



The personal information collected on this form will be used for the purposes of determining At Home Program eligibility and providing benefits and will be treated confidentially in compliance with the Freedom of Information and Protection of Privacy Act.

A. TO BE COMPLETED BY PARENT OR GUARDIAN

Form A: TO BE COMPLETED BY PARENT OR GUARDIAN. Fields include: LAST NAME OF CHILD, FIRST, INITIAL, CHILD'S PERSONAL HEALTH NUMBER, GENDER, DATE OF BIRTH, NAME OF PARENT(S)/GUARDIAN(S), DATE OF BIRTH, DAYTIME PHONE NUMBER, ADDRESS, CITY/TOWN, POSTAL CODE, EVENING PHONE NUMBER, EXTENDED HEALTH BENEFITS, REGISTERED INDIAN, etc.

All Household Members (excluding the child) USE BACK OF PAGE IF YOU REQUIRE MORE SPACE.

Table for Household Members with columns: Last Name, First Name, Relationship to Child, Gender, Date of Birth (YYYY/MM/DD)

Signature of Parent/Guardian section. Includes a list of statements with checkboxes and lines for initials. Statements cover eligibility requirements, awareness of program purpose, information usage, residence, legal status, and consent to information release.

B. TO BE COMPLETED BY THE CHILD'S PHYSICIAN

Form B: TO BE COMPLETED BY THE CHILD'S PHYSICIAN. Fields include: PRIMARY DIAGNOSIS, SECONDARY DIAGNOSIS, SIGNATURE, NAME (PLEASE PRINT), DATE (YYYY/MM/DD)

C. ELIGIBILITY DECISION - this section for Government Office use only

Form C: ELIGIBILITY DECISION. Fields include: REGION, ELIGIBLE/RESPITE/MEDICAL/NOT ELIGIBLE checkboxes, EFFECTIVE DATE (YYYY/MM/DD), AM NUMBER, REGIONAL CONTACT SIGNATURE, NAME (PLEASE PRINT), DATE SIGNED (YYYY/MM/DD)

