

**NOTE: ALL COMMUNICATION BETWEEN THE APPLICANT AND SWCDS IS CONFIDENTIAL. THE PATIENT MUST BE AWARE THE APPLICATION IS BEING MADE.**

Date of Application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If patient is a minor, name of legal guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address/phone of legal guardian if different than patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have dependents? Yes \_\_\_ No\_\_\_\_ How many? \_\_\_\_\_\_\_

Are you a single parent? Yes \_\_\_ No\_\_\_ (If yes, you may claim one dependent as a spousal deduction)

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Do you receive SAP/SES/SIP? Yes \_\_\_ No\_\_\_\_ (If yes, applicant is eligible for maximum reimbursement of expenses as per policy)

Applicants Annual Income: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Line 236 of your Income Tax Return)

Spouse’s Annual Income: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Line 236 of their Income Tax Return)

Applicant’s Total Payable: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Line 435 of your Income Tax Return)

Spouses’ Total Payable: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Line 435 of their Income Tax Return)

Date of Medical Appointment ­­­­­­­­­­­­ ­­­­\_\_\_\_\_\_\_\_\_\_ Name/Address of Medical Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**RELATED MEDICAL EXPENSES (For expenses not covered by other sources: Social Services, Telemiracle, etc.)**

|  |  |
| --- | --- |
| Item | Amount |
| Ambulance |  |
| Transportation (Fuel) |  |
| Parking |  |
| Accommodation |  |
| Other (specify) |  |
| **Total Amount Applied For:** |  |

**MEDICAL EQUIPMENT (For expenses not covered by other sources: Social Services, Telemiracle, etc.)**

|  |  |
| --- | --- |
| Aides to Daily Living |  |
| Mobility Aides |  |
| **Total Amount Applied For:** |  |

**By submitting this application I am confirming that I am NOT receiving funding from any other source for these expenses.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant Signature of Authorizing Director (SWCDS) Date Approved

If submitting electronically, must be sent from your personal email, which will be considered your signature.

 **Instructions for Completing Form**

THE following **MUST** be attached to the application form. If submitting electronically, scan and attach.

**Copies of receipts**- For related medical expenses, aides to daily living, mobility aides

**Verification of specific Medical Appointment dates**. A letter from the Medical Practitioner or an appointment card signed by the medical receptionist.

**Letter from your medical practitioner verifying chronic disease**

**Copies of your and your spouse’s most recent Income Tax Return to include names and lines 236 and 435**

**Any further information you feel will be helpful to the SWCDS in reviewing your application**

**Applying in Advance-** If applying in advance estimate the cost of travel/accommodation. Receipts must be provided before further applications are considered.

**Related Medical Expenses-** Accommodation: If a hostel is available in the community such as the Ronald McDonald House or Cancer Patient Lodge, accommodation reimbursement will be provided at the same rate as the hostel. Every major hospital has nearby accommodation lists with medical rates.

**Medical Equipment Funding-**This funding is to assist with items **NOT** available from any other source (Telemiracle, etc.)

 **Any further information you feel will be helpful to the SWCDS in reviewing your application** available through any other resources (Sask Abilities, Social Services, etc.)

Application Form – Appendix 4-3A