS density line sloping more to the right-hand side: the line would be closer to 0 up until the score of 45, then sharply rising around the score of 50. The opposite should be the case for the moderate disability, which should be located mostly to the left-hand side of the Figure 1. This suggests that the medical information may misrepresent the true extent of individual disability as experienced in daily life.

Figure 1: WHODAS score density line by disability severity



The results presented above come as no surprise as WHODAS was designed explicitly to assess whole- person disability, while the medical approach to assessing disability used in Bulgaria does not directly assess disability, but infers disability based on the underlying health condition or impairment. Sometimes there is a close correlation between severity of health conditions and severity of disability; but sometimes there is no connection. We clearly see this in the case of mental health problems where the impact of the person's environment may greatly increase severity of disability experience (e.g., depression). This is the basic validity problem with medically based disability assessment. As pointed out above, although the presence of a health condition and associated impairments is a precondition for disability, inferring the level of disability from the health condition is scientifically problematic. The level of disability that an individual experiences, as the ICF argues, is determined by an interaction between a health condition and associated impairments and environment in which the person lives. WHODAS was designed to directly capture this disability

experience while assessment of disability based solely on medical grounds cannot do so validly or reliably.

Real life examples

To illustrate the discussion above, we present six randomly selected real-life cases from the WHODAS pilot data set where disability percentage and WHODAS scores differ dramatically (also summarized in Table 2).

Case A is a 62-year-old divorced man with a WHODAS-based functioning score of 63, which would indicate very severe functioning restrictions. He has been determined to have a moderate disability severity of 66 percent. He reports 11 years of education and lives independently in the community but cannot work for health reasons. His main condition is an unspecified cirrhosis of liver, but he further presents a personality disorder and hypertensive heart disease. He reports also having had difficulties because of his health condition on every day of the last month. He is unable to perform usual activities and often must reduce his usual activities or work.

Case B is a 59-year-old married woman with 15 years of education. She is currently working. She suffers an unspecified cirrhosis of liver accompanied by some anemia, hip arthrosis, and gout. Her disability has been rated as very severe, i.e., 93 percent. Her WHODAS score of 36 indicates that she has only moderate functioning problems in day-to-day life. She also reports marginal difficulties in carrying out her activities and work, having to reduce or cut-back activities only about one day per month when she is not feeling too well.

Case C is an 84-year-old married man with a WHODAS-based functioning score of 79. He has been determined to have a 'severe' disability with a percentage of 72 due to Type 2 Diabetes and heart failure. He is retired but still lives independently in the community. His health condition is severely limiting him in his daily life, and he cannot perform his usual activities normally without having to reduce them.

Case D is a 45-year-old educated and working woman. She has never been married. She was diagnosed with diabetes mellitus with multiple complications, including hypertension and chronic pancreas problems. Her work reduction capacity has been rated as very severe, i.e., 94 percent. Based on the ratings of the WHODAS, she reports only moderate functioning problems in daily life, her score being 27. She also reports only marginal difficulties in carrying out her activities and work. She is never totally unable to carry out her work or activities because of her conditions and only must slow down somewhat from time to time.

Case E is a 44-year-old married woman with 17 years of education. She is unemployed but not for health reasons. She is in the severe disability severity group with a percentage of 85. She has been diagnosed with an organic personality disorder without further comorbidities. Her WHODAS score of 22 indicates good functioning, and her health condition is not limiting him in performing daily life activities.

Case F is a 19-year-old married man with 12 years of education living independently in the community. He is unemployed for health reasons. He is in the moderate disability severity group with a percentage of 50. He has been diagnosed with mild mental retardation without further comorbidities. His WHODAS score of 60 is high and indicates severe functioning problems with his health condition limiting him every day of the month, having to reduce activities half of the time.

Table 2: Disability percentages and WHODAS scores and severity grouping - real life cases

Case	Disability % and group	WHODAS score and group
Case A	66% - moderate	63 – very severe
Case B	93% - very severe	36 - moderate
Case C	72% - severe	79 – very severe
Case D	94% - very severe	27 - moderate
Case E	85% - very severe	22 – no difficulty
Case F	50% - moderate	60 – very severe

The real-life cases corroborate the discussion that the assessment based on medical information may misrepresent the true extent of disability an individual experiences. This is important, because an accurate assessment of disability is crucial for persons experiencing disability to access disability benefits. For example, cases A, C, and F will have no access to personal assistants (their disability percentage is less than the threshold of 90 percent), although they experience severe difficulties in functioning. In contrast, cases B and D will be eligible for personal assistance, although their disability experience in terms of functioning is moderate. Including functioning in disability assessment in Bulgaria will, thus, not only improve the accuracy of the extent of disability assessment but will also improve the assessment of the needs of persons with disabilities.

To conclude

The empirical evidence presented in the sections above shows that:

- WHODAS – is a freely available and widely used questionnaire built on the activity and participation domains of the WHO's ICF, that is as close to being the gold standard for the description of disability as possible. It is psychometrically strong, and the data can be analyzed to create a valid and reliable interval-scaled functioning score. This evidence from the Bulgarian pilot corroborates evidence from other international research studies: WHODAS successfully collects functioning information, and as it has been further confirmed by pilot data, it does so with strong psychometric properties of validity and reliability. It performs well in measuring whole-person disability, creates a summary score, and provides an objective and accurate assessment of functioning based on core functioning domains of the ICF. The scores provide interval-scales values ranging normally from 0 to 100 (Figure 6).
- The current system that determines disability severity ranking groups in Bulgaria exhibits well-known scientific concerns about the validity of the assessment and whether it assesses the true extent of disability an individual experiences or can accurately differentiate degrees of disability. The disability degree percentage continuum from 0 percent (no disability) to 100 percent (total disability) is poorly populated in the middle of the scale and polarizes on a few values.
- ***In light of these results from the pilot, we conclude that including the assessment of functioning based on WHODAS[23] into the assessment already in place in Bulgaria will significantly improve the accuracy of the assessment, resulting in a more refined assessment that adds information on the lived experience of the disability to the assessment based on the medical diagnosis.***

[23] We recommend WHODAS, because it is free and firmly empirically proven that it represents the construct of disability in terms of ICF and is psychometrically valid and reliable. Countries may choose to develop their own instruments, but such effort requires time and money, and the instrument will have to be psychometrically tested before being deployed.

Options for including functioning into disability assessment in Bulgaria

Methodological considerations

The WHODAS pilot in Bulgaria has shown that it performs well in capturing the experience of disability. The question is how best to include the functioning information captured by WHODAS into the current disability status assessment system in Bulgaria.

It should be emphasized that we are not suggesting the assessment of type and degree of disability based on medical information should not play a role in disability assessment in Bulgaria. The ICF itself makes it clear that without an underlying health condition and associated impairments of body structures and functions, disability does not exist, so medical information is relevant to disability assessment. While the scientific community finds problematic the direct inference of whole person disability from medical information alone, this information must still be collected and relied on for disability assessment. Information about health states provides a basis for identifying specific physical and mental dimensions of activities and areas of participation that are vulnerable to disability, which can then be directly confirmed by WHODAS data. Medical information also provides essential guidance on the medium- and long-term trajectory of disability that the individual will experience.

As medical information is essential, in this section of the Report, we analyze and discuss possible options for combining medical and functioning information in the assessment of disability in Bulgaria.

As we have done in other countries,[24] several methods were tested on the Bulgarian pilot dataset to address this challenge. These methods can be grouped here into two principal strategies (1) ***averaging*** the medical assessment percentage with the WHODAS score to arrive at a final disability assessment score, and (2) ***flagging*** persons whose WHODAS score, and disability severity group are different from the severity group based on the percentage determined based on medical information.[25]

(1) **Averaging** – averaging the attributed disability percentage and WHODAS score. This approach is based on the theory that, together, medical, and functioning scores contribute, to different degrees, to a realistic and valid assessment of disability. In the main text below, we describe the results of four strategies that were tested using different weighting combinations.

(2) **Flagging** – identifying persons whose WHODAS severity grouping differs from the medically determined severity grouping and flagging these individuals to request from them additional information or reassessment. When an individual has a WHODAS score over or below some cut-off, this suggests that the medical score does not adequately capture the experience of disability and a second-level assessment should be conducted.

Averaging and Flagging are the most intuitively obvious approaches to merging diverse assessments into a single overall assessment. Each is grounded in the ICF understanding of disability as the outcome of an interaction between the underlying health condition and impairments of a person and the physical, human-built, interpersonal, attitudinal, social, economic, and political environment in which the person lives and acts. They differ, however, in how they weigh the impact of the medical and environmental determinants of disability.

[24] Greece, Latvia, and Lithuania. See related World Bank reports.

[25] It is important to add that as WHODAS is used more data are collected, this data can be further analyzed using the techniques from this Note to continually update and recalibrate parameters and cut points. Moreover, these data have other potential policy applications, including in identifying disability trends and planning for the future.

Options for including the assessment of functioning into disability assessment in Bulgaria

Below, we present options to include functioning into disability assessment in Bulgaria. Each option follows the ICF in recommending a combination of medical and functioning assessment (provided by WHODAS). Option A is the situation in which WHODAS scores are considered in a purely discretionary manner. Options B (averaging strategies) and C (flagging strategies) are quantitative. Each of these options has advantages and disadvantages. Our framework for evaluating them – based on the scientific literature – are key scientific principles that determine the credibility of any disability assessment process*: validity* (the extent to which the option relies on a true assessment of disability); *reliability* (the ability of the option to arrive at the same assessment of the same case by different assessors); *transparency* (the degree to which the assessment process and outcomes can be described and understood by all stakeholders); and *standardization* (the extent to which the process resists distortion or alteration over time and across locations).

Option A: Discretionary combination of medical and functioning components

This is the option in which an individual assessor or a committee reviews medical scores and the WHODAS scores and makes a judgment about the extent of disability as the individual or committee sees fit. This is a purely discretionary option, and it is surprisingly common in practice. This approach is subject to manipulation, or whim, lacks validity and reliability, and is utterly non-transparent and non-standardized. The option is given here as a contrast to the remaining options B and C, but also, in fairness, because some countries continue to rely on this option for disability assessment. ***We do not recommend this option***.[26]

Options B and C: quantitative approach

Averaging and Flagging options are quantitatively driven, which makes them very different from Option A. In different ways and for different reasons, they satisfy not only the basic psychometric properties of validity and reliability but each, to different degrees, strives to achieve transparency and standardization.

Option B: Using an averaging algorithm

In the Bulgaria pilot WHODAS data set, there is a relatively high percentage of persons indicating no functioning problems at all (10.7 percent), among which some individuals were in the very severe disability severity ranking group. Averaging the disability percentages with the WHODAS score would adjust the number of persons in each of the disability severity ranking groups by accounting to some degree for the observed disability level assessed by the WHODAS. To get a full sense of the range of possible approaches under Option B, four weighting schemes were tested: (i) 75.0 percent disability percentage & 25.0 percent WHODAS score; (ii) 50.0 percent disability percentage & 50.0 percent WHODAS score; 25.0 percent disability percentage & 75.0 percent WHODAS score; and 0.0 percent disability percentage & 100.0 percent WHODAS score.

Advantages of Option B: (i) An assessment of the level of functioning plays a significant role in the determination of eligibility for disability benefits so that the eligibility for benefits is not solely based on purely medical criteria. (ii) The averaging approach minimalizes the impact of the inherent psychometric problems with the disability percentage based on the Baremic medical assessment used.

[26] Interactions with officers involved in disability assessment in different countries suggest that medical professionals involved in the assessment disability are confident they "know best" and do consider functioning and the experience of disability as part of the medical description of the applicant's situation. One often hears medical assessors claim that they take functioning fully into account when examining medical records. One implicit result from the pilot is that this assumption is not grounded in evidence.

(iii) The assessment of the level of functioning is empirically and statistically verified. (iv) This option yields high levels of validity and reliability. (v) Merging the results of two assessments scaled by means of 'weighted averaging' is fully objective, transparent, and non-discretionary. (vi) The method is not sample-dependent.

Disadvantages of Option B: (i) There are, potentially, an infinite number of combinations of weighting schemes (i.e., 'strategies'), each of which affects the set of eligible applicants differently and has different budgetary and political consequences. This is an unavoidable fact about the nature of disability as a continuum and the fact that there are not yet scientifically verified or objective cut-offs for severity on a Rasch scale 0-100 continuum. (ii) Any strategy selected will be objectionable to individuals who, under that strategy, will not be certified as disabled and thus not eligible for any benefits. This signals the need for clear and transparent information dissemination and a solid grievance redress system that may include using tools for clinical testing and determination of functioning.

Option C: Using the flagging algorithm

We tested three flagging strategies. Flagging persons with severe to very severe functioning problems whose disability severity was certified as moderate would result in many individuals (437 persons) whose disability severity in terms of functioning would have to be reassessed. Only flagging those with very severe functioning problems (WHODAS score of at least 60) who are in the moderate or severe disability ranking groups results in only 31 persons whose disability severity would need to be reassessed and augmented. On the other hand, a relatively large number of individuals (N = 217) in the severe and very severe disability ranking groups presented no disability in terms of the WHODAS scores. From those, almost half had neoplasms as main diagnosis. This reiterates the point raised above that the current disability assessment method does not discriminate well between different degrees of disability.

Advantages of Option C: (i) Scientifically robust and based on actual data. (ii) Shows that the purely medical approach to disability assessment may not accurately assess disability in many cases – in which, as reported in the WHODAS score, a person is experiencing more/fewer functioning problems in their lives than what the health condition/impairment is thought to imply. (iii) High levels of validity and reliability.

Disadvantages of Option C: (i) The WHODAS cut-offs for different degrees of functioning problems were recommendations based on past pilots and some evidence from the scientific literature. Sensitivity analyses are not available to this point. More precise cut-values specific to Bulgaria may be introduced at later time points when more information on functioning is collected (assuming that WHODAS will be introduced in Bulgaria). (ii) Technically robust methodological and procedural instructions will have to be developed to guide the reassessment process to ensure transparency.

Even with the caveat concerning the cut-off points for disability severity, the flagging method may be introduced through a specifically designed (two-step) administrative procedure.

Table 3 gives an overview of the testing strategies that were considered and gives the number of individuals that would be considered having a moderate, severe, or very severe disability after adjusting for the WHODAS-score. Further, the number of individuals that would have their disability severity ranking group changed towards a higher or a lower group are shown.

Table 3: Overview of WHODAS inclusion strategies

General Approach	Nbr.	Description of scores integration formula	Cut-off	Total Moderate Disability	Total Severe Disability	Total Very Severe Disability	Total Upshift Disability	Total Downshift Disability
Actual approach	#1	Reduced Working Capacity [%Disability*]	• No disability < 50% • Moderate 50-70% • Severe 70-90% • Very Severe > 90%	1096	912	1110	0	0
Averaging:	#2	Weighted mean of %Disability (75%) and WHODAS (25%)	Bivariate cut-offs for %Disability cut-offs and equivalent critical WHODAS Score level	1235	938	945	30	334
	#3	Weighted mean of %Disability (50%) and WHODAS (50%)		1342	998	778	74	652
	#4	Weighted mean of %Disability (25%) and WHODAS (75%)		1346	1080	692	224	892
	#5	Weighted mean of %Disability (0%) and WHODAS (100%)		1315	1133	670	552	1211
Flagging:	#6	WHODAS-Score = Severe disability & %Disability = Moderate		1053	955	1110	437	0
	#7	WHODAS-Score = Ver severe disability & %Disability = Moderate or severe		1090	893	1135	31	0
	#8	WHODAS-score = No to mild disability and %Disability = Severe or very severe		1258	805	1055	0	217

**% Disability stands for the medically attributed disability percentage or work capacity reduction percentage*

To make the options concrete, we illustrate them on the six real life cases presented above. This should show how the strategies would change the understanding of the level of disability and highlight the advantage of including functioning into the current disability assessment in Bulgaria. Table 4 presents the expected level of disability given each of the functioning inclusion strategies (yellow = moderate; orange = severe; red = very severe).

Table 4: Disability severity ranking and WHODAS scores and their integration strategies – Examples of individual cases

			Current method severity	Averaging				Flagging		
	WHODAS score	Disability percent	#1	#2	#3	#4	#5	#6	#7	#8
A	63	66						Additional information and second-step assessment		
B	36	93								
C	79	72								
D	27	94								
E	22	85								
F	60	50								

Implementation considerations

The pilot data and analysis show that the current disability assessment system in Bulgaria would benefit significantly from the inclusion of functioning into the assessment method: (i) the assessment of disability would be more precise and accurate, reflecting the real-life experience of disability of applicants; (ii) the assessment will be in line with modern understanding of disability; and (iii) the assessment will be harmonized with the individual needs assessment providing valuable input into it.

Our approach to disability assessment is to combine medical and functioning information and we have provided above several methodological options for doing it. It also affirmatively answers the question of whether Bulgaria has the administrative capacity to implement the change smoothly. There are at least two reasons to be confident about this conclusion:

First, Bulgaria has an advanced information system that could easily accommodate the collection and use of the information on functioning.

Second, Bulgaria has a cadre of experienced social workers in the Social Assistance Agency that could be engaged in the WHODAS administration. While the administrative process will have to be designed and details worked out, it could possibly flow in the following way: a person applying for/referred to the assessment of disability would have two meetings scheduled, one with the social worker to administer WHODAS and subsequently one with the TMEC. The WHODAS information would be sent to NMEC electronically where the form would be checked, and the raw score transformed into the Rasch-based score. TMEC will proceed with the assessment as per the current criteria.

How the two scores will then be combined depends on the choice made by the Government. If the averaging method is chosen, say with 50.0 percent weight given to the TMEC determined degree of disability and 50.0 percent to the WHODAS Rasch score, the two scores will automatically be combined at NMEC, and the final score sent to the TMEC to issue a certificate. Alternatively, the certificate could be issued by NMEC. If the flagging method is chosen, then in cases where the TMEC determined percentage of disability and the WHODAS score fall in the same disability grouping (no, moderate, severe, and very severe), the NMEC will instruct the TMEC to issue the certificate with the proposed disability severity grouping. If they do not coincide, then a secondary assessment will be undertaken either by a different TMEC or a NMEC. Whichever the ultimate choice might be, the result is that the information on functioning will be systematically included in disability assessment using a standardized approach, and the administrative process itself will become more rigorous, standardized, and objective.

Finally, it should also be noted that any new method adopted should be applied to new applicants only. To smooth the transition, disability recertification may be staged over several years.

Recommendations

Based on the above, we recommend that:

(i) ***The Bulgarian Government includes functioning into disability assessment using WHODAS to collect relevant information***. While the choice is political, either averaging or the flagging approach can comfortably be implemented based on the existing information systems and human resources (a cadre of social workers).

Including functioning into disability assessment will:

- *make the assessment of disability more accurate, and reliable, reflecting the real-life experience of disability of applicants,*
- *bring the assessment closer to the modern understanding of disability as formulated by ICF and mandated by UNCRPD, and adopted by Bulgaria; and*
- *align it with the individual needs assessment by providing valuable information input into it. A status assessment that includes functioning will provide a better profile of disability that the person experiences to identify needs that, once addressed, will improve the experience of disability by optimizing the person's functioning.*

(ii) ***A separate assessment tool is developed to assess disability of children.*** The tools used for adults are not suitable for children, because children grow and develop. Determining disability of a two-year old child, for example, must take into account age-specific developmental milestones, her or his development potential and avoid labeling the child as having a disability for life. (WHO does not recommend that WHODAS is used for children and is currently working on a WHODAS instrument for children.)

Part Two: Strengthening Individual comprehensive assessment of needs of persons with disabilities

In this part of the Report, we present (i) a review of the current complex individual needs assessment of persons with disabilities in Bulgaria, (ii) results from the pilot testing of the revised instrument, and (iii) a revised tool, based on the pilot testing and discussions with the social worker who are administering the assessment and persons with disabilities whose needs have been assessed.

A Review of the disability needs assessment in Bulgaria[27]

Legal framework

Comprehensive assessment of individual needs of persons with disabilities (INA) was introduced in Bulgaria by the Persons with Disabilities Act.[28] The PDA created the legal right of persons with disabilities to a complex and individual assessment of needs that examines "the functioning difficulties of a person with a disability, related to her/his health condition and the presence of barriers in the performance of daily and other activities, as well as the type of support needed." This statement reflects the concepts of functioning and disability found in ICF, as well the UNCRPD characterization of 'persons with disabilities'.

