



SIDE B

Please return to:  
**Drug Plan & Extended Benefits Branch**  
 Income Assessment  
 Operations Unit  
 3475 Albert Street  
 Regina, Saskatchewan S4S 6X6  
 Phone: 1-800-667-4884 or 306-787-5023  
 Fax: 306-787-8679  
 Website: [www.health.gov.sk.ca](http://www.health.gov.sk.ca)

## Institutional Supportive Care - Income-Tested Resident Charge 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 Resident 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.

RESIDENT INFORMATION (Please Print)		SPOUSE INFORMATION (Please Print)	
Resident's Surname	First	Spouse's Surname	First
Health Services Number	Date of Birth (YY/MM/DD)	Health Services Number	Date of Birth (YY/MM/DD)
Social Insurance Number		Social Insurance Number	
CONTACT INFORMATION (Please Print)			
Surname	First	Current Mailing Address	
Home Phone Number ( )	Work Phone Number ( )	City/Town/Village	Postal Code

### DECLARATION AND CONSENT

Is the Power of Attorney (POA) signing on behalf of the resident? 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 the 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."

\_\_\_\_\_  
 Signature of Resident, or if applicable, Guardian/Trustee/ Power of Attorney. A witness is necessary if resident signs with an "X" or a mark.

\_\_\_\_\_  
 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 OF Guardian/Trustee/ Power of Attorney/Witness.

\_\_\_\_\_  
 PRINT NAME OF Guardian/Trustee/ Power of Attorney/Witness.