Central Health

COMMUNITY SUPPORTS

AND

RESIDENTIAL SERVICES

FINANCIAL APPLICATION

If you have questions regarding completion of this application, please contact:

Central Health – Client Financial Services Division
3rd Floor, 3 Bell Place, Gander, NL A1V 2T4

Community Supports Intake Clerk: (709) 651-6324

Email: bellplaceintake@centralhealth.nl.ca

Revised November 2018

COMMUNITY SUPPORTS AND RESIDENTIAL SERVICES FINANCIAL APPLICATION

- **Home Support Services**
- **Special Assistance Services: Medical Equipment, Supplies, Oxygen**
- **Personal Allowance, Board and Lodging, Other:** _____

Approval for any of the above-noted services is determined through both financial and clinical assessments. Financial eligibility is determined by an assessment of income.

The attached forms must be completed in full if you are requesting a financial subsidy for any of the above-noted services.

Failure to complete these forms (including the consent forms) may result in delays in processing your application. Please be assured that all information you provide will remain confidential and in accordance with your signed consent.

Please complete and return application to:

Intake Clerk
Client Financial Services
Central Health
3rd Floor, 3 Bell Place
Gander, NL A1V 2T4
Phone: (709) 651-6324 FAX: (709) 651-3556

CENTRAL HEALTH
FINANCIAL ASSESSMENT CHECKLIST

The following checklist outlines the information required to process the financial application:

□ Verification of Birth - Applicant, Spouse, and Dependent(s)
- Birth Certificate may be obtained by contacting Vital Statistics Division-Government Services Centre.

□ Verification of Social Insurance Number - Applicant, Spouse, and Dependent(s)
- Photocopy of SIN card

□ Verification of MCP Number - Applicant, Spouse, and Dependent(s)
- Photocopy of most recent valid MCP card

□ Verification of Income - Applicant and Spouse
- Photocopy of most recent **Notice of Assessment** which you received from Canada Revenue Agency for both applicant and spouse. If you do not have a copy of this assessment, you can telephone 1-800-959-8281 and request a **Printout of Option C**.

- Verification of <u>all</u> sources of monthly income. You may call Service Canada at 1-800-277-9914 to request a statement of monthly Old Age Security and Canada Pension Plan Benefits. For other income, contact the income source for a statement or provide a copy of your recent cheque stubs or bank records showing direct deposited income. (ie. DVA, private pension, annuities, employment income, etc.)

□ Verification of life insurance and/or prepaid funeral - Applicant and Spouse
- Photocopy of policy or contract. The life insurance policy must indicate face value; cash surrender value, beneficiary and yearly / monthly payments.

□ Consent Forms from the Department of Advanced Education, Skills and Labour (AESL)

Please complete and return application along with all required documents to:

Intake Clerk
Client Financial Services
Central Health
3rd Floor, 3 Bell Place
Gander, NL A1V 2T4
Phone: (709) 651-6324 FAX: (709) 651-3556

Updated November 2018

CENTRAL HEALTH SUPPORTIVE SERVICES APPLICATION

Office Use Only: **File #: _____** **CRMS #: _____**

TYPE OF SERVICE- Please check all that apply

☐ **Home Support Services**

Special Assistance Program
☐ Medical Equipment ☐ Health Supplies ☐ Oxygen

Supplementary Financial Benefits (specific clinical criteria must be met*)*
☐ Personal Allowance ☐ Board and Lodging ☐ Other _____

Supportive Services are requested for:
☐ **Applicant** ☐ **Applicant and Spouse**

APPLICANT	**SPOUSE**
Name: _____	Name: _____
☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth: _____	Date of Birth: _____
Social Insurance #: _____	Social Insurance #: _____
MCP #: _____	MCP #: _____

Mailing Address: _____

Street Address: _____

Postal Code: _____ Telephone #: _____

CONTACTS and ADMINISTRATION FOR HOME SUPPORT SERVICES

I hereby give consent for the following to make enquiries or act on my behalf regarding this application:

Name: _____ Relationship: _____Tel. Number_____

Correspondence to be sent to: ☐ Applicant ☐ Contact Person

If approved for home support services, which of the following will you be using?

☐ **Bookkeeper (workers are hired privately by client/family)**
Name of Bookkeeper: _____

☐ **Home Support Agency (workers are hired by the Home Support Agency)**
Name of Agency:_____

ACCOMMODATIONS

☐ Own Home
☐ Mortgage Monthly Payment: $_____
☐ Rent Monthly Payment: $_____
☐ Board and Lodging Monthly Payment: $_____ Is this with a relative? ☐Yes ☐No

FINANCIAL INFORMATION

Have you and/or your spouse had any change in your sources of income in the past 3 years?
Applicant ☐Yes ☐No If Yes, When? _____
Spouse ☐Yes ☐No If Yes, When? _____

Have you had any change in your marital status in the past 3 years (ie: death, divorce, recent marriage)?
☐Yes ☐No If Yes, When? _____

