OSTOMY SUPPLIES PROGRAM
PATIENT APPLICATION

Personal Information (please print)

Applicant		Spouse (if applicable)	
Surname		Surname	
First Name	Initial	First Name	Initial
PEI Health Card number (PHN)		PEI Health Card number (PHN)	
Date of birth (yyyy-mm-dd)		Date of birth (yyyy-mm-dd)	
Marital Status			
Social Insurance Number (SIN) (REQUIRED)		Social Insurance Number (SIN) (REQUIRED)	

Mailing Address

Street/ PO Box			Building/Apt. Number
City/Town	Province PE	Postal Code	Telephone Number
Email address			Mobile Number
Are you a resident of a **Long Term Care Facility?** **Yes** ☐ **No** ☐			

Private Insurance/Coverage

Are you eligible for coverage of ostomy supplies from:	
Workers Compensation Board **Yes** ☐ **No** ☐	Federal Program (including Veterans Affairs, NIHB, RCMP, Department of Defense) **Yes** ☐ **No** ☐
Do you or your spouse have private health insurance that would cover part or all of the cost of your ostomy supplies? **Yes** ☐ **No** ☐	
If "yes" to above, please provide the following information:	
Name of health insurance company	
Terms of Coverage (e.g. insurance pays 80% of the cost of supplies)	
*If there is **more than one plan** that covers your ostomy supplies, please provide information on the additional health plan:*	
Name of health insurance company	
Terms of Coverage (e.g. insurance pays 80% of the cost of supplies)	

PLEASE PROCEED TO PAGE TWO ➔

Personal information on this form is collected under section 31(c) of Prince Edward Island's *Freedom of Information and Protection of Privacy (FOIPP) Act* as it relates directly to and is necessary for providing services under the *PEI Drug Cost Assistance Act*. If you have any questions about this collection of personal information, you may contact the program office at (902) 368-4947 or 1-877-577-3737 or at the address on this form.

Declaration And Consent

I/We, the undersigned, declare that the information provided on this application is true and correct to the best of my/our knowledge.

I/We, the undersigned, understand that refusing to submit information or knowingly furnishing false or incomplete information is an offence under the *Drug Cost Assistance Act*.

For the purpose of verifying program eligibility, I/we authorize the Department of Health and Wellness or Health PEI to obtain information from:

- My employer, my insurer, and my plan administrator regarding private insurance coverage;
- The Provincial Health Plan (the Plan) regarding my eligibility for health services and release of my PHN;
- Retail pharmacies, to access prescription drug cost data in order to verify claims billed to the Drug Cost Assistance Program

I/We, the undersigned, agree to notify the Department of Health and Wellness or Health PEI of any changes to the household, insurance coverage, or any other factor which may affect my level or eligibility of coverage.

I/We, the undersigned, hereby consent to the release by the Canada Revenue Agency (CRA), of income, expense and identifying information from income tax returns or from other sources, copies of notices of assessment or reassessment, and copies of information slips (for example, T2202A, T3, T4 and T5 slips) filed with CRA. The information will be relevant to, and used solely for the purpose of determining and verifying my eligibility and entitlement for assistance, and collecting overpayments of assistance under the Drug Cost Assistance Programs identified above.

A parent or legal guardian may provide consent for all dependents under the age of 18.

This authorization is valid for the taxation year preceding the date of this application, the current taxation year and each subsequent consecutive taxation year for which I apply for assistance under the Drug Cost Assistance Programs identified above.

I understand that there are risks associated with sending personal health information to an unsecured email address, including a risk that my information could be accessed by someone else in transit. I accept the risks and request that Health PEI send my personal health information to me at the email address I have provided.

Name of Applicant	Signature	Date
Name of Spouse	Signature	Date

Please mail, fax or email completed applications to:	**Contact Information:**
PEI Pharmacare PO Box 2000 Charlottetown, PEI C1A 7N8 **Fax:** (902) 368-4905 **Email:** drugprograms@gov.pe.ca	PEI Pharmacare Ph:(902) 368-4947 or 1-877-577-3737

By signing above I certify that the information given on this application and in any documents attached is correct, complete, and fully discloses my household conditions.

I understand that a false statement constitutes fraud and may result in recovery of any benefits paid.

I acknowledge that it is my responsibility to report any change to the information provided within 30 days of the change coming into effect.