The link between INA and the ICF is most clearly made in the Needs Assessment Methodology or – (NAM).[29] The NAM states that the purpose of INA is to obtain detailed information about the situation regarding the participation of the person with a disability in society and to establish the individual needs for support. NAM states that it approaches disability as a general consequence of problems in functioning of a person with a disability, which is an umbrella concept covering all functions and structures of the body, activities, and opportunities for social inclusion, and that it is based on the WHO's bio-psycho-social model of disability. It also stipulates that the assessment should consider: (i) *functioning* of the person with a disability; (ii) *possibilities*; and (iii) *willingness.*

The assessment methodology, in accordance with the ICF, covers the following nine areas of life: training and application of knowledge, common tasks and requirements, communication, mobility, self-care, home life, interpersonal interactions and relationships, main areas of everyday life, and civic and public life.

The characterization of the ICF bio-psycho-social model in NAM is, however, somewhat puzzling. Although disability is described as a problem in functioning (or 'functionality' as it is termed), functionality itself is characterized as a capacity of the body not, as in ICF, the outcome of an interaction between the capacity of the body and environmental factors. Moreover, unlike the ICF, the environment – called 'possibilities' – is described as preventing "the person with a disability from fulfilling its functionality through relevant actions," rather than, as in the ICF, creating the level of functioning in the person's performance of activities. *As these differences are fundamental, it is not accurate to say that the current PDA INA described in NAM is consistent with the ICF*.

Main principles of the PDA INA. Although not entirely aligned with the ICF, PDA INA described in NAM is consistent with recognized international practice in as much as NAM defines eight essential properties of a comprehensive individual needs assessment: (i) Transparency and objectivity; (ii) Inter-

[27] See Chapter 4: Complex individual needs assessment of persons with disabilities in Bulgaria from A. Posarac et al, 2022, *Bulgaria: Disability System and Policy, A Comprehensive Review*. © World Bank

[28] Approved on 12/18/2018; effective on 01/01/2019. https://www.lex.bg/bg/laws/ldoc/2137189213.

[29] The Methodology for Conducting an Individual Assessment of the Needs for Support to Persons with Disabilities. The Council of Ministers Decision. № 64/2019. https://www.lex.bg/bg/laws/ldoc/2137192215/.

institutional collaboration of relevant institutions; (iii) Interdisciplinarity; (iv) Acceptance orientation; (v) Individual approach; (vi) Personal orientation; (vii) External factors; (viii) Purposefulness.

Individual needs assessment tool

INA comprises 3 components (the template for the assessment is provided in the Annex 1 to NAM; see also Annex 1 to this Report).

Component I: information about the person with a disability in connection with social, family, household and health circumstances and others related to her/his difficulties and the possibility for her/his social inclusion, indicated in the self-assessment form. The self-assessment form is an extensive template (see Annex 2 to this Report). It is one of three essential documents used for the preparation of INA (the other two are the application-declaration form[30] and the medical expertise decision by TMEC or NMEC).

Component II: objective findings of the social worker regarding the person's status of health and functioning difficulties and barriers she or he experiences in the performance of daily and other activities.

The information in components I and II is filled in by an SAA social worker leading the case.

Component III: conclusions related to specific support measures in accordance with the stated and determined individual needs of the person with a disability and may include financial support, referrals to social services, personal assistance with the number of hours per month, and other available support measures, under conditions and in a manner established by law.

Each of these three forms is described more fully below:

Individual Needs Assessment Report

The INA Report is a two-page document summarizing information from components I and II, prepared by a social worker assigned to lead the case. Component I, besides basic personal details, contains a "self-assessment of the difficulties in the home environment and outside of it". A Responsible social worker is required to summarize information about the home and outside environment from the Self-Assessment Form. (But the Self-Assessment Form does not ask questions about the person's environment; instead, it asks questions about difficulties in performing actions in seven domains with the “yes”/”no” answer format.) In Component II of the INA Report, the social worker provides information from a disability certificate issued by a TMEC or the NMEC, and summarizes information from the Social Worker Form covering: type of difficulty in functioning, degree of difficulty, degree of inclusion in the social environment, mobility in the social environment and difficulties outside home, need for the provision of a specific type of support, and other functioning difficulties and barriers in everyday life from the self-assessment form or findings during the assessment. INA Report’s Component III contains conclusions regarding supportive measures for which the assessed individual was deemed eligible.

Social Worker Form

This extensive ten-part form is the core of INA Report and is filled out by a social worker to whom the case is assigned. The form contains the following parts: Personal information (Part 1); Medical expertise findings (Part 2); Part 3: information about "functional insufficiency/health condition" in terms of intellectual, physical, mental, and sensory 'insufficiencies' based on findings and opinions of

[30] The application/declaration form is approved by the Executive Director of SAA.

medical specialists. Part 3 is difficult to understand. If it is merely medical diagnosis, then this information is already contained, in full, in the formal disability determination documents. But if Part 3 is supposed to contain other information, it is not clear what the source is, or what 'insufficiencies' are. Parts 4 and 5 are to be completed only if the need for personal assistance is established by TMEC/NMEC and subsequently requested, as the issues raised in these parts deal with "conditions and skills required to establish autonomy". These are the only parts of this form that require the social worker to make personal contact with the person and visit him or her at home to identify the person's difficulties and needs and conduct an interview with the person, or a representative. Part 4 asks questions about problems a person has in motor, self-care, orientation, and self-protection, and psycho-social functions, and Part 5 asks about the 'impact of constraints' on the person's life in social functioning, activities in the home environment, and social relationships. (Items pertaining to self-care and some items pertaining to social functioning are not applicable to children under 18; additionally, activities in the home environment are not applicable to children under 12). For each of the 35 issues listed, difficulty or dependency is assessed on a 5-point scale:

- ***4 = there is a problem: degree of total dependency/difficulties*** – the need for constant support by another person to carry out various activities in daily life more than four times a day due to total loss of physical, mental, intellectual, or sensory autonomy.
- ***3 = there is a problem: degree of very grave dependency/difficulties*** – the need for assistance to carry out various activities in daily life no more than four times a day or a need for limited support for personal autonomy.
- ***2 = there is a problem: degree of grave dependency/difficulties*** – the need for assistance to carry out various activities in daily life up to two times a day or a need for limited support for personal autonomy.
- ***1 = there is a problem: degree of moderate dependency/difficulties*** – Moderate dependency/difficulties: the need to carry out various activities in daily life several times a month or a need for limited support for personal autonomy
- ***0 = there is no problem/there is no need of support***

At the end of each of the seven functioning or impact sections in Parts 4 and 5 a 'Total score' box is provided for the sum of the scores in each section. However, only the total scores for sections 4.1 - 4.4 and 5.1 – 5.3 are used, and they are used only in Part 7 to determine the number of hours of personal assistance the person is assessed to need.

Part 6 collects information on participation in education and labor market. Parts 7-9 collect information on existing family support and need for personal assistance, need for home adaptation, municipal housing, assistive or medical aids, private motor vehicle, rehabilitation services, and monthly financial support. Finally, Part 10 asks for the wishes of the person for services and support, their duration, and motivations for social integration.

Self-assessment form

The self-assessment form[31] for the most part mirrors the Social Worker Form:

- Personal information
- TMEC/NMEC determined percentage of disability (and questions about presence of intellectual, physical, mental, or sensory 'insufficiency')
- Summary of services/supports requested (including personal assistance)
- Functioning questionnaire: I. Motor functioning; II. Self-care; III Orientation and self-protection; IV Psycho-social functions; V. Social functioning; VI. Activities in the home environment; VII Social relationships. After each set of questions, the applicant is asked for a "description of the nature of the problems". (V-VII are only required if the applicant is asking for personal assistance.)
- Detailed requests for specific supports and services (educational, employment, social services, balneological treatment and rehabilitation services, financial support for private vehicle, adaptation of home, municipal housing rent, technical aid, and monthly financial support).

Although the Social Worker and the Self-Assessment forms mirror each other, they are also very different in how they collect information about functioning. While the Social Worker Form uses standard dependency questions from rehabilitation therapy instruments with a five-point scale,[32] the Self-Assessment Form presents the questions in a very simple and direct format and requires only a "yes" or "no" response.

Domains and means of support

PDA identifies domains of support for persons with disabilities and details the corresponding means of support. Domains of support are health, education, employment, housing, accessible environment in urban areas and public buildings, transport, culture, sports, private life, social and political life, justice, and others. *The means* of supporting persons with disabilities with a view toward their social inclusion are among others: medical, professional, social, occupational, and psychological rehabilitation, education, and vocational training, employment services, accessibility and reasonable accommodations, social services, financial support, accessible information, access to justice and legal protection, provision of personal mobility ensuring a maximum degree of independence, personal assistance, universal design, others.

Not all these support measures require an individual needs assessment; those that do are specified in PDA and accordingly included in NAM. They are financial support for the purchase of a private motor vehicle, for housing adjustment, for balneotherapy, and for the municipal dwelling rent subsidy; monthly financial support; personal assistance; social services, and other support. Annex 3 to this Report presents support interventions for which INA is applicable. Detailed description of measures to support persons with disabilities in Bulgaria is provided in Annex 4 of the World Bank Report *Disability System and Policy, A Comprehensive Review*.[33]

Each of these support measures has its specific eligibility requirements and procedures, and, in each case, the Self-Assessment Form must explicitly state the need and a request for the benefit or service.

[31] Described as "Form No 2 under Article 21(3)(2) PDA approved by the Order No RD01-0727 of 29 March 2019 of the SAA Executive Director". It is available at: https://asp.government.bg/bg/deynosti/sotsialno-podpomagane/podkrepa-na-horata-s-uvrezhdaniya/individualna-otsenka-na-potrebnostite.

[32] But only for personal assistance, not for other benefits and services.

[33] A. Posarac et al, 2022, Bulgaria: Disability System and Policy, A Comprehensive Review. © World Bank. Annex 4.

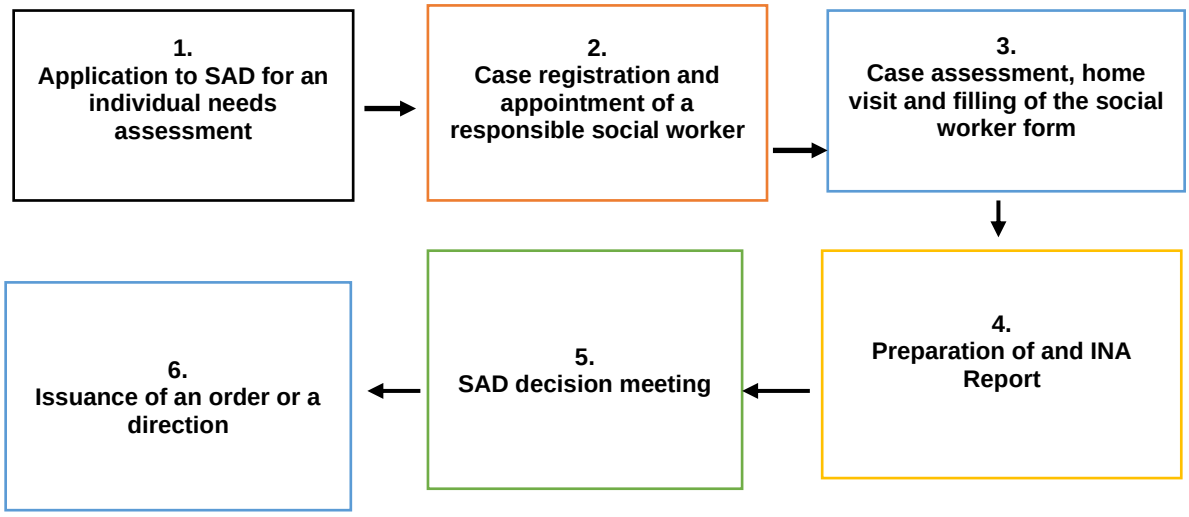
However, looking at the instruments used for the INA, except for sections 4 and 5 to determine the level of dependency and number of hours of personal assistance, other sections mostly look like screening for benefits eligibility, not an assessment of functioning and needs to improve it.

The methodology for determining the personal assistance need is the most detailed (only adults with a disability percentage of 90 or more, or a child with a disability percentage of 50 or more are eligible). The determination of the number of hours of personal assistance is based on the degree of dependency/difficulty and by age group (18 years and over, 12-18 years, and under 12 years). In Part 7 of the social workers form, a total score is calculated as the sum of the scores under the designated sections of Parts 4 and 5 (4.1 - 4.4 and 5.1 – 5.3). This score is then multiplied by 1.234 for people 18 years and above, by 1.313 for those between 12 and 18, and by 1.556 for children under 12. The result, once rounded up, is the maximum number of hours of personal assistance per month. It is not clear how these coefficients have been determined and why they are applied.

Administrative process

The assessment is conducted by a specialized municipal unit of SAA called the Social Assistance Directorate (SAD).[34] The primary functions of the SAD are to conduct INA and provide benefits and support to persons with disabilities as approved by the needs assessment process. SAD is also responsible for providing information and relevant documents (from SAD office or on SAA website) to persons requesting individual needs assessment.[35] All activities of the SAD are managed and supported methodologically by the SAA Regional Directorates, which are organized on a regional basis, according to the administrative division in the country. Methodological support is only provided if requested for a specific case. As noted, the overall process of INA is regulated by the Regulation on the Implementation of Persons with Disabilities Act (Regulation PDA).[36] Figure 2 presents the key INA administrative steps.

Figure 2: PDA Individual Needs Assessment administrative process flow chart



The PDA distinguishes between INA for personal assistance and assessment for other available supports. If the applicant requests personal assistance, then Parts 4 and 5 of the Social Worker Form

[34] Article 21 of the Persons with Disabilities Act. Ibid.
[35] Article 6 of the Social Protection Act. https://lex.bg/laws/ldoc/2134405633/
[36] Articles 14-20. Regulation on Implementation of the Persons with Disabilities Act. https://www.lex.bg/bg/laws/ldoc/2137192229/.

need to be completed, and sections V-VII of the Self-Assessment Form are required; for other benefits and services these are not required. The process for other benefits and services is, as noted, only checking if a person meets eligibility requirements. The needs are assessed only for personal assistance, where the methodology is more complex as a level of dependency is determined and the number of hours of assistance computed.

The INA process is demand based and thus assumes that a person knows which services she/he needs (the person must list the support interventions she/he needs in the application and the self-assessment form). This may not necessarily be correct. Moreover, it is not consistent with the purpose of the needs assessment – to assess the state of functioning of a person with a disability in her/his environment and determine needs for interventions that would improve functioning (and are provided in Bulgaria). While a person may list the services that she/he believes she/he needs and wishes to benefit from, it is the needs assessment that should determine the needs. (Note that persons with disabilities are eligible to receive most benefits irrespective of the needs assessment. Even for personal assistance it is the number of service hours that is determined, not the right per se. The right is guaranteed to all adults with at least 90 percent degree of disability.

Below we briefly present the INA steps:

Application to SAD for INA: Once a person has received from TMEC/NMEC a disability certificate, to receive support measures, she/he must apply for an INA by submitting to a SAD office the following: an application requesting an individual needs assessment and specifying requested benefits, completed Self-Assessment Form, identity card, a copy of the TMEC or NMEC decision, and copies of medical documents, including the documents required for the eligibility criteria (listed in the relevant legislation) for each requested benefit.

***Case registration and assignment of a social worker*:** A SAD office registers the application electronically and issues the application number. The head of the SAD assigns a social worker to handle the case.

***Case review, home visit and filling of the Social Worker Form*:** The assigned social worker reviews submitted documents and if some documents are missing, he or she may request them from the applicant within 14 days from the application. The social worker may also require documents or data from public agencies if required to complete the Social Worker Form (e.g., tax administration or access to labor contracts data base). If the benefit requested is personal assistance or a living space adaptation, the social worker will conduct a home visit and may interview the person with respect to the questions in the Self-Assessment Form. When personal assistance is requested, and the entire Self-Assessment and Social Worker Forms are used, then the primary purpose of the home visit and interview is to determine the level of dependence and the number of hours of personal assistance to be provided as regulated by PAA. It should be remembered that it is the TMEC/NMEC that decides that adults with a disability of over 90 percent (or 80 percent, when one or more comorbidities that cause more than 50 percent degree of disability) and needs personal assistance ("assistance by others"). The needs assessment only serves to determine the level of assistance.

***Preparation of the INA Re*port:** The responsible social worker completes the Social Worker's Form based on the findings from the Self-Assessment Form and the home visit and interview. As mentioned, only when personal assistance is requested, the sections V-VII of the functioning part of the Self-Assessment Form, and Parts 4 and 5 of the Social Worker's Form are completed. Nonetheless, sufficient information to support the need for personal assistance and other requested benefits and services (purchase of a personal vehicle, living space adaptation, rehabilitation and balneotherapy services and targeted support for assistive technology, devices, facilities, and medical equipment) must be collected. It is not clear whether and when supporting documentation for these benefits is

formally required, but it is a practice of SAD (SAA) to request applicants to present all required documentation together with the application to save time. The social worker also drafts the third section of the INA Form, "Conclusions with findings and proposed support measures".

***SAD decision meeting*:** The head of the SAD unit and social workers who are handling INA cases meet at least once a month to discuss all submitted applications and drafts of INA reports prepared by social workers. Other specialists or experts may be invited to participate. After a discussion, the unit prepares the third section of the Report "Conclusions with specific supportive measures". Decisions with respect to supportive measures are discussed and approved, rejected, or revised based on the opinion of the meeting participants. The applicant, a representative, guardian, or parent of the applicant may attend the meeting (at least a three-day notice of the meeting should be given).

The INA Report, with completed conclusions regarding individual support measures is issued in two copies, one of which is handed over to the applicant or her/his representative.

***Issuance of an Order or a Direction*:** After the INA has been completed, the administrative forms required for the provision of requested benefits are issued. The formal document is issued by a head of SAD within 10 days from the issuance of the conclusions from the individual needs assessment, or the presentation of remaining requested documents. This formal document may either be **an order** (to SAA to process a particular benefit) or **a direction** (a referral to other agencies). An order for issuing financial support is applicable for the benefits listed under PDA and provided by SAA. A direction is applicable for personal assistance under PAA, for social services under SAA (only available as of 2022), and for 'other type of support' under PDA. Both orders and directions are given on paper to the person together with the INA conclusion. The person needs these documents when approaching the municipality responsible for provision of personal assistance or social service provider. There is no regulation about sending the document to the responsible institution without the involvement of the person. The person must receive this document personally and then submit it to the relevant institution on his or her own. This is something that can be changed by the introduction of automatic referrals and electronic transmission of documents. PDA states that the validity of the INA is linked to the duration of TMEC/NMEC decision. For persons with TMEC/NMEC decisions for life, a duration of the INA is five years. A new INA can be issued within that time if there is a TMEC/NMEC decision or if there is a change in the person's needs and requested support.

***Grievance redress system*:** The formally regulated INA grievance redress system has two steps. In the first instance, a person who has undergone the INA may submit a grievance either to the head of SAD or to the executive director of SAA. This grievance will be reviewed either by SAA or SAD and it may be rejected, or directions given to SAD to reassess the case. Within a month after having received the appeal, either SAA or SAD will send a letter to the person informing him/her whether the appeal has been approved or rejected. If not satisfied, the person may submit an official complaint to the Administrative Court.[37] This is a standard grievance redress system administrative and institutional set up used in many EU countries: in the first instance, a person can file a grievance with a government body responsible for a specific administrative decision. If not satisfied, the next step is filing a grievance with the Administrative Court that is responsible for handling complaints pertaining administrative decisions of various government bodies.

[37] Article 24, paragraph 5. Ibid.

Key findings and recommendations

Findings

The introduction in 2019 of the individual needs assessment of persons with work incapacity and type and degree of disability is an important step in the implementation of UNCRPD in Bulgaria. UNCRPD mandates that persons with disabilities have the right to the provision of health and social services "based on the multidisciplinary assessment of individual needs and strengths".

