

**PEI Pharmacare Drug Programs and Diabetes Programs:
Ukrainian Evacuee and Government Assistance Refugee
Income Waiver and Status Confirmation Form**

The submission of this form does not replace program eligibility and enrolment requirements. If applicable, program application(s) must also be submitted.

This form replaces Canadian Revenue Agency income verification for the following income tested programs*:

- Catastrophic Drug Program
- Ostomy Supplies Program
- Insulin Pump Program
- Glucose Sensor Program

For non-income tested drug programs, refer to: www.princeedwardisland.ca/en/information/health-pei/drug-programs

Personal Information (please print)

Applicant										Spouse (if applicable)									
Surname										Surname									
First Name					Initial					First Name					Initial				
PEI Health Care Card number (PHN)										PEI Health Care Card number (PHN)									
Social Insurance Number (SIN): <input type="checkbox"/> NA										Social Insurance Number (SIN): <input type="checkbox"/> NA									
Date of Birth (yyyy-mm-dd)										Date of Birth (yyyy-mm-dd)									
Street/PO Box										Building/Apt Number									
City/Town					Province PE					Postal Code					Telephone Number				
Email address					Landing Date:					Mobile Number									

Applicant is requesting access to PEI Drug Programs or Diabetes Programs as a (select one):

- Ukrainian evacuee under the Canada-Ukraine Authorization for Emergency Travel (CUAET) program OR
- Government Assisted Refugee (GAR); **for application to income tested programs as a GAR, please submit a copy of your:**
 - Interim Federal Health Program (IFHP) eligibility document; AND
 - Immigration and Refugee Board of Canada (IRB) formal letter/document detailing your Government Assisted Refugee status.

Dependent Information - Include all dependent children living with you under the age of 18 or aged 18 to 25 and attending a post secondary institution on a full time basis. Dependents living with you aged 18 or older but NOT attending school must complete their own application form. (If more space is required, please attach a separate sheet)

Surname	First Name	Initial	Gender		Date of Birth			Provincial Health Card Number
			M	F	Year	Month	Day	

I acknowledge that it is my responsibility to report any change to the information provided within 30 days of the change coming into effect.

*The allowance of proof of income waiver is limited to those who are not covered by federal drug programs, until such time one is required to file a tax return through the Canada Revenue Agency.

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 *Drug Cost Assistance Act*. Personal information is collected under Prince Edward Island's Health Information Act as it relates directly to and is necessary for providing services under the Drug Cost Assistance Act. If you have any questions about this collection or use of personal information, you may contact the program office at (902) 368-4947 or 1-877-577-3737 or at the address on this form.

Name of Applicant	Signature	Date
Name of Spouse	Signature	Date