Fertility Support Program Application

Department of Health and Wellness

Personal Information (please print)

APPLICANT

Surname	First Name	Initial

Date of Birth (month/day/year)	PEI Health Care Number (PHN)	Social Insurance Number (SIN) REQUIRED

ADDRESS

Street # and Name	Apt. #

City/Town	Province	Postal Code
	PE	

Home Telephone	Cell
( )	( )

Spouse Information (if applicable)

Surname	First Name	Initial

Date of Birth (month/day/year)	Social Insurance Number (SIN) REQUIRED

Private Insurance/Coverage

Are you eligible for coverage from:

Yes ◯ **No** ◯ Federal Program (including Veterans Affairs, NIHB, RCMP, Department of Deference)

Yes ◯ **No** ◯ Your employer

Do you or your spouse have access to private health insurance that would cover part or all of the cost of your IVF and /or IUI treatments or prescribed medications? **Yes** ◯ **No** ◯

If "Yes", please provide the following information:

Health Insurance Company Name

Plan Number	Terms of Coverage (e.g. insurance pays 80% of the cost of medications or IVF/IUI Procedure)

If there is more than one plan that covers your IVF/IUI treatment or medications, please provide information to the additional plan:

Health Insurance Company Name

Plan Number	Terms of Coverage (e.g. insurance pays 80% of the medications or IVF/IUI Procedure)

Personal health information on this application collected under section 17 of the Health Information Act *and is necessary to assess the applicant's request for funding based on eligibility. If you have any questions about this collection of personal health information, you may contact the program office at (902) 368 5290.*

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 refusing to submit information or knowingly furnishing false or incomplete information 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, and collecting overpayments of assistance under the Health and Dental Services Cost Assistance 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 if I wish to withdraw this consent, I may submit a written request at any time.

I understand that there are risks associated with sending personal health information to an unsecured email address, including a risk that my information could be accessed by someone else in transit. I accept the risks, and request that the Department of Health and Wellness or Health PEI send my personal health information to me at the email address I have provided.

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

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

Mail completed application to:	**For further information, contact:**
Fertility Support Program P.O. Box 2000 Charlottetown, PE C1A 7N8	Email: fertilitysupportprogram@gov.pe.ca Tel: 902-368-6414

Application Checklist:

- Meet eligibility criteria
  - Are a permanent PEI resident as defined by the *Drug Cost Assistance Act*;
  - Have a valid PEI Health Card; and
  - Have filed your most recent income tax return in PEI.
- Fertility Support Program Application Form – completed and signed by all required parties.
- Fertility clinic letter confirming you are an eligible candidate for IVF and/or IUI.