As implemented in practice, the PDA INA methodology is yet to be consistent with the modern concept of disability. PDA created the legal right of persons with disabilities to a complex and individual assessment of needs that examines "the functional difficulties of a person with a disability, related to her/his health condition and the presence of barriers in the performance of daily and other activities, as well as the type of support needed." This statement reflects the concepts of functioning and disability found in the WHO's ICF, as well the UNCRPD's characterization of 'persons with disabilities'. However, although the NAM describes disability as a problem in functioning, functioning itself is characterized as a capacity of the body not, as in ICF, the outcome of an interaction between the capacity of the body and environmental factors. Moreover, unlike the ICF, the environment – called 'possibilities' – is described as preventing "the person with a disability from fulfilling its functionality through relevant actions," rather than, as in the ICF, creating the level of functionality in the person's performance of activities. As these differences are fundamental, it is hard to say that the current INA described in NAM is consistent with the ICF.

Currently PDA INA plays a limited role as a needs assessment procedure. Within the current context of medical certification of disability and eligibility rules for support measures to persons with disabilities, INA plays a limited role. Decisions on the needs for important support measures, such as personal assistance or the need for technical aids is *de facto* made by Medical Assessment Committees (MAC) – in the case of temporary disability and TMECs/NMEC as part of disability certification. Thus, INA serves as an instrument to determine the level (hours) of personal assistance and as an eligibility screening tool for measures administered by SAA or a referral tool for measures implemented by other government bodies (where, such as the case of social services, additional needs assessment may be conducted).

INA assesses the needs only in cases where personal assistance is deemed necessary by TMEC/NMEC decision. Even in this case, the need for personal assistance is formally determined by TMEC/NMEC. INA only serves to assesses the level of dependence, so that the number of hours of personal assistance can be determined. In the case of all other support interventions for which it is used, INA only serves as simple eligibility screening, not a needs assessment, tool.

Medical approach to disability permeates. The certification of disability in Bulgaria is exclusively made based on medical criteria. This approach is not consistent with the functioning approach to disability used in INA. In addition, the social worker form (in Part 3) introduces the notion of "functional insufficiency" (intellectual, physical, psychological, sensory and "other illnesses") in a "yes"/"no" answer format, which has nothing to do with functioning, but it seems to pertain to impairment/medical diagnosis. Information on functioning is collected only in the case when a person requests personal assistance. Thus, it is difficult to understand how the needs are assessed without first assessing problems in functioning experienced by a person with a disability.

While legal provision stipulate that needs assessment should focus on functioning, the tools used for INA are heavily focused on disability as a medical issue. Looking at the tools, the following is observed:

The Social Worker Form

Part 2: Medical Expertise Findings and Part 3 Information on the functional insufficiency/health condition of the person with disability is unnecessary as the full NMEC/TMEC/MAC report should already be available. In addition, Part 3 introduces a completely different concept ('functional insufficiency') that serves no function in the assessment.

Part 4: Information on the existing problems with the functioning of the person with disabilities and

Part 5: Information on the impact of constraints on the life of the person with disability are only used to determine the level of dependency and the number of hours of personal assistance. It is far more detailed than is required for that purpose. In addition, in parts 'total scores' are calculated merely by adding up the scores for each question, but the result is technically questionable since the scores for each question are not comparable and cannot be added together. Moreover, the initial score is augmented by coefficients, but it is not clear why and which methodology was used to determine them. This total score is then brought forward in 7.3 Need for personal assistance. There is no justification or rationale for how this total score affects the decision.

Part 6: Participation in education or in the labor market only asks the open-ended question 'What kind of support is the person with disability applying for?' but gives no indication of whether that support is needed or on what basis that decision is made.

Part 7: People surrounding the person with disability and need for social services/personal assistance,

Part 8: Targeted aid, and Part 9: Provision of monthly financial support merely record the eligibility decisions about several kinds of supports (personal assistance, housing, technical aids, and medical devices, financial support for motor vehicle, balneological treatment and/or rehabilitation services, monthly financial support). By legal provisions, persons with disabilities are eligible to receive these benefits if they meet eligibility conditions. In their case, the social worker checks eligibility, not the need.

Part 10: Wishes of the person with disability and additional information merely repeats information already collected or asks about the person's motivation for social integration. Again, there is no indication how this information is used.

In summary, the social worker form either collects information already collected (parts 2,3) or records if a person meets eligibility requirements for support without even indicating what evidence was used or what the basis for the decision was. In the case of personal assistance, the scoring mechanism is technically questionable as it is not technically founded to simply add up scores from different domains because, *inter alia*, they are not commensurable.

The Self-assessment Form

The Self-assessment Form is a long list of questions, including a series of questions in seven domains of functioning with answers in a “yes” and ”no” format. Many questions pertain to demographic information that should already be available from TMEC/NMEC and the civil registry. The “yes”/”no” format severely limits the value of information that is collected through this questionnaire. Conversation with social workers suggests that many persons with disabilities find it difficult to fill in the questionnaire. Moreover, the self-assessment plays a limited role in the assessment.

Administrative process to apply for the individual needs assessment is complex and time-consuming. The applicants are required to submit documents, most of which should be available in the Civil Registry, Information System for Control of Medical Expertise/Regional Files of Medical Expertise

Medical Files, Social Security Institute, National Employment Agency, Tax Administration, etc., and an applicant should not be asked to provide them, save for an application, identity document and a self-assessment form. Even an application submission could be eliminated, and each person who has gotten a certificate from TMEC/NMEC (or a referral from MAC) could automatically be referred to SAD for a needs assessment. A referral could also include (agreed) documents in electronic format. A person with a disability could then be invited to submit a self-assessment and indicate which service she/he would wish to receive (he or she should be given information about all benefits available to persons with disabilities). Ideally, parts of the needs assessment templates should be populated automatically, including personal information, TMEC/NMEC certificate information, etc.

Methodological guidelines and instructions on how to conduct PDA INA need strengthening. Existing guidelines, methodological explanations, and instructions on how to conduct INA need to be strengthened by a detailed explanation of what is meant by the description of each qualifier in each domain, use of vignettes, how to observe cross dependency across domains and spot inconsistencies that require further probing. Instructions on how to assess the environment need expansion too. Collecting information on functioning necessitates a deep understanding of functioning and a modern concept of disability as conceptualized by ICF.

Recommendations

Considering that the needs assessment is new, and that the implementation thus far could be considered as trial and a learning period, based on the above observations, we **recommend**:

- ***Use INA as a needs assessment tool, not a tool for support interventions' eligibility screening.***
- ***Revise the needs assessment tools*** to collect information on problems in functioning, identify the needs the fulfillment of which within the existing services and support measures can improve functioning and the experience of persons with disabilities in their everyday life, and, considering the wishes of persons with disabilities, link them to the support measures and institutions that provide them. Make appropriate changes in the TMEC/NMEC decision-making process, including eliminating medical information from the needs assessment tools.
- ***Apply a full needs assessment to all persons with disabilities***. This might be time and effort-consuming, but it is consistent with legal requirements and the rollout could be gradual.
- ***Consider having TMEC/NMEC/MACs recommending (not deciding on) support measures and make decisions only after a full functioning and needs assessment has been completed***.
- ***Simplify administrative process*** by introducing an automatic referral from TMEC/NMAC to individual needs assessment, minimizing documents requirements from the applicant and using advanced information systems already in operation to automatically pull out personal and other information and documents.
- ***Modify the self-assessment form to focus on environmental questions (barriers and facilitators)*** and include a selection of ICF categories with a rating scale 0-4, rather than the current YES and NO response options. Prepare a guide to make it easier for applicants to fill it out.
- ***Prepare expanded and strengthened technical guidelines and methodological instructions and regularly (re)train*** staff in their implementation. Staff skills are crucial for INA proper implementation.
- ***Develop a separate INA instrument for children.*** Disability of children and their needs are different from adults and the INA instrument should be developed to respond to what the children specific characteristics are.

- ***Establish a technical and methodological individual needs assessment unit in SAA*** (or the Disability Policy Directorate of MLSP) that would conduct econometric and statistical analyses of the INA data and monitor the trends.

Pilot testing of the revised needs assessment tool

Based on the INA review findings and recommendations, in collaboration with the Social Assistance Agency and after a careful study of similar instruments used in England, France, Germany, and Serbia, the INA tool was revised, and pilot tested. The revised tool was designed to serve as a needs assessment tool that also identifies the need for personal assistance and its extent (number of hours). In this way, the tool more closely reflects the intent of PDA regarding INA (see section on legal framework above). The objective of the pilot- testing was to explore how it relates to disability as determined by TMEC/NMEC, as well as to the functioning assessment WHODAS score. More importantly, the objective of the pilot was to test how the social workers and the beneficiaries found the instrument – its usefulness for the purpose of determining the needs and ease and comfort of its implementation. Below we present the pilot-testing results.

Descriptive statistics of the revised INA pilot sample

A sample of 561 person was randomly selected from the WHODAS pilot sample of 3,118 individuals, to participate in the pilot testing of the revised INA instrument. All of them had previously undergone INA, as part of the administrative procedure to establish their eligibility for the requested disability support measures. To be able to request personal assistance, a person with a disability must be certified by TMEC to have a degree of disability of 90-100 percent and that she or he needs personal assistance. The data collection field work was implemented in June 2022 by 51 social workers of the Social Assistance Agency. Majority of interviews were face-to-face (82.4 percent), 13.9 percent were over the phone and 3.7 percent over a video call.

Table 5: INA instrument pilot test sample descriptive statistic

N	**561**
Gender	
Female	313 (55.8%)
Male	248 (44.2%)
Age (mean, years)	55.68
Years of Education - mean	11.75
Marital Status	
Never married	141 (25.2%)
Currently married	256 (45.7%)
Separated	12 (2.1%)
Divorced	46 (8.2%)
Widowed	82 (14.6%)
Cohabiting	23 (4.1%)
Living Condition	
Independent in the community	549 (98.0%)
Assisted living	9 (1.6%)
Hospitalized	2 (0.4%)
Work Status	
Paid work	136 (24.5%)
Self-employed	10 (1.8%)
Student	1 (0.2%)
Retired	169 (30.5%)
Unemployed (health reasons)	209 (37.7%)
Unemployed (other reasons)	25 (4.5%)
Other	5 (0.9%)

Characteristics of the sample are presented in Table 5. Three quarters of the sample population (75.6 percent) were cases of disability recertification. About one fifth (19.6 percent) were older people for whom TMECs assessed the degree of disability, and 80.4 percent were working-age adults in whose case TMECs certified the degree of permanently reduced work capacity (a reminder that in both cases, for simplicity and clarity, we use the term persons with disabilities). More women than men (55.8 and 44.2 percent, respectively) participated in the pilot test. The average age was 55.7 years, reflecting the fact that most of persons with disabilities in Bulgaria are over 50 years of age. Most participants were currently married (45.7 percent), 14.6 percent were widowed, 8.2 percent were divorced, and 4.1 percent were cohabiting. A significant share – one fourth – reported to have never being married. This is an important information for policy planning as they are likely to need more support from the social services as they age. Almost all participants lived independently in the community (98.0 percent). The participants had an average of 11.7 years of education. Most reported either being unemployed for health reasons (37.7 percent) or being retired (30.5 percent). Only about one-fourth (26.3 percent) reported being employed or self-employed.

Chronic diseases as determinant of disability dominate. Looking at the health conditions of the participants (i.e., main diagnosis in ICD-10 codes), neoplasms (N=128; 22.4 percent) and diseases of the circulatory system (N=122; 21.4 percent) dominate. Mental and behavioral disorders were reported by N=76 or 13.3 percent of participants. ICD chapter VI Diseases of the nervous system are seen as primary diagnosis in about 10.6 percent of participants (N=58). ICD chapters IV Endocrine, nutritional, and metabolic diseases, XII Disease of the musculoskeletal system and connective tissue, and IV Diseases of the eye and the adnexa are seen in a little more than 5 percent of the individuals that did the need assessment. Table 6 presents the frequency and percentages of observed ICD-10 diagnostic chapters for the applicants' main health condition

Table 6: Prevalence of health conditions in the study population by ICD-10 Health Condition Category

ICD-Chapter	N	%
I Certain infectious and parasitic diseases	1	0.18
II Neoplasms	128	22.42
III Diseases of the blood	4	0.70
IV Endocrine, nutritional, and metabolic diseases	40	7.01
V Mental and behavioral disorders	76	13.31
VI Diseases of the nervous system	58	10.16
VII Diseases of the eye and adnexa	31	5.43
VIII Disease of the ear and mastoid process	5	0.88
IX Diseases of the circulatory system	122	21.37
X Diseases of the respiratory system	4	0.70
XI Diseases of the digestive system	7	1.23
XII Diseases of the skin and the subcutaneous tissue	2	0.35
XIII Diseases of the musculoskeletal system and connective tissue	36	6.30
XIV Diseases of the genitourinary system	15	2.63
XVII Congenital malformations, deformations, and chromosomal abnormalities	5	0.88
XIX Injury, poisoning and certain other consequences of external causes	22	3.85
XX External causes of morbidity and mortality	3	0.53
XXI Factors influencing health status and contact with health services	12	2.10

About 60 percent of the sample population reported a very severe degree of disability (90 and above 90 percent). Table 7 presents descriptive statistics for the INA pilot-test sample by level of disability severity ranking group. About 60 percent of the applicants were certified as having a very severe disability (N = 338). Relative to the whole sample, persons in this group were older (mean age 58.5). With higher disability severity, the likelihood of being employed decreases. In the moderate and

severe disability ranking groups, respectively 49.5 percent and 42.4 percent have a paid employment and only 10.7 percent in the very severe disability ranking group. On the other hand, the percentages of retired (40.1 percent) and unemployed applicants (44.5 percent) were significantly higher in the very severe disability ranking group. These characteristics are not unexpected, as disability and its severity increase with age.

Table 7: INA sample descriptive statistics by certified disability severity (moderate: 50-69.99%; severe: 70-89.99; very severe: 90-100%)

	Moderate	Severe	Very Severe
N	104 (18.7%)	118 (21.1%)	338 (60.4%)
Gender			
Male (%)	36 (34.6%)	49 (41.5%)	163 (48.2%)
Female (%)	68 (35.4%)	69 (58.5%)	157 (51.8%)
Age (mean, years)	52.8	50.2	58.5
Years of education (mean, years)	12.86	11.95	11.34
Marital status (% of the total in parentheses)			
Never married	21 (20.2)	44 (37.3)	76 (22.5)
Currently married	56 (53.8)	51 (43.2)	149 (44.1)
Separated	5 (4.8)	2 (1.7)	5 (1.5)
Divorced	6 (5.8)	6 (5.1)	34 (10.1)
Widowed	5 (4.8)	11 (9.3)	66 (19.5)
Cohabiting	11 (10.6)	4 (3.4)	8 (2.4)
Living arrangement (% in parentheses)			
Living independent in the community	104 (100.0)	116 (98.3)	329 (97.3)
Assisted living	0 (0.0)	2 (1.7)	7 (2.1)
Hospitalized	0 (0.0)	0 (0.0)	2 (0.6)
Work Status (% in parentheses)			
Paid work	50 (49.5)	50 (42.4)	36 (10.7)
Self-employed	5 (5.0)	2 (1.7)	3 (0.9)
Non-paid work	0 (0.0)	0 (0.0)	0 (0.0)
Student	0 (0.0)	1 (0.8)	0 (0.0)
Keeping house	3 (3.0)	0 (0.0)	2 (0.6)
Retired	13 (12.9)	21 (17.8)	135 (40.2)
Unemployed (health reasons)	26 (25.7)	34 (28.8)	149 (44.3)
Unemployed (other reasons)	4 (4.0)	10 (8.5)	11 (3.3)
Other	0 (0.0)	0 (0.0)	0 (0.0)

Most frequently requested support interventions are financial support, balneotherapy, technical aids, road toll vignette, and personal assistance. Table 8 presents requested interventions by disability group severity. Almost all 99.5 percent requested financial assistance. This is expected because, in Bulgaria, persons with permanent disabilities 50 percent and over are eligible to receive it. One-third requested balneotherapy, 26.2 percent asked for support with technical aids, and 18 percent requested support for transportation (mainly the free road toll electronic vignette). The number of requests increases by the severity of disability, reflecting the fact that eligibility for certain interventions depends on disability severity, with the severe disability group being entitled to all interventions.

Personal assistance was requested by 33.0 percent of the INA pilot sample population. As a reminder, in Bulgaria, a person with a disability must be certified by TMEC to have a degree of disability

of 90 percent or higher and to need personal assistance. The INA establishes only the level of dependence and the corresponding number of hours of assistance. According to the Law on Personal Assistance, personal assistance is a support mechanism for persons with disabilities for their full and active participation in society, to carry out activities corresponding to their personal, domestic, or social needs, to overcome obstacles to functional limitations, to help them exercise their fundamental rights, and to have opportunities for choice, independent living, and access to services and activities.[38]

Not all persons with a very severe disability requested personal assistance. Out of 338 persons with very severe disability in the sample, only 184 or 54.4 percent requested personal assistance. 20 (or 6.0 percent) did have a certificate that they needed a personal assistance but did not request it. The rest (almost 40 percent) could not request it, because TMECs did not certify that they needed it, although their disability was certified as very severe (90 percent and over). It is not clear how TMECs determine the need for personal assistance and why almost half of the severely disabled persons in our sample were not certified to need it. As discussed in Part One of this Report, the disability certification in Bulgaria is based on medical criteria, posing a question about how the provision from the Law on Personal Assistance pertaining to activities and participation in life and to overcome "functional limitations" are considered by TMECs when determining the needs for personal assistance.

Table 8: Requested types of interventions – total and by severity of disability

	Total	Moderate	Severe	Very severe
Personal assistance	185 (33.0%)	0 (0%)	1 (0.2%)	184 (32.9%)
Financial support	557 (98.8%)	103 (18.4%)	117 (20.9%)	337 (60.2%)
Support for family member	25 (4.5%)	5 (0.9%)	9 (1.6%)	11 (2.0%)
Transport	101 (18.0%)	22 (3.9%)	25 (4.5%)	54 (9.6%)
Parking	45 (6.2%)	9 (1.6%)	9 (1.6%)	27 (4.8%)
Social services	19 (3.4%)	1 (0.2%)	6 (1.1%)	12 (2.1%)
Residential accommodation	8 (1.4%)	0 (0%)	1 (0.2%)	7 (1.3%)
Balneotherapy	187 (33.35)	1 (0.18%)	1 (0.2%)	185 (33.0%)
Technical aids	147 (26.2%)	10 (1.8%)	17 (3.0%)	120 (21.4%)
Employment assistance	6 (0.1%)	3 (0.5%)	1 (0.2%)	2 (0.4%)
Home adaptation	10 (1.8%)	1 (0.2%)	2 (0.4%)	7 (1.3%)
Rental subsidy	7 (0.1%)	0 (0%)	2 (0.4%)	5 (0.9%)
Other services	21 (3/7%)	2 (0.4%)	4 (0.7%)	15 (2.7%)

Most of the persons who requested personal assistance were assessed as having the highest degree of dependence (degree 4 or total dependence). Of 185 individuals who requested personal assistance in their application for needs assessment, 86.6 percent were found eligible for personal assistance with the highest degree of dependency – the 4th degree (and a full-time – 168 hours per month – personal assistance); 8.6 percent with a 3rd degree of dependence (84 hours of assistance per month) and the rest (4.8 percent) with degrees 1 and 2 (15 and 42 hours of personal assistance per month).