Applicant's Income (per month)	Spouse's Income (per month)
Old Age Security (OAS): _____	Old Age Security (OAS): _____
Canada Pension Plan (CPP): _____	Canada Pension Plan (CPP): _____
Veterans Pension or Allowance (DVA):_____	Veterans Pension or Allowance (DVA):_____
Private and/or Disability Pensions: _____	Private and/or Disability Pensions: _____
Employment Earnings:_____	Employment Earnings:_____
E.I. Benefits: _____	E.I. Benefits: _____
Worker's Compensation: _____	Worker's Compensation: _____
Child Support/Maintenance: _____	Child Support/Maintenance: _____
Investment Income: _____	Investment Income: _____
Income from Rental Property: _____	Income from Rental Property: _____
Income Support (AES): _____	Income Support (AES): _____
Other: _____	Other: _____
Total Monthly Income: _____	Total Monthly Income: _____

Do you have any dependents under the age of 18? ☐Yes ☐No *If yes, how many?* _____
Please attach the names and verification of income for all dependents.

_____ _____
Name of Dependent DOB

_____ _____
Name of Dependent DOB

_____ _____
Name of Dependent DOB

MEDICAL INFORMATION

Do you and your spouse have medical insurance covering the following benefits:

Prescription Drugs	☐Yes	☐No	Coverage Amount: _____	Supplier: _____
Home Supports	☐Yes	☐No	Coverage Amount: _____	Supplier: _____
Medical Supplies	☐Yes	☐No	Coverage Amount: _____	Supplier: _____
Medical Equipment	☐Yes	☐No	Coverage Amount: _____	Supplier: _____
Oxygen	☐Yes	☐No	Coverage Amount: _____	Supplier: _____

Are you or your spouse a diabetic? ☐Yes, Applicant ☐Yes, Spouse ☐Neither

LIFE INSURANCE

Do you have life insurance?

☐ Yes ☐ No Coverage Amount: _____ Company: _____

Does your spouse have life insurance?

☐ Yes ☐ No Coverage Amount: _____ Company: _____

If Yes, please provide all insurance documents including beneficiary and cash surrender value, if applicable.

DECLARATION

1. I/We declare that the information provided in this application is true to the best of my/our knowledge.
2. I/We declare that the information provided in this application is being collected for the purpose of administering a subsidy towards the cost of home supports or other supplementary benefits. This information will only be disclosed to Central Health personnel who need the information to carry out the responsibilities of their job and to other organizations that may need to be contacted in order to process the application. Section 32 (c) of the Access to Information and Protection of Privacy Act (ATIPPA) authorizes Central Health to collect personal information that "..relates directly to and is necessary for an operating program or activity of the public body".
3. I/We hereby grant Central Health or its agents, permission to carry out necessary inquiries for the purpose of determining my/our income and liabilities.
4. I/We hereby grant Central Health permission to investigate any or all of the statements made herein, being fully aware that discovery of any false statements will cancel this application. I/We further agree that such action by Central Health will be without penalty or liability for damages.
5. I/We understand that this application does not constitute an agreement by Central Health or its representatives to provide a subsidy for home supports or any other supplementary benefits.

Applicant: _____ Date: _____

Spouse: _____ Date: _____

Completed by: _____ Date: _____

Witness (if applicant signed with an "X")

Name: _____ Signature: _____

Central Regional Health Authority
CONSENT TO OBTAIN/SHARE CLIENT INFORMATION from/with
Department of Advanced Education Skills and Labour

File Number: **Program:**

Client/Applicant		Spouse/Co-Applicant (if applicable)	
Date of Birth	SIN	Date of Birth	SIN
MCP Number		MCP Number	

The Central Regional Health Authority may need to obtain client personal information from, or share client personal information with, the Department of Advanced Education and Skills to determine client eligibility for financial support and related services, and to process payments for services for which a client is eligible.

By personal information we mean:

- Client name, age, marital, family and aboriginal status, and education
- Client financial status
- Client identifying numbers such as SIN, MCP or other file numbers assigned to the client
- Information related to the supports and services required.

The information obtained under this consent will be used solely for the purposes listed above and will not be shared with any other person or organization without consent, except as required or permitted by law.

Note: Service may be delayed if this consent is not signed.

CONSENT

In signing this form I agree that the Central Regional Health Authority has my consent to obtain personal information about me and my spouse/co-applicant from and/or share personal information about me and my spouse/co-applicant with the Department of Advanced Education and Skills for the purposes of determining eligibility for financial benefits and other services or to process payments for services for which I am eligible.

This authorization is valid for as long as I am receiving financial services from the Central Regional Health Authority.

I understand that I can withdraw this consent at any time by notifying the Central Regional Health Authority in writing.

Signature of Client/Applicant _____

Signature of spouse/Co-Applicant _____ Date: _____

Substitute Decision Maker (if applicable):

I confirm that I have the authority to act for the client in decisions pertaining to the client's care and services.

_____
Name of Authorized Person (please print)

_____ _____
Signature of Authorized Person Date

Newfoundland Labrador

Government of Newfoundland and Labrador
Department of Advanced Education, Skills and Labour

RIGHTS, RESPONSIBILITIES AND CLIENT CONSENT FORM

Name of Client _____ Name of Spouse (if applicable) _____ File # _____

Address _____

All new and re-opened applicants for income support benefits must complete this form upon application for services and during the regular review process.

