Reset Form

Application for Orthodontic Treatment Funding for Cleft Palate Patients

Please fill out section A and ask the orthodontist or pediatric dentist to fill out section B. If you are applying for additional funding, fill out section C and attach a Notice of Assessment or Re-assessment from Revenue Canada (or an Option C printout obtainable from a Revenue Canada tax office) for each parent or guardian.

Mail completed application to: Dr. A. O. Adegbembo
Senior Dental Consultant
Public Health - Dental Programs
152 St. Peters Road
P.O. Box 2000
Charlottetown PE C1A 7N8

Section A: To be completed by parent applying for funding for orthodontic treatment.

Child's Name: Last _____ Date of Birth (MM/DD/YYYY): _____

First _____

Parent's Names: Mother _____

Father _____

Address: _____
_____
_____
_____

Phone Numbers: home_____-_____ work _____-_____

_____ _____
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 or Pediatric Dentist: _____

Signature: _____ Date: _____

Section C: Complete only if you are applying for further financial assistance over and above the 50% treatment funding level Funding:

Pubic Health, Dental Programs will pay 50% (maximum of $2,500) of the approved orthodontic treatment. In cases where there is a need for further financial assistance, the patient can apply for 75% coverage (maximum of $3,750) or 100% coverage (maximum of $5,000**).**

Depending on your total family income (based on line 236 of the tax guide), you might be eligible for 75% or 100% funding. For further information on the funding levels, phone 368-4917.

Please attach a copy of the latest income tax assessment or re-assessment from Revenue Canada, or an Option C printout (obtainable from a Revenue Canada tax office), for each parent or guardian. Any information provided will be kept confidential and will be used only by the assessment committee.

Do you have any other medical/dental insurances that will cover a portion of the cost? ○ No ○ Yes

Insurance Company Name and portion covered _____

Names and ages of other children:

Child	Age	Child	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I am applying for a higher level of funding than the usual 50%. I verify the above information to be correct.

_____ _____

Signature of parent/guardian Date

The *Freedom of Information and Protection of Privacy (FOIPP) 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.