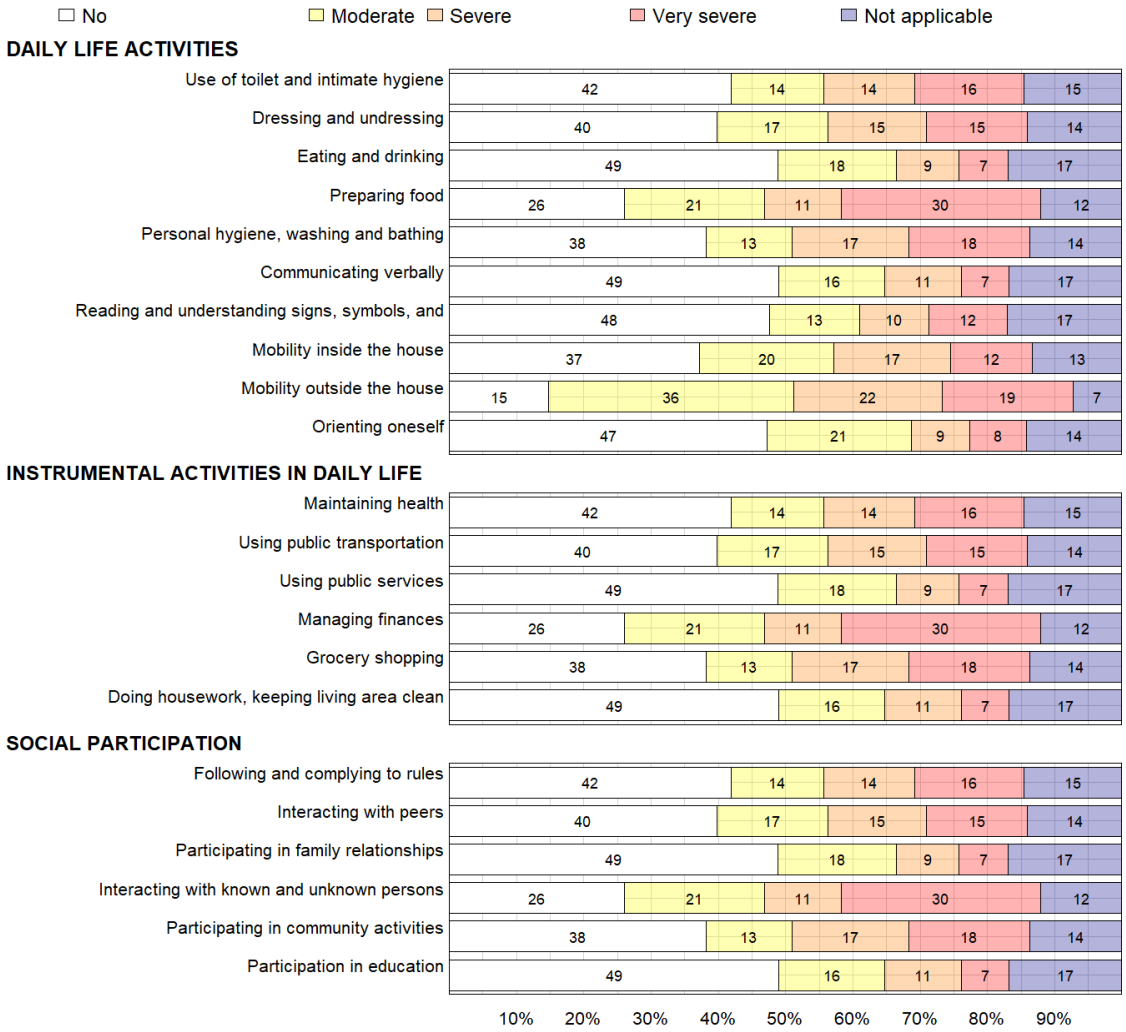
The pilot-test results

Below, we present the results from the pilot testing the revised instrument. The key section in INA tool that serves as a basis to put together the personal profile of functioning and corresponding needs contains 24 questions representing *categories* in the ICF terms, with four response options: no, moderate, severe, and very severe difficulties. Each response option is briefly described in the

[38] http://extwprlegs1.fao.org/docs/pdf/bul204057.pdf/

questionnaire to help the social worker conducting the interview choose appropriately. Figure 3 presents the results concerning reported difficulties in 24 categories of activities and participation.

Figure 3: Reported difficulties in daily life because of disability by activities and participation categories (in %)



The revised INA instrument suggests that many more persons with disabilities need assistance by others than under the current system. Under the current system, 185 (33 percent) out of 561 persons with disabilities in the pilot-test sample requested personal assistance based on the TMECs decisions. In the pilot, considering answers pertaining to the 24 categories of activities and participation (see above) and looking at other information collected, an individual profile of functioning was created and described in detail. Based on this functioning profile, the need for personal assistance was determined, and for those assessed to need assistance, the level of dependence and the number of hours of personal assistance was determined. The result is that 250 persons or 44.6 percent out of the test pilot sample have a functioning profile that requires assistance by others (Table 9). Among them, 172 or 69 percent were assessed to need full-time assistance (level 4 dependence; 168 hours of assistance per month); 34 (13.6 percent) to need part-time assistance (level 3 dependence; 84 hours per month of personal assistance); 17 (6.8 percent) level 2 dependence with 42 hours of personal assistance per month; and 27 (10.8 percent) level 1 dependence with 15 hours per month of personal assistance).

Table 9: Needs assessment pilot sample by estimated level of dependence (% in parentheses)

	No	1st Level Moderate	2nd Level Grave	3rd Level Very Grave	4th Level Total
TOTAL	311 (55.4)	27 (4.8)	17 (3.0)	34 (6.1)	172 (30.7)
Gender					
Male	125 (40.2)	8 (29.6)	7 (41.2)	23 (67.6)	85 (49.7)
Female	186 (59.8)	19 (70.4)	10 (58.8)	11 (36.4)	87 (50.3)
Age (mean, years)	52.70	54.78	61.65	58.47	60.10
Education (mean years)	12.54	11.19	9.41	11.79	10.63
Marital Status (%)					
Never married	78 (25.1)	9 (33.3)	7 (41.2)	5 (14.7)	42 (24.6)
Currently married	149 (47.9)	10 (37.0)	6 (35.3)	17 (50.0)	74 (43.3)
Separated	11 (3.5)	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.6)
Divorced	22 (7.1)	1 (3.7)	0 (0.0)	5 (14.7)	18 (10.5)
Widowed	36 (11.6)	6 (22.2)	3 (17.6)	5 (14.7)	32 (18.7)
Cohabiting	15 (4.8)	1 (3.7)	1 (5.9)	2 (5.9)	4 (2.3)
Living Condition (%)					
Independent in the community	305 (98.1)	27 (100.0)	16 (94.1)	34 (100.0)	167 (97.7)
Assisted living	4 (1.3)	0 (0.0)	1 (5.9)	0 (0.0)	4 (2.3)
Hospitalized	2 (0.6)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Work Status (%)					
Paid work	126 (40.9)	5 (18.5)	0 (0.0)	2 (5.9)	3 (1.8)
Self-employed	10 (3.2)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Student	1 (0.3)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Retired	57 (18.5)	9 (33.3)	9 (52.9)	10 (29.4)	84 (49.7)
Unemployed (health reasons)	96 (31.2)	12 (44.4)	4 (23.5)	21 (61.8)	76 (45.0)
Unemployed (other reasons)	15 (4.9)	1 (3.7)	3 (17.6)	1 (2.9)	5 (3.0)
Other	3(1.0)	0 (0.0)	1 (5.9)	0 (0.0)	1 (0.6)

Data in Table 9 show that those assessed as not needing personal assistance are younger (on average 52.7 years old) and more likely to have a paid employment (40.9%) than those with higher levels of dependency. For example, individuals assessed to have the highest level of dependency were older (60 years on average), almost half were retired, and another 45 percent were unemployed due to health reasons.

INA and disability status assessment based on functioning (WHODAS)

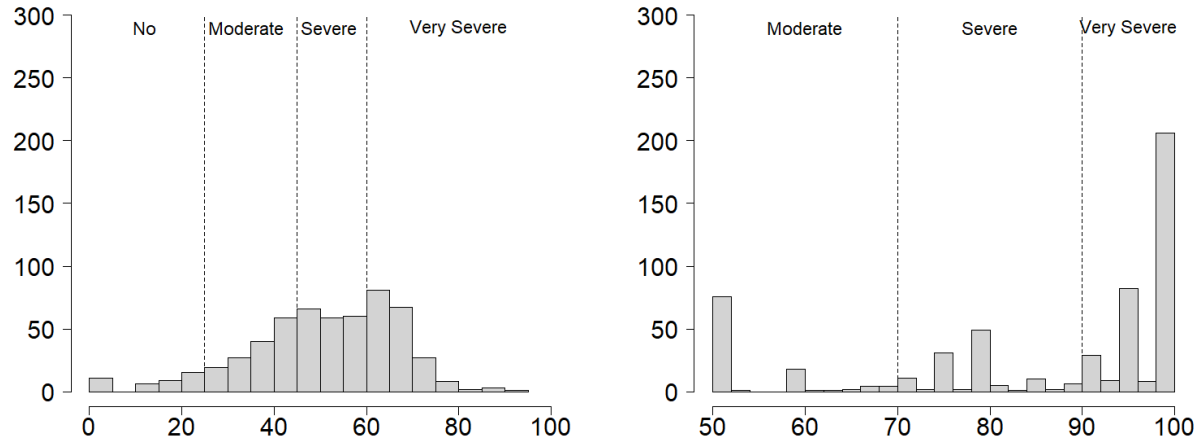
Throughout this Report we have made a case for the need to harmonize the methodology for disability status assessment and the needs assessment in Bulgaria. Currently, the former is based on medical criteria and the latter uses functioning in its conceptualization of disability.

The disability assessment in Bulgaria assigns percentages of disability based on medical criteria, where 50 or higher percentage is the basis for the certificate of disability. The certificate opens the gate to disability benefits whose menu depends on the degree of disability: 50-69.99 percent (moderate), 70.00-89.99 percent (severe), and 90-100 percent (very severe). To explore options to include functioning into disability assessment, as described in Part One of this Report, we piloted the WHO disability measurement tool WHODAS. Using statistical tools, we transformed the WHODAS raw scores into a scale of 0-100 and distributed the WHODAS pilot sample population into disability groups (no, moderate, severe, and very severe).

To investigate whether INA would benefit from a disability status assessment based on functioning we looked at the INA pilot-test population disability percentages, WHODAS functioning scores and needs assessment results. The results are presented below.

The current medical assessment of disability does not differentiate well degrees of disability. This is important because access to different benefits depends on an accurately assessed degree of disability. The needs assessment cannot change that, even if it shows the obvious Figure 4 presents, for the needs assessment population, the distribution of the WHODAS scores and the disability percentages. The WHODAS scores follow a normal, albeit somewhat flat, distribution across the continuum. On the other hand, disability percentages polarize, especially in the two extremes with the lowest (50 percent) and the highest (100 percent) disability. The WHODAS scale, thus, results in a more refined assessment on the 0-100 continuum.

Figure 4: Distribution of WHODAS scores and disability % by cut-off groupings



Like for the entire WHODAS pilot sample, the needs assessment sub-sample also presented moderately correlating WHODAS functioning scores and disability percentages (r = 0.52) – Figure 5. Figure 5 further shows that high functioning scores based on WHODAS, i.e., scores ≤ 25, are also found in the group of persons who were certified by TMEC as needing personal assistance and that high as well as low functioning levels are observed for each disability severity ranking group (%), from moderate to very severe. In other words, medical-based disability assessment features not only imprecise determination of *the* percentage of disability, but also false positives and false negatives.

Figure 5: Disability percentages and WHODAS score distribution with respective cut-offs

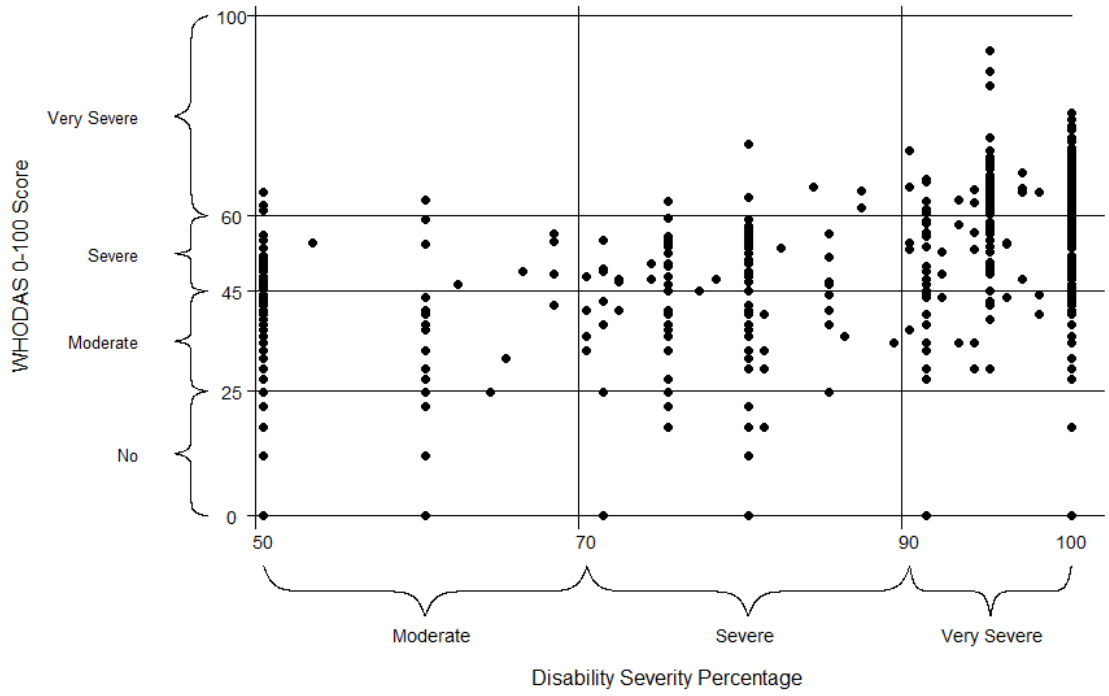


Table 10 presents descriptive statistics for the needs assessment sample by level of disability based on the WHODAS score. Forty participants in the pilot (7.3 percent) had a WHODAS score below or equal to 25, indicating no functioning problems, i.e., no disability. About 33.8 percent of the participants were categorized as having a very severe disability (N = 189). This is significantly smaller than 338 individuals in the sample certified by TMECs as having a disability degree of 90 or more percent. On the other hand, 33 percent (N = 185) had a WHODAS score that placed them into a group of severe functioning restrictions (disability); much higher than the number of persons in the sample, certified as having a severe disability (118 persons). This is consistent with the observation from the WHODAS pilot itself that WHODAS functioning scores discriminate better different levels of disability, which Is not the case with the medical assessment (Figure 5).

There are more women than men in the moderate and severe disability grouping; the proportion is almost equal in the very severe disability group. The age increases significantly across disability groups, from 50 percent in the group of persons with no disability to 60 percent in the group of persons with very severe disability. The number of years of education, on the other hand, decreases significantly, the mean number of years being highest in the group of persons with no functioning problems. Most individuals in the group with the highest disability severity are either retired (49.2 percent) or unemployed for health reasons (46 percent). Employment decreases with the level of disability: no disability: 75 percent are employed; 49.7 percent in the moderate disability group, and 17.1 percent in the severe disability group. Almost no one is employed in the severe disability group. The situation with the unemployment is exactly the opposite.

Table 10: INA pilot sample characteristics by WHODAS-based disability severity (% in parentheses)

	No	Moderate	Severe	Very severe
N	41 (7.3)	145 (25.9)	185 (33)	189 (33.8)
Gender				
Male	16 (39.0)	59 (40.7)	77 (41.6)	96 (50.8)
Female	25 (61.0)	86 (59.3)	108 (58.4)	93 (49.2)
Age (mean; years)	50.1	51.4	54.9	60.9
Years of education (mean)	13.00	12.6	11.9	10.6
Marital Status (%)				
Never married	10 (24.4)	32 (22.1)	55 (29.7)	44 (23.3)
Currently married	20 (48.8)	74 (51.0)	82 (44.3)	80 (42.3)
Separated	3 (7.3)	4 (2.8)	4 (2.2)	1 (0.5)
Divorced	3 (7.3)	11 (7.6)	14 (7.6)	18 (9.5)
Widowed	3 (7.3)	14 (9.7)	24 (13.0)	41 (21.7)
Cohabiting	2 (4.9)	10 (6.9)	6 (3.2)	5 (2.6)
Living Condition (%)				
Independent in the community	41 (100.0)	143 (98.6)	180 (97.3)	185 (97.9)
Assisted living	0 (0.0)	0 (0.0)	5 (2.7)	4 (2.1)
Hospitalized	0 (0.0)	2 (1.4)	0 (0.0)	0 (0.0)
Work Status (%)				
Paid work	30 (75.0)	71 (49.7)	33 (17.8)	2 (1.1)
Self-employed	0 (0.0)	7 (4.9)	2 (1.1)	1 (0.5)
Non-paid work	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Student	0 (0.0)	0 (0.0)	1 (0.5)	0 (0.0)
Retired	1 (2.5)	23 (16.1)	53 (28.6)	92 (49.2)
Unemployed (health reasons)	8 (20.0)	30 (21.0)	85 (45.9)	86 (46.0)
Unemployed (other reasons)	1 (2.5)	8 (5.6)	10 (5.4)	6 (3.2)
Other	0 (0.0)	4 (2.8)	1 (0.5)	0 (0.0)

Data in Table 10 suggest that the WHODAS score discriminates disability groups well. The disability gradient increases in a way that is expected based on empirical evidence from other studies: increasing severity of disability with age, decreasing education years, decreasing paid work, increasing unemployment, etc.

Looking at the requested types of assistance by WHODAS score disability groups and by the certified percentage of disability groups, one observes significant shifting across groups (Table 11). The shift is mostly to the left, i.e., lower disability and in particular from very severe to severe disability. This is especially pronounced in the case of requests for technical aids and balneotherapy, where the majority of requests come from persons certified as having a severe disability. The shift in personal assistance is observed too, but it is much smaller.

Table 11: Requested support by WHODAS score disability severity and % degree of disability severity
(total sample population N=561; % in parentheses)

	WHODAS					Disability Severity Ranking Group		
Short Label	**Yes**	**No/mild**	**Moderate**	**Severe**	**Very severe**	**Moderate**	**Severe**	**Very severe**
Personal assistance	186 (33.0)	0 (0)	2 (0.4)	22 (3.9)	161 (28.8)	0 (0)	1 (0.2)	184 (32.9)
Financial support	558 (99.5)	40 (7.1)	144 (25.7)	185 (33.0)	188 (33.6)	103 (18.4)	117 (20.9)	337 (60.2)
Support for a family member	25 (4.5)	2 (0.4)	7 (1.3)	11 (2.0)	5 (0.9)	5 (0.9)	9 (1.6)	11 (2.0)
Transport	101 (18.0)	10 (1.8)	32 (5.7)	38 (6.8)	21 (3.8)	22 (3.9)	25 (4.5)	54 (9.6)
Parking	45 (8.0)	1 (0.2)	15 (2.7)	21 (3.8)	8 (1.4)	9 (1.6)	9 (1.6)	27 (4.8)
Social services	19 (3.4)	0 (0)	2 (0.4)	9 (1.6)	8 (1.4)	1 (0.2)	6 (1.1)	12 (2.1)
Residential accommodation	8 (1.4)	0 (0)	1 (0.2)	4 (0.7)	3 (0.5)	0 (0)	1 (0.2)	7 (1.3)
Balneological treatment	188 (33.5)	3 (0.5)	28 (5%)	57 (10.2)	99 (17.7)	1 (0.9)	1 (0.2)	185 (33.0)
Technical aids	147 (26.2)	6 (1.1)	22 (3.9)	32 (5.7)	87 (15.5)	10 (1.8)	17 (3.0)	120 (21.4)
Employment assistance	6 (1.1)	0 (0)	3 (0.54)	3 (0.5)	0 (0)	3 (0.5)	1 (0.2)	2 (0.4)
Home adaptation	10 (1.8)	0 (0)	0 (0)	7 (1.3)	3 (0.5)	1 (0.2)	2 (0.4)	7 (1.3)
Rental subsidy	7 (1.3)	0 (0)	0 (0)	5 (0.9)	2 (0.4)	0 (0)	2 (0.4)	5 (0.9)
Other services	21 (3.7)	0 (0)	3 (0.5)	8 (1.4)	10 (1.8)	2 (0.4)	4 (0.7)	15 (2.7)

Table 12: WHODAS and % based disability severity by pilot assessed degree of dependence (% in parentheses)

		No	1st Degree	2nd Degree	3rd Degree	4th Degree
TOTAL		**311 (55.4)**	**27 (4.8)**	**17 (3.0)**	**34 (6.1)**	**172 (30.7)**
WHODAS-score based disability group	No	41 (13.2)	0 (0)	0 (0)	0 (0)	0 (0)
	Moderate	131 (42.1)	5 (18.5)	6 (35.3)	1 (2.9)	2 (1.2)
	Severe	122 (39.2)	11 (40.7)	9 (52.9)	23 (67.7)	20 (11.7)
	Very Severe	17 (5.5)	11 (40.7)	2 (11.8)	10 (29.4)	149 (87.1)
Percent of disability group (the current system)	Moderate	98 (31.5)	4 (14.8)	1 (5.9)	1 (2.9)	0 (0)
	Severe	100 (32.2)	8 (29.6)	7 (41.2)	1 (2.9)	2 (1.2)
	Very Severe	113 (36.3)	15 (55.6)	9 (52.9)	32 (94.1)	169 8.8)

WHODAS scores predict levels of dependency and the need for personal assistance better than the current medically based percentages of disability. Table 12 presents for each assessed level of dependency in the pilot-testing of the revised INA instrument, the number, and percentages of disability severity groups categorizations, based on the WHODAS or the percentage of disability. As noted, 311 persons were assessed as not needing personal assistance. Among them, based on the WHODAS score, only 17 were "missed" by the needs assessment. In contrast, 113 persons with a disability percentage of 90 plus percent, were not assessed as in need of personal assistance.

