Cleft Palate Orthodontic Treatment Funding program

Application Form

Please fill out section A and ask the orthodontist or pediatric dentist to fill out section B. If you are applying for additional funding, please complete the declaration and consent form on the reverse for Dental Health staff to assess your family income and determine eligibility for additional funding.

Mail completed application to:

Public Health - Dental Programs
Attn: Cleft Palate Orthodontic Treatment Funding Program
152 St. Peters Road
P.O. Box 2000
Charlottetown, PE C1A 7N8

Section A

To be completed by the parent applying for funding for orthodontic treatment

Child's Name	First Name			
	Last Name			
	Date of Birth			
Parent's Name	Mother's Name			
	Father's Name			
Address				
Phone Numbers:	**Home**		**Office**	

Signature of Parent/Guardian		**Date**

Section B

To be completed and signed by orthodontist or pediatric dentist

The above named patient requires orthodontic treatment for a malocclusion directly related to a cleft palate. An estimate and payment schedule is attached or will be submitted on request. Dental records will be submitted if requested by the review committee.

Orthodontist/Pediatric Dentist (Name)	**Signature**		**Date**

The *Freedom of Information and Protection of Privacy (FOIPP) Act and the Health Information Act* of Prince Edward Island governs the collection, use and disclosure of personal information contained in this form. If you have any questions about the collection, use or disclosure of your personal information, please contact the Health PEI Privacy and Information Access Coordinator at (902) 368-4942.

Section C: Complete only if your are applying for more than 50% funding subsidy level

Personal health information on this application collected under section 17 of the Health Information Act and under The Freedom of Information and Privacy Protection Act and is necessary to assess eligibility.

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 knowingly providing false or misleading information or records is an offence under the Health and Dental Services 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 Health and Dental Services 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 under the Health and Dental Services Cost Assistance Act, and collecting overpayments of assistance under the Freedom of Information and Privacy Protection Act identified above.

This authorization is valid for the two taxation years preceding the date of this application, the current taxation year and subsequent consecutive taxation year for which I apply for assistance under Health and Dental Services Cost Assistance Program identified above.

I understand that I may withdraw my consent from the Department or Health PEI to collect, use and disclose my information by providing written notice, but that my right to withdraw consent may be subject to limited exceptions. I may contact the Department of Health and Wellness or Health PEI for further information about how to withdraw consent, and the potential impacts if I withdraw my consent.

Applicant Name (Print)	*Signature*	*Date*
Spouse Name (Print)	*Signature*	*Date*

- *By signing above, I certify that the information given in this application and in any documents attached is correct and complete.*
- *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.*