Your personal information will be used to assess your household's eligibility for income support benefits; to determine the amount of assistance; to identify your employment, medical and other service needs; and to prevent and detect fraud.

Rights

The Department of Advanced Education, Skills and Labour (hereinafter referred to as the "Department") respects your rights for privacy. As stated in the *Access to Information and Protection of Privacy Act (ATIPPA, 2015),* all clients: have the right to the protection of their personal information; have the right to access their personal information that is held within the department; and have the right to request the correction of their personal information if there has been an error or omission.

Responsibilities

I agree to report to the Department any changes in my circumstances, or the circumstances of my family (spouse, common-law spouse, children or dependent students) as this may affect eligibility and rates of assistance.

I understand that excess payments can result from a failure to report changes in circumstance. This failure to report could mean that I will not get increases in my benefits or I might have to pay back money I received over the allowable amount. If I am in doubt as to whether a change in circumstance will affect eligibility, I agree to notify an employee of the Department. Some examples of changes in circumstances are: change in address; the receipt or expected receipt of money, goods or other assets from any source; increases or decreases in the number of dependants; a child turning 18; changes in health status; changes in marital status or changes in living arrangements.

Client Consent to Release and Exchange Personal Information

I give consent to the Department to obtain and verify information or documents required to confirm my eligibility, or the eligibility of family members (spouse, common-law spouse, children or dependant students), for income support services.

I give consent to any department, agency or person having such information or documents to release them to the Department's employees. This information may be about individual needs, income, assets, employment (including Record of Employment documents), marital status or any entitlement I may have to benefits under

other programs. Some examples of these departments, agencies or individuals include, but are not limited to: Human Resources and Skills Development Canada - Service Canada; provincial departments of Education and Early Childhood Development, Justice and Public Safety, Health and Community Services and Finance; agencies such as Newfoundland and Labrador Housing; WorkplaceNL; regional health authorities; governments and agencies in other provinces and territories; financial institutions such as banks, mortgage companies, credit unions, credit bureaus and insurance companies; employers; or other organizations or individuals that may have information that is deemed necessary for the Department to verify eligibility for income support benefits and services.

I give consent to disclose and use my information for program evaluation and research to improve the quality of services offered by the Department.

Consent for Canada Revenue Agency to Release Taxpayer Information

I authorize the Canada Revenue Agency to release information from my income tax records and other relevant taxpayer information to an official of the Department. The information will be used solely for the purpose of verifying my eligibility, determining my entitlement for income support benefits and for the general administration and enforcement of the Income Support Program under the *Income and Employment Support Act*. This information will not be disclosed to any other person or organization without my approval. This authorization is valid for:

(a) the most recently available of the two taxation years prior to the year of signing this form,
(b) the current taxation year and,
(c) each subsequent consecutive taxation year for which we require income support benefits.

I understand that my consent to release personal information is required to apply for or receive benefits from the Income Support Program. The failure to provide this consent or the withdrawal of my consent will make me ineligible for income support benefits.

If I wish to withdraw my consent, I may do so at any time by contacting or writing to my local office of the Department of Advanced Education, Skills and Labour.

Signature of Applicant/Client	**Social Insurance Number of Applicant**	**Current Date**
Signature of Power of Attorney or Trustee for Applicant (if applicable)		**Current Date**
Signature of Spouse	**Social Insurance Number of Spouse**	**Current Date**
Signature of Power of Attorney/Trustee for Spouse (if applicable)		**Current Date**

Newfoundland Labrador

Government of Newfoundland Labrador
Department of Advanced Education, Skills and Labour

DECLARATION BY PROXY

Re: Income Support Benefits for _____ File:_____
(applicant/recipient)

I, _____ of _____ (proxy address)
(proxy name)
_____
_____

Solemnly declare as follows:

1. I am the person making the statements on the Application for Income Support attached hereto and identified by my signature at the place provided for signature of applicant.
2. I have full knowledge of the facts concerning the statements made on the said form.
3. The said applicant for Income Support is by reason of infirmity unable to give the information required and to complete the declaration and I make the statements on his/her behalf.
4. All the statements made herein are true, and I have not concealed or omitted any information respecting his/her financial circumstances.
5. I make this solemn declaration conscientiously believing the foregoing to be true.

_____

Signature of Person Making Declaration

Declaration of an Approved Professional

I, _____ have seen the applicant and certify that it is my assessment that the said applicant is unable, by reason of infirmity, to give the information required in the application for Income Support and to complete the declaration. Furthermore, the above mentioned _____ who has given the information and made the declaration is, in my opinion, a competent and proper person to do so on behalf of said applicant.

Declared before me at _____this _____day of _____ 20 ____

Signature: _____

Title: _____

Note: An Approved Professional may be a Lawyer, Social Worker, Physician or any professional approved by the Department of Advanced Education, Skills and Labour.

Form #: 14-721
January 2017