Social workers' and respondents' feedback on the revised Needs Assessment Tool

To get feedback from the social workers and the pilot test participants, we asked 15 social workers and 20 respondents to complete a short survey. In the feedback, social workers and respondents shared their opinions and impressions regarding the revised needs assessment tool. In addition, a focus group discussion was held with a group of social workers.

Both persons with disabilities and the social workers reacted very positively to the revised needs assessment tool.

Respondents' views

A total of 20 respondents were asked three multiple-choice questions: Question 1: "The new needs assessment tool's questions were understandable to you?", Question 2: "The new needs assessment tool reflects the difficulties you face in everyday life?", and Question 3: "If you can remember the previous questionnaire (the one that was used officially, not as a pilot), and can compare them, which one would you prefer?". All 20 respondents responded to the survey. Figures 6 to 8 show the answers.

Figure 6: Question 1 - The new needs assessment tool's questions were understandable to you?

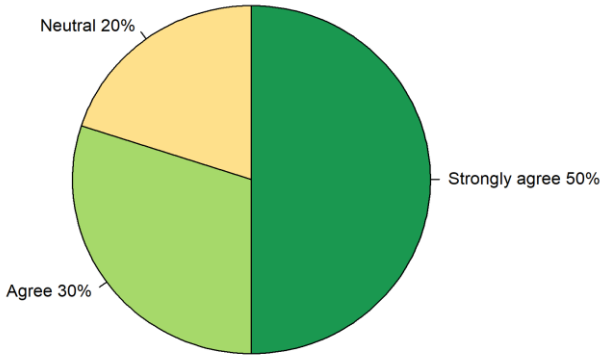


Figure 7: Question 2: The new needs assessment tool reflects the difficulties you face in everyday life?

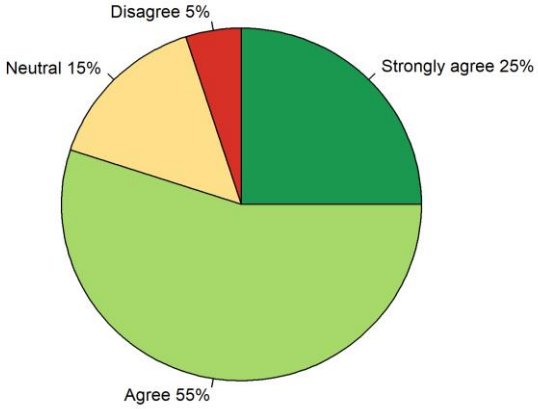
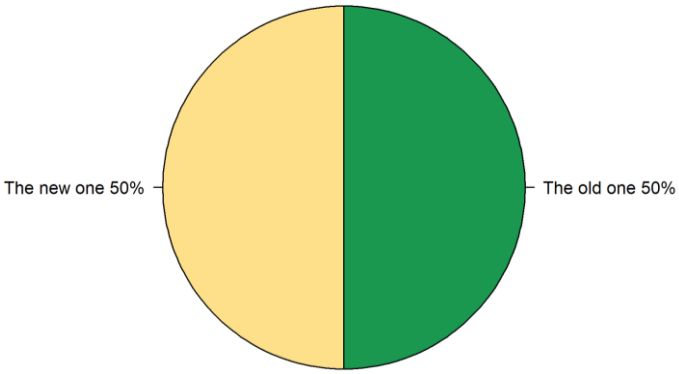


Figure 8: Question 3 - If you can remember the previous questionnaire (the one that was used officially, not as a pilot), and can compare them, which one would you prefer?



Majority – 80 percent of respondent confirmed that the questions were understandable and reflected difficulties they face in their everyday life. At the same time, they were split in half concerning whether they would prefer the new or the old instrument. This suggests that as SAA goes ahead with the current tool revisions, it should continue to consult persons with disabilities.

Social workers' views

The feedback from social workers on the revised needs assessment tool was favorable. Fifteen social workers were approached and all of them responded to 5 multiple choice question. The INA revised tool was perceived as a comprehensive assessment of functioning, activities, and participation: (i) 93 percent of surveyed social workers thought that the tool reflects difficulties that a person faces in everyday life; and (iii) 80 percent thought that the revised tool is more appropriate tool to evaluate persons individual needs than the current one. This favorable opinion on the revised tool was corroborated in the face-to-face focus group discussion with a group of social workers who participated in the pilot-test.

However, the social workers also noted that the tool took longer to complete than the current one, and some questions needed to be explained to the interviewees. All surveyed social workers made this point. Below are three randomly selected opinions (verbatim).

> *"The new Needs assessment tool takes longer to complete but is more comprehensive and gives a clearer picture of the health status, functionality and needs of the person with a disability in the section: assistance in daily activities, mobility, instrumental activities, social participation. It is a better tool in assessing the applicant's personal assistance needs."*
>
> *"It took me longer. It's more detailed and descriptive. Maybe over time I'll learn to fill it up faster, but at this stage it's taken me longer."*
>
> *The new Needs assessment tool takes longer to complete but gives a more accurate picture of the difficulties in everyday life, mobility, and social participation. It precisely defines the degree of need for personal assistance."*

Technical and methodological guide, training, and automatic pre-loading of the tool with personal and demographic information, and standardizing response options would help shorten the time needed to fill out the instrument. Many social workers made a point that the revised tool should be accompanied by a technical and methodological guide and that the social workers should be trained on how to use it. Also, Bulgaria has several information systems containing comprehensive information on persons with disabilities. The Social Assistance Agency is linked to and has an automated exchange of information with most of the government information systems. It should, thus, be able to prepopulate most of the INA tool, except for the part that pertains to the activities and participation information that should be collected in a face-to-face interview at the person's residence. Also, standardization of the assessment will not only lead to a faster assessment but will also reduce the fatigue of the interviewer and the interviewee. Further, a standardization especially of the response mode, through provision of predefined response categories to check will shorten the assessment time and make the collected data more fit for an in depth and rigorous analysis at individual and population level. A standardization will also increase the accuracy with easier reporting of the complex and multidimensional observations collected by the revised INA tool.

Should INA be multidisciplinary? Some social workers suggested that the INA should be multidisciplinary. While certainly a good idea, its implementation would increase the cost in terms of human resources and time needed to complete the assessment. A good example is France, where it takes several months (and often up to 8 months) to complete the needs assessment, which is multidisciplinary. The SAA social workers can consult, if needed, colleagues from other agencies, and skills development in areas such as mental health, rehabilitation, and psychology would increase their capacity to perform this holistic INA.

Based on the revised INA instrument pilot-test and feedback from the persons with disabilities and the social workers, the INA tool was revised and is presented below (Annex 1 to this Report). Furthermore, the self-assessment form was simplified and aligned with the INA tool as well (Annex 2 to this Report). As SAA moves ahead with the tool implementation, we recommend that (i) persons with disabilities and social workers are involved in all further steps; (ii) a methodological guide is developed, and (iii) all social workers are trained (with regular refresher courses) in topics related to disability, functioning and the needs of persons with disabilities, interviewing techniques and in general the INA tool administration.

Summary of findings with recommendations

The pilot testing of the revised INA instrument showed that significantly more people with disabilities need help from others than decided on by the current disability assessment system. The application of the revised instrument suggested that 250 persons from the pilot-test sample of 561 persons need some assistance by others. This is significantly higher than 185 persons in the sample who requested personal assistance based on their certified disability degree of 90 percent of over and determined need for personal assistance by a disability assessment commission.

Most of these persons in need of personal assistance were from the group of persons with severe disability (90 percent and over) for whom the disability assessment commissions did not determine the need for personal assistance. This signals that the assessment of needs, including for personal assistance should be a responsibility of the INA process, not pre-determined by medical expertise commissions.

The disability assessment based on functioning (WHODAS) and the individual needs assessment were aligned better than INA and the disability status assessment based on medical expertise. Hence, disability status assessment and the needs assessment approach to disability should be harmonized. To that end, a disability status assessment should include functioning as well.

Qualitative feedback from persons with disabilities and the social workers who participated in the pilot test of the revised INA tool was overwhelmingly positive. Both groups agreed that the tool reflects difficulties that a person faces in everyday life and that the revised tool was more appropriate to evaluate person's individual needs than the current one. However, the social workers also noted that the tool took longer to complete than the current one, and some questions needed to be explained to the interviewees.

Technical and methodological guide, training, automatic pre-populating of the tool with personal and demographic information, and standardizing response options would help shorten the time needed to fill out the instrument. Many social workers made a point that the revised tool should be accompanied by a technical and methodological guide and that the social workers should be trained on how to use it. Also, Bulgaria has several information systems containing comprehensive information on persons with disabilities. The Social Assistance Agency is linked to and has an automated exchange of information with most of the government information systems. It should, thus, be able to prepopulate most of the INA tool, except for the part that pertains to the activities and participation information that should be collected in a face-to-face interview at the person's residence. Also, standardization of the assessment will not only lead to a faster assessment but will also reduce the fatigue of the interviewer and the interviewee. Further, a standardization especially of the response mode, through provision of predefined response categories to check, will shorten the assessment time and make the collected data more fit for an in-depth and rigorous analysis at individual and population levels. Standardization will also increase the accuracy with easier reporting of the complex and multidimensional observations collected by the revised INA tool.

Based on the revised INA instrument pilot-test and feedback from the persons with disabilities and the social workers, the INA tool, as well as the self-assessment form, were revised. As SAA moves ahead with the tool implementation, we recommend that (i) persons with disabilities and social workers are involved in all further steps; (ii) a methodological guide is developed, and (iii) all social workers are trained (with regular refresher courses) in topics related to disability, functioning and the needs of persons with disabilities, interviewing techniques and in general the INA tool administration.

Concluding remarks

Bulgaria has adopted the approach to disability espoused by UNCRPD – the approach that understands disability as interaction between a person with a health condition and/or impairment and her or his environment. Accordingly, over the last decade, significant changes to legal, institutional and policy frameworks have been made with the objective of making them consistent with UNCRPD.

This Report focuses on two important systems for persons with disabilities: the system that assesses disability, and the system that assesses the needs of persons with disabilities for support. Both are found in need of strengthening, albeit in different ways. The disability assessment system is based on medical criteria only and as such it does not comply with the national approach to disability. The needs assessment system mostly serves as a screening tool for various benefits, not as a needs assessment tool as intended by the Persons with Disabilities Act of Bulgaria.

To provide empirically based advice to Government on how to strengthen these two systems, two pilots were conducted. In one, the WHO's Disability Assessment Tool (WHODAS) that collects information on functioning to assess disability was piloted. In the other, a revised individual needs assessment tool was piloted. Both pilots rendered valuable statistical evidence, based on whose analysis recommendations on how to strengthen these two systems were made.

The most important recommendations are:

(i) Disability assessment system:

- ***Include functioning into disability assessment.*** While the choice is political, options presented in this Report to combine medical and WHODAS based functioning information can comfortably be implemented based on the existing information systems and human resources.

  Including functioning into disability assessment will:

  - *make the assessment of disability more precise, accurate, and reliable, reflecting the real-life experience of disability of applicants,*
  - *bring the assessment closer to the modern understanding of disability as formulated by ICF and mandated by UNCRPD, and adopted by Bulgaria; and*
  - *align it with the individual needs assessment by providing valuable information input into it. A status assessment that includes functioning will provide a better profile of disability that the person experiences to identify needs that, once addressed, will improve the experience of disability by optimizing the person's functioning.*

- ***Develop a separate tool to assess disability of children.*** The medical criteria, as well as functioning tools used for adults are not suitable for children, because children grow and develop. Therefore, a different methodology and tools are needed to assess disability of children.

(ii) Individual needs assessment:

- ***Deploy the revised, pilot-tested INA instrument.***
- ***Modify the self-assessment form to focus on environmental questions (barriers and facilitators).***
- ***Develop a separate INA instrument for children.***
- ***Apply a full needs assessment to all persons with disabilities.***
- ***Consider having medical expertise commissions recommending (not deciding on) assistance by others and make decisions only after a full functioning and needs assessment has been completed.***
- ***Simplify and automate INA administrative process by fully utilizing significant available information systems resources.***
- ***Prepare expanded and strengthened technical guidelines and methodological instructions and regularly (re)train staff in their implementation.***
- ***Establish a technical and methodological individual needs assessment unit in SAA.***

ANNEX 1

INDDIVIDUAL NEEDS ASSESSMENT (INA) INSRUMENT

Bulgaria: Assessing needs and degree of dependence for persons certified as persons with disabilities

A note on the proposed instrument

This version of the INA instrument was prepared following a review of the one currently in use, extensive consultations with stakeholders, learning from experience of other countries and pilot-testing of the revised instrument. It is expected that it will be further fine-tuned by SAA.

Adhering to the current legal provisions, all sections in this questionnaire, except section XII – Disability in daily life - apply to all persons certified as having at least 50 percent disability or reduced work capacity requesting to have a needs assessment. Section XIII, which is also used to assess the level of dependence and the number of hours of personal assistance applies to persons certified by TMEC/NMEC as having at least 90 or higher percent degree of permanent disability and for whom TMEC has decided that she or he needs personal assistance.

However, in compliance with the provisions of PDA, we propose that INA instrument is applied in full to all persons requesting a needs assessment. To allow the SAA to adjust to the increased workload in relation to the needs assessment, this could be done gradually. First, the full questionnaire, including a home visit should apply to all persons with disabilities with 90+ percent of disability (irrespective of whether their disability certificate includes personal assistance or not). The second phase could be to add persons with 70 or higher percentage of disability. And finally, the third phase would be to include persons with 50 or higher percentage of disability.

The INA tool should be in electronic format available in the on-line regime in the Social Assistance Agency Information System (SAAIS). Prior to the home visit and the interview this form should be automatically pre-populated from data contained in various information systems (medical expertise information system, regional health files, Social Assistance Agency, Agency for People with Disabilities, civil registry, etc.). This will make the collection of information easier; it is also an opportunity to verify the accuracy of information. Ideally, most of the fields would be pre-populated from the links to various information systems. This should not be a problem given an advanced state of several relevant information systems in Bulgaria.

We propose that SAA prepares a technical and methodological guide to accompany the revised tool, as well as to train the staff in implementing it.

Finally, As the SAA goes ahead with revisions of the tool that is currently in use, we strongly advice that a reference group comprising individuals with disabilities and social workers is established to advice the finalization and deployment of the revised INA tool.

The Social Assistance Agency Form – to be filled by the information system automatically and by the responsible social worker

Information about the interview

Who conducted the interview?	Interviewer: name, patronymic, family name Job title: Employer (SAA branch): name of the employer and other details
Date of the interview	
How was the interview conducted?	face-to-face telephone video call combination of _____
Where was the interview conducted?	at the beneficiary's place of residence at someone else's home (indicate whose) at ASA office (give address)
Who provided the information?	The applicant The applicant with help from (provide name and contact details) By proxy (give name and contact details)
Duration of the interview	
Were people other than the applicant interviewed?	No Yes (if yes, provide information on neighbor, family member, doctor, etc.)

PART A: PERSONAL AND BACKGROUND INFORMATION

Based on automatically provided information and interview with the individual, please complete templates I – VI .

I. Personal information

Unique Identification Number	
Case number (SAA assigned for the needs assessment)	
Designation	Mr., Mrs., Miss
Name	
Patronymic	
Family name	
Family name at birth	
Gender	M, F, other
Date of birth	Date Age (in full years and months, example: 55 years and 3 months)
Place of birth	
Current full address	Number, street, city, postal code
Telephone (land line) number	Does not have a land line If yes, number:
Mobile telephone	Does not have a mobile telephone If yes, number:
E-mail address	Does not have one If yes, e-mail address:
Access to internet	NO If YES Yes, but I do not use it

	Yes, but I do not know how to use it There is internet at home, Uses public facilities
Legal representative	No legal representative If yes: name, patronymic, family name, full address, telephone, and email address
Contact details from one person close to the applicant	Name, patronymic, family name, full address, telephone, and email address

II. Marital status and family

Marital status	Unmarried Married Widow(er) Separated Divorced Civil union Lives with a partner Unspecified

Family members living in the same household			
Full name	Relationship	Age	Employment status
			Employed full-time Employed part-time Not working In education Retired

III. Economic situation

Status	Since when (date) – fill out all that apply
Employed full-time	
Employed part-time	
Unemployed, looking for a job (registered as unemployed with the EA)	
Unemployed, looking for a job (**not** registered as unemployed with the EA)	
Student (for young adults)	
Disabled since childhood, never employed.	
Disabled since childhood, employed full-time	
Disabled since childhood, employed part-time	
Disabled since childhood, unemployed, looking for a job	
Retired (old age pension)	
Retired (disability pension)	
Left employment when certified as disabled	
Continued working after certification	
Did not work prior to certification	

IV. Employment situation in relation to certification

If the person was employed before disability certification and left employment after disability certification	
Why did you leave employment (multiple answers are possible)?	Does not want to work Concerned about health and does not want to work Health is now a priority Not able to work Wants to work, but only part-time, or a couple of days per week Wants to work, but needs a job that is close to his or her home Wanted to stay employed, but the employer could not provide an adequate job Other _____
Will you consider working in the future?	No Depends on health Yes
If looking for a job, what obstacles do you face in finding a job?	No available jobs No assistance in finding a job Does not know how and where to look for a job No assistance to travel to and from work Other _____

V. Education and profession

Education	
What is the highest level of education achieved?	Less than primary Primary education Secondary education Vocational education University Master's degree Doctorate
Current profession, if working	
If left the job due to disability, profession before disability	

VI. Disability and health related information

NOTE: Most of the information below should be automatically uploaded from the medical expertise information system.

NOTE: the current form of disability certificate filled in by TMEC/NMEC does not have any description why person was assesses as having a disability. We strongly urge SAA and MLSP to engage with MOH to add a section to the form that would provide clear and detailed description of why TMEC/NMEC assesses the person as a person with a disability.

TMEC/NMEC case number	
Date of the TMEC/NMEC decision	
Assessment was for (all legal options to be listed)	Extended sick leave (temporary disability) Permanent disability Reduced work capacity Disability …
Type of assessment	First time Reassessment
If reassessment	Date of first-ever assessment Date of the last assessment before this one
Details on TMEC (NMEC) that conducted the assessment	Name of institution where TMEC is located Address of the institution Members of the commission with specialty and contact details 1. 2. 3. …
Name of the health condition with ICD codes	Primary health condition (name and ICD code) Secondary health conditions (names and ICD codes)
Degree of disability (%)	
Degree of disability in previous assessment (%)	% Does not know
Degree of disability in the first ever assessment	% Does not remember
Duration of certificate	Months (if less than a year) Years Date of the certificate expiration
For the first-time assessment: Was the person on sick leave before TMEC/NMEC?	NO YES If YES, for how long (in months)
Who referred you to TMEC Contact details of a medical doctor who referred the person to TMEC	
Description of the disability the person is experiencing (based data)	***This description should be part of the TMEC/NMEC decision and should be copied or uploaded here. It is currently not the practice, but it is extremely important and TMECs and NMEC should be obliged by MOH to provide such description.***
Medical therapy the person is currently receiving	Provide a description in brief (could be standardized jointly with MOH)

PART B: EVIDENCE OF DISABILITY-RELATED NEED

The following templates VII to XII collect the evidence and information that will be used in PART C for the determination of disability needs and level of personal assistance

VII. Personal factors: Plans, wishes and goals of the person

(Description of the person's perspectives, if possible, based on his/her statements.)

