Ministry of Health

Drug Plan and Extended Benefits Branch

SIDE B

RETURN BY MAIL TO:
MINISTRY OF HEALTH
Drug Plan & Extended Benefits Branch
Operations Unit
3475 Albert Street – 2nd Floor
Regina, Saskatchewan S4S 6X6
PHONE: 1-800-667-7581 or 306-787-3317
FAX: 306-787-8679

SPECIAL SUPPORT PROGRAM ANNUAL APPLICATION

- Completing Side B means that you must apply for the program each year.
- Provide a copy of your Notice of Assessment OR pages 1 to 4 of your Income Tax Return showing Line 150 (for both Applicant and Spouse).
- If you do not file income tax, please include a written explanation and provide all documentation from all sources of income. (some examples: cheque stubs, T4 slips)
- Incomplete applications will result in delays in processing. Please ensure you have provided all information.
- Coverage is effective the date complete information is received, subject to approval.

SURNAME / FIRST NAME APPLICANT		SURNAME / FIRST NAME SPOUSE
CURRENT ADDRESS		
CITY	POSTAL CODE	PHONE NUMBER --

APPLICANT INFORMATION	SPOUSE INFORMATION
DATE OF BIRTH (DD / MM / YYYY) / /	DATE OF BIRTH (DD / MM / YYYY) / /
HEALTH SERVICES NUMBER (HSN)	HEALTH SERVICES NUMBER (HSN)
SOCIAL INSURANCE NUMBER (SIN)	SOCIAL INSURANCE NUMBER (SIN)

DECLARATION AND CONSENT

Is the Power of Attorney (POA) signing on behalf of the applicant? YES ☐ NO ☐
If YES, then copies of the POA documents MUST be attached. NOTE: If a Trustee, Guardian or POA is signing for the Applicant, a copy of the legal document must be attached to this consent form. Due to the variety of POA documents, some may not be considered acceptable for CRA , such as POA specific to or limited to a bank or financial institution.

"I declare that all the information I have provided is complete and correct in all respects and fully discloses my total income from all sources. I further consent to the use of this information by Saskatchewan Ministry of Health for the purpose of determining my entitlement for other Health Care benefits or programs but will not be disclosed to any other person or organization without my approval."

____________________________DATE _________________
SIGNATURE OF **APPLICANT**, or if applicable, GUARDIAN / TRUSTEE / POWER OF ATTORNEY. A witness is necessary if Applicant signs with an "X" or a mark.

___________________________________ DATE _______________
SIGNATURE OF **SPOUSE** or if applicable, GUARDIAN / TRUSTEE / POWER OF ATTORNEY. A witness is necessary if Spouse signs with an "X" or a mark.

____
PRINT NAME IF GUARDIAN / TRUSTEE / POWER OF ATTORNEY/ WITNESS

____
PRINT NAME IF GUARDIAN / TRUSTEE / POWER OF ATTORNEY/ WITNESS

ADDITIONAL INFORMATION

Include any written explanation or information that you feel may help for the review of this request. For example, income changes, new medication or changes in medication, capital gains. **(If providing additional information about capital gains, please attach a copy of schedule 3). Ensure you include supporting documentation.**

____

____