Based on your conversation with the applicant, provide a summary of what are the applicant's plans, wishes, and goals. (The current life situation, issues identified in relation to participation, and relevant contextual factors must be considered.)

VIII. Support measures and services requested or currently received by the applicant (to be further expanded or corrected to include all currently available benefits and services as provided by the law – information to be uploaded from the self-assessment form)

Support measure or service	Requested by applicant	Currently received (date received, ending date)	Amount (hours, sessions, etc.) or kind of services
Personal assistance	YES/NO	YES/NO	
Monthly financial assistance	YES/NO	YES/NO	
Annual toll road vignette	YES/NO	YES/NO	
Targeted financial aid for personal vehicle purchase	YES/NO	YES/NO	
Parking	YES/NO	YES/NO	
Social services	YES/NO	YES/NO	
Placement in an institution	YES/NO	YES/NO	
Balneotherapy	YES/NO	YES/NO	
Technical aid (separately for each aid)	YES/NO	YES/NO	
Assistance with employment	YES/NO	YES/NO	
Assistance with education	YES/NO	YES/NO	
Home accommodation and/or home adaptation	YES/NO	YES/NO	
Targeted aid for renting municipal housing	YES/NO	YES/NO	
Other services, supports, or assistance (please specify) By each intervention asked for	YES/NO	YES/NO	

IX. Income (for means-tested benefits)

This information is relevant for means-tested support (to be finetuned based on current legal requirements)

Personal income	Monthly amount
Salary	
Income from self-employment	
Income from agriculture	
Disability pension	
Old-age pension	
Survivors' pension	
Social allowance from the government	
Help from family members, friends, etc.	
Other (list, if needed)	
Family income (please provide an estimate of a total family income, including your personal income)	

X. Dwelling

Dwelling					
Type of dwelling	Owned	Owned by whom in the family?	Rented	Who pays the rent	Describe the general condition of the dwelling
Single house					
Apartment					
Features of dwelling					
Number of rooms					
Does the applicant have a separate room	Yes No				
Is there a bathroom with a toilet in the dwelling?	Yes No Toilette and bath are separate Toilette is outside				
Are the bath and toilet accessible?	Yes No No need Describe				
Amenities	Water Electricity Heating Central Heating Individual house heating Stove				No Yes (inside the house) Yes (outside the house) YES NO YES NO

XI. Community environment

Barriers in the close environment/community – check all items that present a problem.

☐ No asphalted or paved streets

☐ Inaccessible sidewalks, curbs

☐ No entrance ramps to public places such as _____

☐ Poor infrastructure to access shops, pharmacies, health facilities, and public transportation

☐ No parking places

☐ Other environmental barriers: _____

XII. Disability in daily life

Instructions to interviewer:

- ***Keep in mind that disability is impacted not only by the health condition or impairment (physical and mental) but also the person's environment. In other words, two similar persons, with the same health condition, may experience different degree of disability and have very different needs, depending on how supportive their physical, built, and social environment is.***
- ***For each activity or area of life below, only record the level of disability not, for example, the impact of income level or the fact that the person does not know how to do the activity, does not want to do the activity, or that the activity is not expected or appropriate.***
- ***Each activity or area of life is complex and composed of several simpler activities (e.g., preparing food includes opening packages, peeling, and chopping, serving). Inability to do some of the simpler activities will make it difficult to do the complete, complex activity.***

The Disability in Daily Life Tool is divided into four groups: Activities of Daily Life, Mobility, Instrumental Activities of Daily Life, and Areas of Social Participation, and uses a qualitative scale (No problem, Moderate, Severe, and Very Severe) with descriptions of each level for guidance).

DISABILITY IN DAILY LIFE

DAILY LIFE ACTIVITIES				
SELF-CARE				
1. Use of toilet and intimate hygiene				
Uses the toilet independently, maintains the intimate hygiene and keeps the toilet clean.	Uses the toilet independently but needs to be reminded to clean the toilet and maintain the intimate hygiene.	Needs help of other person to use the toilet and maintain the intimate hygiene and the toilet.	Dies not use the toilet on her own, cannot maintain the intimate hygiene and not able to clean the toilet.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
2. Dressing and undressing				
Dresses and undresses independently and appropriate for weather and occasion. Keeps the clothes clean and neat.	Dresses and undresses independently but may need some assistance and reminding about selecting appropriate clothing and keeping it clean and neat.	Puts on and off simple pieces of clothing. Needs help for more complex dressing or undressing. Needs help to keep the clothes clean and neat and to choose appropriate clothing.	Cannot dress or undress. Cannot choose appropriate clothing and not able to keep the clothes clean and tidy.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
3. Eating and drinking				
Eats and drinks on her own with appropriate habits and manners.	Able to eat and drink independently but lacks appropriate habits and manners (makes a mess when eating, cannot clean the dishes).	Eats and drinks with help from other or technical aids.	Cannot take food and drink on his or her own. Needs to be fed.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
4. Preparing food				
Cooks independently.	Prepare simple meals independently but not more complex ones.	Cooks, but only with help.	Cannot do it at all.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
5. Personal hygiene, washing, and bathing				
Maintains personal hygiene independently	Maintains personal hygiene independently but	Needs assistance or technical aids to maintain personal	Not capable to wash and bathe and does	**Remarks**

(washes hands, face, feet, showers, and bathes).	needs to be reminded or to develop hygiene habits.	hygiene, bathe, and wash.	not have hygiene habits.	
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
Does this person need help for self-care? ☐ *Yes, every day* ☐ *Yes, periodically* ☐ *Yes, constantly (continuous care)* ☐ *He doesn't need any help*		**Who is helping ?** **NO HELP** ☐ *Yes, family member* ☐ *Yes, friend, neighbor* ☐ *Yes, paid personal assistant (wife, husband, child, etc., no relation)* ☐ *Yes, employees of a health institution, daycare*		**Remarks**
COMMUNICATING				
6. Communicating verbally				
Communicates effectively. Can express herself/himself clearly and fully understands others.	Understands others well but has difficulties expressing herself clearly.	Has difficulties expressing herself/himself and understanding others and needs assistance or technical aid.	Limited or no capacity of communication.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
7. Reading and understanding signs, symbols, and words				
Reads and understands signs, symbols, and words.	Reads but cannot understand all signs, symbols, and words.	Reads and understands only with assistance from others or technical aid.	Limited or no capacity to read or understand signs, symbols, and words.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
Does this person need help for communicating? ☐ *Yes, every day* ☐ *Yes, periodically* ☐ *Yes, constantly (continuous care)* ☐ *He doesn't need any help*		**Who is helping ?** **NO HELP** ☐ *Yes, family member* ☐ *Yes, friend, neighbor* ☐ *Yes, paid personal assistant (wife, husband, child, etc., no relation)* ☐ *Yes, employees of a health institution, daycare*		**Remarks**
MOBILITY				
8. Mobility inside the house				
Moves freely and independently within the house.	Moves independently but may need assistance on	Moves only with assistance or technical aid.	Cannot move at all.	**Remarks**

	occasion, for example, to get out of bed or to climb stairs.			
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
9. Mobility outside the house				
Moves independently and fully: walking, jumping, running, etc.	Moves independently. Does not run and jump, walk longer distances, across uneven terrain, uphill or with other obstacles.	Moves outside the house but only with help from another person or a technical aid.	Cannot move at all.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
10. Orienting oneself				
Fully orients herself in known and unknown space.	Orient herself/himself in familiar space, but with difficulty in unfamiliar space.	Needs help to orient herself/himself in familiar and unfamiliar space.	Does not have a sense of orientation, even in familiar space.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
Does this person need help for mobility ? ☐ *Yes, every day* ☐ *Yes, periodically* ☐ *Yes, constantly (continuous care)* ☐ *He doesn't need any help*		**Who is helping ?** **NO HELP** ☐ *Yes, family member* ☐ *Yes, friend, neighbor* ☐ *Yes, paid personal assistant (wife, husband, child, etc., no relation)* ☐ *Yes, employees of a health institution, day care*		**Remarks**
INSTRUMENTAL ACTIVITIES IN DAILY LIFE				
11. Maintaining health				
Takes medicines, observes schedules, and attends therapy on her/his own.	Takes medicines or therapies independently but may need to be reminded.	Takes medicines or therapies independently but prepared and supervised by another person.	Cannot take prescribed medication or participate in therapy.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
12. Using public transportation				
Uses public transport freely and independently.	Uses public transport independently but has some difficulty orienting and respecting rules.	Uses public transport only when accompanied by another person or with technical aids or only when	Cannot do it at all.	**Remarks**

		using public adapted transport.		
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
13. Using public services (utilities, government services, etc.)				
Uses public services on her/his own.	Understands the purpose of some public services and uses only some of them.	Needs assistance to use public services (someone to explain the purpose, provide help with the use of services, etc.).	Not able to use public services.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
14. Managing finances				
Using and manages money.	Understands the use of money and budgeting and management of money but may need supervision.	Needs assistance in using money and budgeting or managing money	Does not understand the purpose, value, or use of money.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
15. Grocery shopping				
Does grocery shopping independently.	Does grocery shopping but needs supervisions to select items and spend money appropriately.	Needs assistance or technical aid to shop.	Cannot do it.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
16. Doing housework, keeping living area clean				
Doing housework, has fully developed habits of cleaning personal or common living space.	Does housework for personal or common living space independently but needs to be reminded to do it and to be supervised.	Needs assistance with housework and to maintain personal or common living space.	Not capable of doing housework and maintaining own and common areas clean.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
Does this person need help for instrumental activities in daily life? ☐ *Yes, every day* ☐ *Yes, periodically* ☐ *Yes, constantly (continuous care)*		**Who is helping ?** **NO HELP** ☐ *Yes, family member* ☐ *Yes, friend, neighbor*		**Remarks**

☐ *He doesn't need any help*		☐ *Yes, paid personal assistant (wife, husband, child, etc., no relation)* ☐ *Yes, employees of a health institution, daycare*		
SOCIAL PARTICIPATION				
17. Interacting with peers				
Initiates, develops, and maintains contact with peers, fully engages in friendships. Leads active social life.	Interacts with peers but not frequently, needs to be reminded and the interaction is not always socially appropriate. Social life not very active but exists.	Cannot interact or communicate with peers without assistance or technical aid. With help, maintains friends and socializes with them	Cannot interact with peers. Not capable to engage in social life.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
18. Participating in family relationships				
Successful and meaningful family relationships. Fully active in family life.	Aware of the importance of family relations and wishes to participate but requires help.	Understands family relationships but cannot meaningfully participate in family life, even with help.	Does not understand family relationships or participate in them.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
19. Interacting with known and unknown persons				
Successful and appropriate interactions with known and unknown persons.	Recognizes and communicates with persons she/he knows, but not with persons she does not know. Needs help to interact with strangers.	Recognizes with difficulty persons with whom she/he is in daily contact. Cannot recognize persons she sees sporadically. Needs help for both.	Does not interact with known or unknown persons (cannot recognize persons she sees frequently).	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
20. Participating in community activities				
Spontaneously, voluntarily, and actively participates; initiates activities.	Passive and limited active, independent participation. Does not initiate activities and may require supervision.	Passive observer but participates only with personal assistance or support.	No participation in community activities at all.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	

Does this person need help for participation in social life? ☐ *Yes, every day* ☐ *Yes, periodically* ☐ *Yes, constantly (continuous care)* ☐ *He doesn't need any help*		**Who is helping ?** **NO HELP** ☐ *Yes, family member* ☐ *Yes, friend, neighbor* ☐ *Yes, paid personal assistant (wife, husband, child, etc., no relation)* ☐ *Yes, employees of a health institution, day care*		**Remarks**
21. Participation in education/training (only answer if applicable to the person – if a person is not in education or training, this item is not applicable).				
Attends school independently, regularly, and diligently, learning commensurate.	Attends school independently but needs supervision and support to successfully participate and learn.	Needs assistance or technical aids to fully participate in regular school.	Not included in education.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
Does this person need help to participate in education? ☐ *Yes, every day* ☐ *Yes, periodically* ☐ *He doesn't need any help*		**Who is helping ?** **NO HELP** ☐ *Yes, family member* ☐ *Yes, friend, neighbor* ☐ *Yes, paid personal assistant* ☐ *Yes, social services* ☐ *Yes, school*		**Remarks**
22. Participation in labor market				
Employed, self-employed or a farmer and works full-time performing all tasks successfully. Not employed but would be able to work full-time and complete all tasks successfully.	Employed, self-employed or a farmer and works full-time. Needs workplace accommodation to perform tasks successfully. Not employed but would be able to work full-time. Would need workplace accommodation to complete tasks successfully.	Works but needs assistance, workplace accommodation and job accommodation. Not employed but would need workplace accommodation, assistance, and job accommodation.	Not able to work.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
Does this person need help to participate in the labor market? ☐ *Yes, every day* ☐ *Yes, periodically* ☐ *Yes, full-time*		**Who is helping ?** **NO HELP** ☐ *Yes, family member* ☐ *Yes, friend, neighbor* ☐ *Yes, paid personal assistant*		**Remarks**

☐ *He doesn't need any help*		☐ *Yes, employment office* ☐ *Yes, employer*		
23. Avoiding danger				
Recognizes risky situations and avoids them	Understands risky situations but deliberately endangers herself or others.	Needs assistance or technical aid to become aware or understand risky situations.	Does not understand or perceive dangers to oneself or others.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
Does this person need help to be safe and avoid danger? ☐ *Yes, every day* ☐ *Yes, periodically* ☐ *Yes, constantly (continuous care)* ☐ *He doesn't need any help*		**Who is helping ?** **NO HELP** ☐ *Yes, family member* ☐ *Yes, friend, neighbor* ☐ *Yes, paid personal assistant (wife, husband, child, etc., no relation)* ☐ *Yes, employees of a health institution, daycare*		**Remarks**

ASSESSMENT OVERVIEW (1)

Which benefits and services has this person requested? (Check all that apply): TO BE DESIGNED AS A MULTIPLE CHOICE OF ALL APPLICABLE SERVICES AND BENEFITS (the social worker will then check those the applicant requested). Examples

☐ *Technical aid* ☐ *Daycare* ☐ *Residential care* ☐ *Balneological treatment and/or rehabilitation* ☐ *Counselling*

☐ *Residential care.* ☐ *Home adaptation* ☐ *Municipal rent* ☐ *Financial assistance …*

Which types of services and benefits is this person currently receiving? (Check all that apply). TO BE DESIGNED AS A MULTIPLE CHOICE OF ALL APPLICABLE SERVICES AND BENEFITS: Examples:

☐*NONE* ☐ *Technical aid* ☐ *Daycare* ☐ *Residential care* ☐ *Balneological treatment and/or rehabilitation* ☐ *Counselling*

☐ *Residential care.* ☐ *Home adaptation* ☐ *Municipal rent* ☐ *Financial assistance …*

N – no problem; **M** – moderate problem; **S** – severe problem; **VS** – very severe problem

		Severity of the problem	Need for assistance	Current state of help	Remarks
		N, M, S, or VS	Based on the assessment does this person need help (applicable only if at least one M) ?	Who is helping currently (check all that apply)?	
	SELF-CARE				
	1. Use of toilet and intimate hygiene		☐ *Yes, every day* ☐ *Yes, periodically* ☐ *Yes, constantly (continuous care)*	**NO HELP** ☐ *Yes, family member* ☐ *Yes, friend, neighbor*	
	2. Dressing and undressing				
	3. Eating and drinking				

	4. Preparing food		☐ *She/He doesn't need any help* ☐ *She/He needs help, but no one's helping.*	☐ *Yes, privately paid help* ☐ *Yes, government through benefits and services*	
	5. Personal hygiene, washing and bathing				
COMMUNICATING					
	6. Communicating verbally		☐ *Yes, every day* ☐ *Yes, periodically* ☐ *Yes, constantly (continuous care)* ☐ *She/He doesn't need any help* ☐ *She/He needs help, but no one's helping.*	**NO HELP** ☐ *Yes, family member* ☐ *Yes, friend, neighbor* ☐ *Yes, privately paid help* ☐ *Yes, government through benefits and services*	
	7. Reading and understanding signs, symbols, and words				
MOBILITY					
	8. Mobility inside the house		☐ *Yes, every day* ☐ *Yes, periodically* ☐ *Yes, constantly (continuous care)* ☐ *She/He doesn't need any help* ☐ *She/He needs help, but no one's helping.*	**NO HELP** ☐ *Yes, family member* ☐ *Yes, friend, neighbor* ☐ *Yes, privately paid help* ☐ *Yes, government through benefits and services*	
	9. Mobility outside the house				
	10. Orienting oneself				
INSTRUMENTAL DAILY LIFE ACTIVITIES					
	11. Maintaining health (following therapy, etc.)		☐ *Yes, every day* ☐ *Yes, periodically* ☐ *Yes, constantly (continuous care)* ☐ *She/He doesn't need any help* ☐ *She/He needs help, but no one's helping.*	**NO HELP** ☐ *Yes, family member* ☐ *Yes, friend, neighbor* ☐ *Yes, privately paid help* ☐ *Yes, government through benefits and services*	
	12. Using public transportation				
	13. Using public services				
	14. Managing finances				
	15. Grocery shopping				
	16. Doing housework, keeping living area clean				

SOCIAL PARTICIPATION					
	17. Interacting with peers		☐ *Yes, every day* ☐ *Yes, periodically* ☐ *Yes, constantly (continuous care)* ☐ *She/He doesn't need any help* ☐ *She/He needs help, but no one's helping.*	**NO HELP** ☐ *Yes, family member* ☐ *Yes, friend, neighbor* ☐ *Yes, privately paid help* ☐ *Yes, government through benefits and services*	
	18. Participating in family relationships				
	19. Interacting with known and unknown persons				
	20. Participating in community activities				
	21. Participation in education				
	22. Participation in labor market				
	23. Avoiding danger				

ASSESSMENT OVERVIEW (2)

Here, based on the information you have collected, describe the assistance this person needs by activity and level of problem and need. IT IS IMPORTANT TO LIST THE ASSISTANCE THIS PERSON NEEDS (THEREFORE, YOU SHOULD FOR THE MOMENT IGNORE HER OR HIS REQUEST, THE MACs', TMECs' and NMEC's DECISION ABOUT TECHNICAL AID AND PERSONAL ASSISTANCE AND CURRENT ASSISTANCE THIS PERSON IS RECEIVING). FOCUS ON WHAT THIS PERSON NEEDS TO IMPROVE HER OR HIS FUNCTIONING AND OVERALL DISABILITY EXPERIENCE. IN ADDITION TO THE SUPPORT INTERVENTIONS FOR WHICH INA IS REQUIRED BY LEGISLATION, THINK OF SERVICES SUCH AS DAY CARE, HEALTH CARE, MEDICAL REHABILITATION, ASSISTANCE TO COMMUNICATE (SIGN LANGUAGE INTERPRETATION), VOCCATIONAL REHABILITATION, PSYCHO-SOCIAL COUNSELLING, ETC.

Activity and area of life	Level: N, M, S, VS	For persons for whom the need for help was identified in Sheet 1, describe services that would be relevant for her or him
DAILY LIFE ACTIVITIES		
Self-care		
1. Use of toilet and intimate hygiene		☒ Personal assistance ☐ Monthly financial assistance ☐ Annual toll-road vignetted ☐ Targeted financial aid for personal vehicle purchase ☐ Parking ☐ Social services ☐ Placement in an institution ☐ Balneotherapy ☐ Technical aid (separately for each aid) ☐ Assistance with employment ☐ Assistance with education ☐ Home accommodation and/or home adaptation ☐ Targeted aid for renting municipal housing ☐ Other services, supports, or assistance (please specify) By each intervention asked for
2. Dressing and undressing		
3. Eating and drinking		
4. Preparing food		
5. Personal hygiene, washing, and bathing		
Communicating		
6. Communicating verbally		☐ Personal assistance ☐ Monthly financial assistance ☐ Annual toll-road vignetted ☐ Targeted financial aid for personal vehicle purchase ☐ Parking ☐ Social services ☐ Placement in an institution ☐ Balneotherapy ☐ Technical aid (separately for each aid) ☐ Assistance with employment ☐ Assistance with education ☐ Home accommodation and/or home adaptation ☐ Targeted aid for renting municipal housing
7. Reading and understanding signs, symbols, and words		

		☐ Other services, supports, or assistance (please specify) By each intervention asked for
MOBILITY		
8. Mobility inside the house		☐ Personal assistance ☐ Monthly financial assistance ☐ Annual toll-road vignetted ☐ Targeted financial aid for personal vehicle purchase ☐ Parking ☐ Social services ☐ Placement in an institution ☐ Balneotherapy ☐ Technical aid (separately for each aid) ☐ Assistance with employment ☐ Assistance with education ☐ Home accommodation and/or home adaptation ☐ Targeted aid for renting municipal housing ☐ Other services, supports, or assistance (please specify) By each intervention asked for
9. Mobility outside the house		
10. Orienting oneself		
INSTRUMENTAL DAILY LIFE ACTIVITIES		
11. Maintaining health		☐ Personal assistance ☐ Monthly financial assistance ☐ Annual toll-road vignetted ☐ Targeted financial aid for personal vehicle purchase ☐ Parking ☐ Social services ☐ Placement in an institution ☐ Balneotherapy ☐ Technical aid (separately for each aid) ☐ Assistance with employment ☐ Assistance with education ☐ Home accommodation and/or home adaptation ☐ Targeted aid for renting municipal housing ☐ Other services, supports, or assistance (please specify) By each intervention asked for
12. Using public transportation		
13. Using public services		
14. Managing finances		
15. Grocery shopping		
16. Doing housework, keeping living area clean		
SOCIAL PARTICIPATION		
17. Following and respecting rules		☒ Personal assistance ☐ Monthly financial assistance ☐ Annual toll-road vignetted ☐ Targeted financial aid for personal vehicle purchase ☐ Parking
18. Interacting with peers		
19. Participating in family relationships		
20. Interacting with known and unknown persons		
21. Participating in community activities		
22. Participation in education		

23. Participation in labor market		☐ Social services ☐ Placement in an institution ☐ Balneotherapy ☐ Technical aid (separately for each aid) ☐ Assistance with employment ☐ Assistance with education ☐ Home accommodation and/or home adaptation ☐ Targeted aid for renting municipal housing ☐ Other services, supports, or assistance (please specify) By each intervention asked for
24. Avoiding danger		

PART C: DISABILITY IN DAILY LIFE PROFILE, DETERMINATION OF ASSISTANCE

C1. Disability in daily life profile (please describe in the field below)

C2. Assistance the applicant needs (based on the assessment, irrespective of whether it was requested or not and whether it is available or not). This is very important, because the person may not know all services available to her/him, and there may be a need for services not available (important for service development planning).

Based on the assessment (name and family name) would benefit from the following assistance (check all appropriate):

☐ Personal assistance
☐ Monthly financial assistance
☐ Annual toll-road vignetted
☐ Targeted financial aid for personal vehicle purchase
☐ Parking
☐ Social services
☐ Placement in an institution
☐ Balneotherapy
☐ Technical aid (separately for each aid)
☐ Assistance with employment
☐ Assistance with education
☐ Home accommodation and/or home adaptation
☐ Targeted aid for renting municipal housing
☐ Other services, supports, or assistance (please specify)
By each intervention asked for

… (Provide other forms of assistance that in your judgement this person needs.

C3. Determining assistance

Consider all information collected above.

(i) Determining the level (number of hours) of personal assistance

Based on all the information gathered from Parts A and B, your conversation and interview with the applicant, and especially the results of the DISABILITY IN DAILY LIFE tool above, identify Degree of dependence on intensive support as set out in the Personal Assistance Act. The personal assistance mechanism shall be based on state-guaranteed financial support, individual needs, and the personal choice of the personal assistance user. The right to provide personal assistance is exercised when requested. The determination of the number of hours of personal assistance is based on the following four levels of dependence on intensive support:

Fourth degree of dependence – right to personal assistance of up to 168 hours a month
Third degree of dependence – right to personal assistance of up to 84 hours a month
Second degree of dependence – right to personal assistance of up to 42 hours a month
First degree of dependence – right to personal assistance of up to 15 hours a month

We recommend that the Government considers combining degrees 3 and 4 should, as it is very difficult to differentiate "very severe dependency" and "total dependency". A simpler degree scale would be easier to implement. For instance: full-time personal assistance for very severe or complete dependency; part-time (50% of hours) for severe dependency, and 25% for moderate dependence. That would be 168, 84, and 42 hours of personal assistance per month. Meanwhile, until the legislation has been changed, the four degrees above remain in effect.

Personal assistance requested: YES NO

In the space below provide a detailed description of the applicant's needs for personal assistance based on their level of dependency/difficulty.	
In terms of personal assistance, the person needs (check all that apply)	Level of dependence on intensive support and number of hours
☐ Assistance for inclusion in social environment/participation ☐ Assistance (chaperone, companion) for mobility outside, visits to the doctor ☐ Appointed Personal Assistant ☐ Home social patronage (house cleaning, shopping, etc.) ☐ Assistance for independent living ☐ Assistance for self-care ☐ Assistance to communicate ☐ Help with mobility inside the house …	☐ Continuous care – 24-hour service ☐ Periodically ☐ Every day Degree of dependence: _____ Number of hours_____

(ii) Need for home adaptation

Fill in this part with information on the housing conditions of the person with a disability

Support requested: YES NO

Are the current living conditions of the person with disability appropriate?	Yes Partially No	☐ Good conditions, with running water and heating, furnished, clean, safe, well maintained ☐ Relatively good, only a little neglected, with need for small repairs, but no central heating ☐ Insufficient: poor maintenance, no running water, or electricity or heating, unsafe, no toilet or no bath in the dwelling
Does the average monthly income per member of the family of the person with	Yes No	The average monthly income per family member for the last 12 months is in the amount of:

disability meet the eligibility requirements for financing the adaptation of the home under the People with Disabilities Act?		Poverty line:
Has the person with disability received targeted aid for adaptation of the home for the last 10 years?	Yes No	If yes, when
Is home adaptation needed?	Yes No	Adaptations needed: ☐ Guardrails (for safety) ☐ Handrails (for guidance and support) ☐ Internet access ☐ Elevator ☐ Ramps ☐ Other home adaptations _____

c. Need for use of municipal housing and rental subsidy

Fill in this section with information on the existence of conditions for the provision of targeted aid for the person with a disability to rent municipal housing.

Support requested: YES NO

Does the person with a disability have a contract for accommodation in municipal housing?	Yes No	If Yes: Who has signed the contract (first name and family name): Relationship with the person with disability: - parent of a child with a disability - legal representative of a person with permanent disability placed under full legal incapacity.
What is the status of the person with disability	1.Person living on his/her own, 2.Child with permanent disability, 3.Person placed under full legal incapacity, 4.Other:	
Additional relevant information		

d. Need for technical aid (AATEMD)

Fill in this section with information on the existence of conditions for providing targeted aid for assistive devices, medical equipment, and other technical aid. The observed need should be used only as a base for referral of the person to his general practitioner/MAC/rehabilitation professional to determine the need for assistive technology. Social workers are not trained to do this job.

Support requested: YES NO

Does the person with disability use any technical aid?	Yes No	If yes, list all technical aid: ☐ Antidecubital mattress ☐ Antidecubital pillow ☐ Armpit crutches ☐ Bathroom chair ☐ Batteries for Hearing aids ☐ Cane ☐ Catheter ☐ Diaper ☐ Dressing chair ☐ Electric Wheelchair

		☐ Forearm crutches ☐ Hearing aids ☐ Orthopedic shoes ☐ Prosthetic socks ☐ Cart or Trolley for shopping ☐ Rollator ☐ Blood pressure monitor ☐ Toilet chair. ☐ Trunk support device ☐ Walker ☐ Wheelchair ☐ Wheelchair table ☐ Wig Other: _____
Is the need for using technical aid established by TMEC/NMEC/MAC?	Yes No	If yes, list all of them: ☐ Antidecubital mattress ☐ Antidecubital pillow ☐ Armpit crutches ☐ Bathroom chair ☐ Batteries for Hearing aids ☐ Cane ☐ Catheter ☐ Diaper ☐ Dressing chair ☐ Electric Wheelchair ☐ Forearm crutches ☐ Hearing aids ☐ Orthopedic shoes ☐ Prosthetic socks ☐ Cart or Trolley for shopping ☐ Rollator ☐ Blood pressure monitor ☐ Toilet chair. ☐ Trunk support device ☐ Walker ☐ Wheelchair ☐ Wheelchair table ☐ Wig Other: _____
Additional information (If needed)	In addition to devices above, list those you assessed that a person needs: ☐ Antidecubital mattress ☐ Antidecubital pillow ☐ Armpit crutches ☐ Bathroom chair ☐ Batteries for Hearing aids ☐ Cane ☐ Catheter ☐ Diaper ☐ Dressing chair ☐ Electric Wheelchair ☐ Forearm crutches ☐ Hearing aids ☐ Orthopedic shoes ☐ Prosthetic socks ☐ Cart or Trolley for shopping ☐ Rollator ☐ Blood pressure monitor ☐ Toilet chair. ☐ Trunk support device ☐ Walker ☐ Wheelchair ☐ Wheelchair table ☐ Wig Other: _____	
Does the person with disability use?	Yes No	If yes, list all technical aid:
Is the need for using AATEMD established by TMEC/NMEC/MAC?	Yes No	If yes, list all of them.
Additional information (If needed)	In addition to devices above, list those you assessed that a person needs (for referral to relevant responsible bodies): ☐ Antidecubital mattress ☐ Antidecubital pillow ☐ Armpit crutches ☐ Bathroom chair ☐ Batteries for Hearing aids ☐ Cane ☐ Catheter ☐ Diaper ☐ Dressing chair ☐ Electric Wheelchair ☐ Forearm crutches ☐ Hearing aids ☐ Orthopedic shoes ☐ Prosthetic socks ☐ Cart or Trolley for shopping ☐ Rollator ☐ Blood pressure monitor ☐ Toilet chair. ☐ Trunk support device ☐ Walker ☐ Wheelchair ☐ Wheelchair table ☐ Wig Other: _____	

e. Need for purchase of a private motor vehicle (PMV)

Fill in this section with information pertaining to the conditions for providing financial aid for the purchase of a private motor vehicle (PMV).

Support requested: YES NO

Does the person with disability own a PMV at present?	Yes No	Type Year of production
Are there established mobility difficulties?	Yes No	
Does the use of a PMV help the social integration and independent life of the person with a disability?	Yes No	Please specify in what way:
What is the status of the person with a disability	1. Working 2. Student 3. Other Please specify:	
Does the average monthly income per member of the family of the person with disability meet the eligibility requirements for financing the purchase of a PMV under the Persons with Disabilities Act?	Yes No	The average monthly income per family member for the last 12 months is in the amount of: Poverty line:
Has the person with disability received targeted aid for the purchase of a PMV for the last 5 years?	Yes No	If yes, when
Additional clarifications (if needed)		

f. Medical and rehabilitation services

Support requested: YES NO

Check below the need for rehabilitation services you have assessed that a person needs:

☐ Medical rehabilitation services
☐ Balneotherapy
☐ Pain management
☐ Kinesitherapy
☐ Chiropractic
☐ Psychologist
☐ Psychiatrist
☐ Speech Therapy

☐ Home visits from a health professional
Other: _____

Specifically for eligibility for balneological treatment and rehabilitation*: Fill in this section with information on the need for providing the person with a disability with balneological treatment and/or rehabilitation services. The need is assessed based on the degree of the permanent loss of ability to work or the type and degree of disability of the person with a disability as per TMEC/NMEC decision*

Does the person with disability need to use balneological treatment and/or rehabilitation services?	Yes No	Clarification
Does the person with disability need escort to use balneological treatment and/or rehabilitation services?	Yes No	Clarification
Additional clarification if applicable		

g. Provision of monthly financial support

Fill in this part with information on the need to provide monthly financial support to people with permanent disabilities who are above the age of 18. The need is assessed in accordance with the degree of the permanent loss of the ability to work or the type and degree of disability of the person with a disability as established by a medical expert authority

Support requested: YES NO

Type of pension received	1. Invalidity pension due to general disease 2. Invalidity pension due to an accident at work or occupational disease 3. Social invalidity pension 4. Other
Additional information	

h. Support for employment

Support requested: YES NO

Does a person receive support for employment at present?	YES NO If yes, list support:
The person is willing to work and needs the following assistance	- Registration with the employment office - Job search assistance - Employment mediation - Training - A companion to go to training - Assistance with transportation to and from employment office and or training - Assistance for communication (sign language interpretation, material in Braille, etc.) - Other

i. Wishes of the person with disability and additional information

Fill in this section with the wishes of the person with a disability to use (a) certain social service(s) or other support measures, the duration of that use and the wishes for development

What services/support measures does the person with a disability wish to use?	
What is the motivation of the person with a disability for social integration?	
Please note any other circumstances, if relevant	

PART D: DECISION ON SUPPORT MEASURES

In the process, after all information has been gathered, including the home visit and the conduct of the interview, responsible social worker prepares a description of the state of need and proposes with justification the existing support measures to which the applicant is eligible. The material prepared in section C (C1, C2, and C3) will be discussed in a meeting chaired by the manager. The decision on the level of dependence and number of hours of personal assistance and other benefits will be made during that meeting based on the presented material.

Decision on the assistance and services (both directives – to ASA and recommendations or referrals to other administrators of support measures).

NEEDS: In the space below, provide a description of the applicant's needs			
List available support interventions and services for which the person is eligible:			
	Requested	Directive	Referral
Personal assistance	YES/NO		Municipality
Financial assistance	YES/NO	SAA	
Medical rehabilitation	YES/NO		MD/General practitioner
…			

ANNEX 2

SELF-ASSESSMENT

1. Personal details

Your personal identification number	
First name, patronymic, and family name of the person with a disability	
Date of birth	
Current address (*City/town, municipality, region, street, Number, floor, apartment)*	
Telephone number	Landline Mobile phone
E-mail address	@
First name and family name of a legal representative (if applicable)	No legal representative If yes, provide the requested info
Contact details: address, telephone number, e-mail address	If no, skip
Name and family name of one trusted person	Name and family name Relationship to her/him Spouse Son/daughter Other relatives Friend
Contact details of this person	Address Telephone number Email
Your medical doctor: first name and family name, medical institution, telephone number	
NMEC/TMEC /MCC:	Yes/No Name of the TMEC Location Number of the document: Date issued
Your % of disability/reduced work capacity	

2. Marital status and family

Marital status (check the correct answer)	Unmarried Married Widow(er) Separated Divorced Civil union Lives with a partner Unspecified
What is your living arrangement?	I live in an institution I live by myself in my home I live with my spouse in my home I live with other family members in the same house

3. Economic situation

Status	Since when (date) – fill out all that apply
Employed full-time	
Employed part-time	
Unemployed, looking for a job (registered as unemployed with the EA)	
Unemployed, looking for a job (**not** registered as unemployed with the EA)	
Student (for young adults)	
Disabled since childhood, never employed.	
Disabled since childhood, employed full-time	
Disabled since childhood, employed part-time	
Disabled since childhood, unemployed, looking for a job	
Retired (old age pension)	
Retired (disability pension)	
Left employment when certified as disabled	
Continued working after certification	
Did not work prior to certification	

4. Employment situation in relation to disability certification

If you were employed before disability certification and left employment after disability certification	
Why did you leave employment (multiple answers are possible)?	Does not want to work Concerned about health and does not want to work Health is now a priority Not able to work Wants to work, but only part-time, or a couple of days per week Wants to work but needs a job that is close to his or her home Wanted to stay employed, but employer could not provide an adequate job

	Other _____
Will you consider working in the future?	No Depends on health Yes
If looking for a job, what obstacles do you face in finding a job?	No available jobs No assistance in finding a job Does not know how and where to look for a job No assistance to travel to and from work Other _____

5. Education and profession

Education	
What is the highest level of education achieved?	Less than primary Primary education Secondary education Vocational education University Master's degree Doctorate
Current profession, if working	
If left the job due to disability, profession before disability	

6. Income (for means-tested benefits)

This information is relevant for means-tested support (to be finetuned based on current legal requirements)

Personal income	Monthly amount
Family income (please provide an estimate of a total family income, including your personal income)	

7. Which benefits and services are you requesting?

What services/support measures are you applying for (circle YES for all that apply)?		
1	Monthly financial support	Yes/No
3	Targeted aid for the purchase of a private motor vehicle	Yes/No
4	Targeted aid for adaptation of the home	Yes/No
5	Targeted aid for balneological treatment and/or rehabilitation services	Yes/No
6	Targeted aid for renting municipal housing	Yes/No
7	Personal assistance	Yes/No
8	Social services	Yes/No
9	Support for education	Yes/No
10	Support for employment	Yes/No
11	Other support _____	Yes/No
12	Other support _____	Yes/No
…	…	Yes/No

8. Need for personal assistance and technical aids (answer only if you are requesting this assistance)

Personal assistance	I have a decision of TMEC that I need personal assistance
Technical aid	I have a decision from MAC/TMEC that I need technical aid.

9. Which benefits and services are you currently receiving?

What services/support measures are you currently using (circle YES for all that apply)?		
1	Personal assistance	Yes/No
2	Monthly financial assistance	Yes/No
3	Annual toll road vignette	Yes/No
4	Targeted financial aid for personal vehicle purchase	Yes/No
5	Parking	Yes/No
6	Social services	Yes/No
7	Placement in an institution	Yes/No
8	Balneotherapy	Yes/No
9	Technical aid (separately for each aid)	Yes/No
10	Assistance with employment	Yes/No
11	Assistance with education	Yes/No
12	Home accommodation and/or home adaptation	Yes/No
13	Targeted aid for renting municipal housing	Yes/No
14	Other services, supports, or assistance (please specify) By each intervention asked for	
	…	

10. Are you familiar with the data base on persons with disabilities of the Agency for Persons with Disabilities?

NO YES, but I do not use it Yes, and I use it.

11. Tell us about your immediate and mid-term life plans (you can choose multiple options):

1. I wish to take care of my health.
2. I wish to find a job.
3. I wish to complete my education.
4. I wish to develop skills and find a job.
5. I wish to be retired and enjoy my retirement.
6. I wish to focus on my family.

12. Tell us here how you experience your disability in your everyday life (circle the option that describes your situation the best). Keep in mind that you should tell us how your health condition in interaction with your environment impacts your life. For example, you may not be able to cook because you do not know how to cook, or you do not like cooking. But that is not related to your disability. Similarly, an illiterate person cannot read, but this is not because of disability. Please think carefully before circling the answer.

SELF-CARE				
1. Use of toilet and intimate hygiene				
I use the toilet independently, maintain the intimate hygiene and keep the toilet clean.	I use the toilet independently but need to be reminded to clean the toilet and to maintain the intimate hygiene.	I need help of another person to do these.	I am not able to do these by myself. Someone must do it for me.	**Remarks**
2. Dressing and undressing				
I dress and undress independently and appropriate for weather and occasion. I keep the clothes clean and neat.	I dress and undress independently but may need some assistance and reminding about selecting appropriate clothing and keeping it clean and neat.	I can dress and undress for simple pieces of clothing. I need help for more complex dressing or undressing. I also need help to keep my clothes clean and neat and to choose appropriate clothing.	I am not able to do these by myself. Someone must do it for me.	**Remarks**
3. Eating and drinking				
I eat and drink on my own and have appropriate habits and manners. I can clean the table and wash dishes.	I can eat and drink on my own, but I spill food and drinks and need some help to clean the table and dishes.	I eat and drink with help from others or technical aids. Someone must bring the food and do dishes and clean the table.	I am not able to do these by myself. Someone must feed me.	**Remarks**
4. Preparing food				
I prepare all food by myself.	Can prepare simple meals independently but not more complex ones.	With assistance can cook simple meals.	Someone must cook for me.	**Remarks**
5. Personal hygiene, washing and bathing				
I maintain personal hygiene independently (wash hands, face, feet, take showers, and baths).	I maintain maintaining personal hygiene independently but need to be reminded to do it.	I need assistance or technical aids to maintain personal hygiene, bathe, and wash.	I am not capable to wash and bathe and someone must do it for me.	**Remarks**
COMMUNICATING				
6. Communicating verbally				
I am fully capable of communicating effectively. I express myself clearly and fully understand others.	I understand others well but have difficulties expressing myself clearly.	I have difficulties expressing myself and understanding others and need assistance or technical aid.	Cannot communicate.	**Remarks**

7. Reading and understanding signs, symbols, and words				
I am fully capable of reading and understanding signs, symbols, and words.	I read, but cannot understand all signs, symbols, and words.	I have difficulties reading and understanding and need assistance or technical aid.	I cannot read or understand signs, symbols, and words.	**Remarks**
MOBILITY				
8. Mobility inside the house				
I move freely and independently within the house.	I can move independently in the house but on occasion I may need assistance on, for example to get out of bed, or to climb stairs.	Cannot move without assistance or technical aid.	Cannot move at all.	**Remarks**
No problem	**Moderate problem**	**Severe problem**	**Very severe or total problem**	
9. Mobility outside the house				
I move outside independently and fully: walking, jumping, running, etc.	I can move outside, but have difficulties running and jumping, walking longer distances, across uneven terrain, uphill or with other obstacles.	I can move outside the house but only with help from another person or a technical aid.	Cannot move outside at all.	**Remarks**
10. Orienting oneself				
I fully orient myself in known and unknown space.	I orient myself in familiar space, but with difficulty in unfamiliar space.	I need help to orient myself in familiar and unfamiliar space.	Does not have a sense of orientation, even in familiar space.	**Remarks**
INSTRUMENTAL ACTIVITIES IN DAILY LIFE				
11. Maintaining health				
I take my medication, observes appointment schedules, and attends therapy on my own.	I take medicines and observe therapies independently but may need to be reminded.	I can take medicines or therapies independently but prepared and supervised by another person.	Cannot take prescribed medication or participate in therapy.	**Remarks**
12. Using public transportation				
I use public transport freely and independently whenever I need to.	I use public transport independently but have some difficulty orienting myself and	Can use public transport only when accompanied by another person or with technical	Cannot do it at all.	**Remarks**

	following schedules and rules.	aids or use public adapted transport.		
13. Using public services				
I use all public services when I need them.	I can use some public services but need some help to navigate and use some of them.	I need someone to help me use public services.	Not able to use public services. Someone must do that for me.	**Remarks**
14. Managing finances				
I am fully capable of using and managing my money.	I understand the purpose of money and budgeting and management, but I need reminders and supervision to budget and spend the money with purpose.	I need someone to help me use, budget, or manage money	Does not understand the purpose, value, or use of money.	**Remarks**
15. Grocery shopping				
I do all my shopping by myself.	I can do the shopping, but I need some supervision and help to select items and spend money appropriately.	I need full assistance or technical aid to shop.	Cannot do it.	**Remarks**
16. Doing housework, keeping living area clean				
I am fully capable of doing housework, and I keep my living space tidy and clean.	I can do housework for personal or common living space independently, but I need to be reminded to clean.	I need assistance to do housework and maintain personal or common living space.	Not capable of doing it.	**Remarks**
SOCIAL PARTICIPATION				
17. Interacting with peers				
I have friends and I lead active social life.	I interact with peers but not frequently. My social life is not very active but exists.	I interact and communicate with peers but only with assistance from others or technical aid. With help, I maintain friends	Cannot interact with peers. Not capable to engage in social life.	**Remarks**

		and socialize with them.		
18. Participating in family relationships				
I have meaningful family relationships. I am fully active in family life.	I understand the importance of family relations and try to participate, but I need some help.	I understand family relationships, but it is difficult for me to meaningfully participate in family life, even with help.	Does not understand family relationships or participate in them.	**Remarks**
19. Participating in community activities				
I spontaneously, voluntarily, and actively participate in community activities and often initiate activities.	I participate in community activities but sporadically. I need to be reminded and encouraged to participate.	I need help to participate in community activities.	No participation in community activities at all.	**Remarks**

I am aware of my criminal and civil liability for providing untrue information.

First name and family name and signature of the person with a disability

First name and family name and signature of the legal representative:

Date:

NOTE: There should be an option to fill out this form on-line

ANNEX 3

Support interventions to persons with disabilities for which an individual needs assessment is applicable

Monthly financial support	
Regulated by	Persons with Disabilities Act, Regulation on the Implementation of the Persons with Disability Act, Individual assessment methodology
Regulating agency	MLSP
Implementing agency	SAA
Description	Monthly financial support for persons with disabilities to compensate the expenses related to overcoming limitations resulting from the type and degree of disability and depending on their needs, as defined in the individual needs assessment. The allowance is awarded to all permanently disabled persons above the age of 18[39] and it depends on the degree of disability determined by TMEC/NMEC. The allowance differentiates between the following groups of persons with permanent disability: 1. persons with 50-70.99 percent degree of disability 2. persons with 71-90 percent degree of disability 3. persons with >90 percent degree of disability 4. persons with >90 percent degree of disability, entitled to receive assistance support from other people who are receiving disability pension due to general illness or due to work accident or occupational illness 5. persons with >90 percent degree of disability, entitled to assistance support from other people receiving social disability pension.
Eligibility criteria	Certified disability Older than 18 Persons with permanent disabilities between the age of 18 and 20 can receive this allowance if they do not benefit from the family allowance for children with disabilities. Completed individual needs assessment (INA) process. In the case of this allowance, INA is a formality, because the right to receive it depends exclusively on the degree of disability, determined by TMEC.

[39] According to the Persons with Disabilities Act, permanently disabled persons are individuals with a permanent physical, mental, intellectual, or sensory deficit, which in interaction with the environment could impede their full and effective participation in social life, and for whom an expert medical assessment has ascertained a type and degree of disability or a degree of permanently reduced work capacity of at least 50 percent.

Level of benefit	The amounts are as follows (2020): 1. For a degree of disability 50-70.99 percent: 7 percent of the poverty line[40] (25.41 BGN), 2. For a degree of disability 71-90 percent: 15 percent of the poverty line (54.45 BGN), 3. For a degree of disability >90 percent: 25 percent of the poverty line (90.75 BGN), 4. For a degree of disability >90 percent + care by others + disability pension due to general illness /work accident/ occupational illness: 30 percent of the poverty line (108.90 BGN), 5. For a degree of disability above 90 percent + care by others + social disability pension: 57 percent of the poverty line (206.91 BGN).
Benefit delivery/payment frequency	Monthly
Benefit duration and renewal requirements	For the period of validity of the TMEC's decision. 5 years, if the TMEC decision is for life and in the cases when the type and degree of disability or permanently reduced capacity to work have been established after a person had reached the age required for the contributory old-age pension but within the period of the decision of the TMEC (or NMEC).[41] Up to 3 months, if the medical documents do not state a period.
Application and decision making	Application procedure: Application by a person with a disability or his or her legal representative to the SAA municipal office, according to the person's current address. The following documents need to be attached to the application: (a) a copy of completed self-assessment form with filled in sections required for this benefit and (b) a copy of the TMEC decision. The application can be submitted in person/by post mail/by courier. Electronic submission is possible only with an electronic signature. Review and decision: If some information is missing, the applicant is given 14 days to correct the situation. A social worker is assigned to the person. He/she prepares an individual needs assessment with an obligatory contact with the applicant.

[40] The poverty line is determined annually by the Council of Ministers following an official methodology. For 2020, the poverty line was 363 BGN.

[41] The Persons with Disabilities Act (2018) introduced the terms "people with disabilities" and "permanently disabled people": (i) "People with disabilities" shall mean persons with a physical, mental, intellectual, or sensory deficit, which in interaction with the environment could impede their full and effective participation in social life. (ii) "Permanently disabled people" shall mean persons with a permanent physical, mental, intellectual, or sensory deficit which, which in interaction with the environment could impede their full and effective participation in social life, and for whom an expert medical assessment has ascertained a type and degree of disability or a degree of permanently reduced work capacity 50 and over 50 percent." Ibid.

	The social worker submits the case to a commission under a specialized department of the same SAA municipal office. The commission reviews the case and issues an order for granting the allowance.
Grievance redress mechanisms	The order can be appealed within 14 days, following the Administrative Processes Code.
Monitoring arrangements	MLSP
Financing agency	SAA (MLSP)
Sources of financing	State Budget through MLSP budget allocation
Targeted disability allowances	
Regulated by	Persons with Disabilities Act (PDA), Regulation on Implementation of the APD
Regulating agency	MLSP
Implementing agency	SAA
Description	There are four types of targeted disability allowances, depending on the type of disability. They apply to both children and adults with disabilities. 1. **Purchase of a personal motor vehicle** for permanently disabled people with mobility difficulties. The benefit reimburses partially the cost of a car purchase. 2. **Home adaptation** for permanently disabled people using a wheelchair. The benefit reimburses some expenses for renovation of living space. 3. **Rehabilitation and balneotherapy services,** based on a need established by a medical specialist. The benefit covers expenses up to the set limit for a person with disabilities and the same (actual amount up to the set limit) for an accompanying person for those persons with disabilities who are with assigned assistance and care from other people. The benefit is paid based on documents confirming that therapy and/or rehabilitation had taken place. This targeted support can be used both in public and private establishments. When used in publicly owned rehabilitation centers – the amount is paid to a hospital/rehabilitation facility; in the case of a private facility – the funds are reimbursed to a person, after he/she has incurred the cost. 4. Payment of **municipal housing rent** for permanently disabled people living alone or for single parents with permanently disabled child/children residing in municipal housing. The rent is paid to municipality.
Eligibility criteria	**Purchasing a personal motor vehicle** (income tested): • >90 percent type and degree of disability/permanently reduced work capacity, • Persons are in employment or in education, • The car should be owned by a person with disability (beneficiary), her/his family,

	• The monthly average income per member of a household in the last 12 months equal to or below the poverty line. **Adaptation of a home** (income tested): • >90 percent type and degree of disability, as well as children with a certain type and degree of disability, • Proof that a child or adult with disabilities uses a wheelchair for movement, • The monthly average income per member of a household in the last 12 months equal to or below the poverty line. **Rehabilitation and balneotherapy service** • Adults: >90 percent permanently reduced work capacity; permanently disabled children: =>50 percent disability, and disabled servicemen • A medical prescription for balneotherapy and/or rehabilitation according to their specific needs, **Rent payment of municipal housing**: • Degree of disability =>50 percent, • A permanently disabled person is single, • A single parent with a permanently disabled child with =/>50 percent disability, • A rental contract with a municipality for renting a dwelling in municipal housing (concluded with the permanently disabled person, or if he or she has been placed under full judicial disability - with his or her lawful representatives. To receive a targeted benefit, a person needs to go through INA. However, the INA has no impact on the decision (it does not serve as a base to establish eligibility).
Level of benefit	**Purchase of a personal motor vehicle**: up to four times the amount of the poverty line for the respective year (max of 1452 BGN for 2020). **Adaptation of a home**: up to two times the amount of the poverty line for the year during which the adaptation was made (726 BGN for 2020) **Rehabilitation and balneotherapy service** covers the actual expenses for rehabilitation as per the paid invoice, with the limit of 80 percent of the poverty line (290.40 BGN) for both the person with disability and the person who has accompanied her/him. **Payment of municipal housing rent**: amount of the rent according to the contract and regulations of the municipality.[42]
Benefit delivery/payment frequency	**Purchase of a personal motor vehicle**: After the purchase of the car, the person/family applies with relevant documents for reimbursement. The payment is made in the month following the month when the request was approved, in cash or via a bank transfer.

[42] The rent amount is determined by the Municipal Property Act of the respective municipality.

	Adaptation of home: Same as above. **Rehabilitation and balneotherapy service**: The allowance is paid based on the documents confirming therapy/rehabilitation. Payment: 10 days after confirming eligibility if private facility is used; or direct payment to the state-owned facility. In the second case, a person uses rehabilitation services based on an order, without paying. **Municipal housing rent**: Monthly transfer to municipality.
Benefit duration and renewal requirements	For personal motor vehicle: once in 5 years. For adaptation of home: once in 10 years. For balneotherapy and rehabilitation: once in a calendar year. For rent: for the period of validity of the TMEC decision, as long as the municipal housing is rented. All benefits require new application for the next period.
Application and decision making	***Application*** An application should be submitted to a municipal SAA office, according to the person's current address. Attached to the application: (a) completed self-assessment form filled in sections relevant for targeted disability allowances; (ii) a copy of the TMEC decision. According to the regulation, after the approval of the need based on INA, the applicant is required to submit additional document.[43] *For purchase of a vehicle*: A copy of the registration certificate for their personal motor vehicle, Documents proving the family's gross income over the last 12 months, A proof of the vehicle purchase. *For home adaptation*: An itemized invoice for renovation and proof of payment, Documents proving the family's gross income over the last 12 months, *For balneotherapy/rehabilitation* There are two options, depending on where the service is used. If the service is provided in a private establishment: medical prescription from a specialist for the need for balneotherapy and/or rehabilitation services, and an invoice and the proof of payment. If the service is to be provided by a state-owned establishment: medical prescription from a specialist for the need for these services. Subsequently, an order is issues within a 10-day period; the person presents the order to the state-owned establishment and uses the service. *For public housing rent*:

[43] There is a practice of SAA to ask persons to submit all needed documents together with the application for INA, to save them time and efforts.

	Rental contract. ***Approval and payment*** The processes include INA (within one month), a review of documents and eligibility requirements, a decision on the eligibility, issuance of an order and payment. Some allowance-specific steps include: (i) for the home adaptation, a site visit by the case manager (SAA employee) to verify that the adaptation and its purpose; (ii) for rehabilitation and balneotherapy service when the service is used in a state-owned facility, the service provider is required to submit certain documents to the SAA[44]; and (ii) for the municipal housing rental, a municipality sends the invoice to the responsible SAA office.[45]
Grievance redress mechanisms	The decision can be appealed within 14 days, following the procedure of the Administrative Processes Code.
Monitoring arrangements	MLSP
Financing agency	SAA
Sources of financing	State budget
Personal assistance to persons with disabilities	
Regulated by	Personal Assistance Act, Order № RD-07-7 from June 28, 2019, on inclusion in the personal assistance mechanism, Persons with Disabilities Act, Regulation on Implementation of PDA, Methodology for Individual Needs Assessment for support to people with disabilities
Regulating agency	MLSP
Implementing agency	SAA, municipal administration
Description	Personal assistance is regulated as a support mechanism to persons with disabilities for their full and active participation in society, to carry out activities corresponding to their personal, domestic, or social needs, to overcome obstacles to functional limitations, to help them exercise their fundamental rights, and to have opportunities for choice, independent living, and access to services and activities. Only in cases when the choice is not made, a municipality as a provider should find and propose a personal assistant. In most cases, this assistant is a spouse or a close relative of the person with disability.[46] The personal assistance mechanism allows parents and relatives who take care of persons with disabilities to receive

[44] Before the 5th of the next month, a service provider should submit the following documents to the responsible SAA office, requesting a reimbursement: medical prescription, invoice (original) and a receipt listing all expenses incurred for the person with disability and her or his companion. The provider should certify that services were indeed used. The territorial directorate of SAA should reimburse the provider not later than the 25th of the same month.

[45] While the person is informed that she/he was granted the public housing rental allowance, all other issues (invoice, reimbursement, etc.) are handled internally between the municipality and the responsible SAA office.

[46] The motivation for this law was to provide a mechanism through which, spouses, children and other informal care and support givers to persons with disabilities will be compensated.

	remuneration for this work under a labor contract. The contract includes social security coverage. The Social Services Act, which came into force in 2019, recognizes assistant services as a social service. The Personal Assistance Act regulates that anyone (employed, unemployed, self-employed), pensioner or a person with a disability may be an assistant. This differs, for instance, from the programs under the National Employment Action Plan (implemented only in 2020) which requires that only persons registered as unemployed can be employed as home assistants. A person requesting personal assistant services need to undergo an individual needs assessment by SAA (PDA INA). For other assistants' programs, an assessment is also conducted, but the assessment tools and methods vary by municipality or service provider (see above). The level of personal assistance depends on the INA assessed level of dependance – it ranges from several times a month to 8 hours daily.
Eligibility criteria	Eligible to receive services of the personal assistant are persons with a permanent disability of >90% and in need of assistance and care by others, as established by TMEC/NMEC; and children/young persons with type and degree of disability (for young persons) >90% and without specific assistance by others as established by TMEC/NMEC. Completed individual needs assessment. While the assessment per se does not determine the right to personal assistance, as that right depends on the TMEC/NMEC conclusion about the need for assistance by others, it is used to determine hours of support the applicant would receive. The individual needs assessment is based on a self-assessment questionnaire about limitation in functioning in performing daily activities a person with disability experiences, as well as on an assessment instrument filled out by a social worker responsible for the case. The INA conclusions should include a statement about whether the person needs the assistance and in which of the four levels of benefit he/she falls. The assessment is conducted by a local SAA office. Once the level of personal assistance support is determined, the person with disability contacts the local administration, submits the issued "direction for personal assistance" and provides the name of the personal assistant. The municipality signs a contract with the personal assistant who then starts receiving a salary for her/his services.
Level of benefit	There are four levels of this benefit: For the first degree of dependence – up to 15 hours per month, For the second degree of dependence – up to 42 hours per month, For the third degree of dependence – up to 84 hours per month, For the fourth degree of dependence – up to 168 hours per month. Persons with disabilities who are awarded this benefit have some of their other benefits in cash reduced: (i) for children whose families receive a family allowance for children with disability, by up to 380 BGN. The exact deduction depends on the allocated number of hours of support; (ii) for adults receiving pension and a supplement for assistance from others, the amount of the supplement is deducted.

Benefit delivery/payment frequency	Monthly, upon submission of a monthly report by assistant, signed by a person with disability, to the municipality.
Benefit duration and renewal requirements	Personal assistance is awarded for the validity of the TMEC/NMEC decision on disability, which is usually 3 to 5 years. For persons for whom the TMEC decision is valid for life, the renewal period is 5 years. The renewal procedure is the same as for the original application. During the renewal, there may be a gap in the service provision.
Application and decision making	The person submits to the local SAA office a request for INA, completed self-evaluation form, the TMEC/NMEC decision, and her/his ID document. The request must be reviewed within 20 days and a home visit is conducted. The aim of the home visit is for the social worker to meet the person and get a better understanding of his/her situation. The process is completed with the issuance of the individual assessment report together with a "direction" for the use of personal assistance service, including the number of its hours. After having received INA and the direction, the person submits a request to receive personal assistance to the municipality as service provider, according to her/his current address. In the request, the name of the person she/he has chosen to be his/her personal assistant should be indicated, as well as the name of an alternative personal assistant. If he/she cannot indicate a specific person, the municipality suggests a personal assistant. The chosen personal assistant submits documents required for the appointment and formally starts the position after signing the contract.
Grievance redress mechanisms	Appeal/ complaint is possible at all stages following internal grievance mechanism of the SAA and a municipality and following the Administrative Process Code. If person is not satisfied with the service provided, she/he can refuse to sign the service report and take the matter with the municipality.
Monitoring arrangements	MLSP monitors the Personal Assistance Act implementation, the municipality supervises provision and quality of personal assistance services, SAA monitors the entire process.
Financing agency	SAA, NSSI
Sources of financing	The State Budget: municipalities receive funds through the Social Assistance Agency. National Social Security Institute: funds saved through deduction from support by others allowance on the account of personal assistance (see the level of benefits above) are transferred to the provider municipality. Social Assistance Agency: funds saved through deduction from the allowance for a child with a disability on the account of personal assistance (see the level of benefits above) are transferred to the provider municipality.