



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

Form with fields: NAME OF CHILD, DATE OF BIRTH (YYYY/MM/DD), AREA CODE AND PHONE NUMBER, ADDRESS, CITY/TOWN, POSTAL CODE

SPECIFIC DIAGNOSIS (i.e.: TYPE OF IMPAIRMENT, LOCATION AND DEGREE OF INVOLVEMENT)

Medical Supplies Required:

Table with 4 columns: ITEM NAME, DESCRIPTION/SIZE/PRODUCT NUMBER, QUANTITY (per day, per month), LENGTH OF TIME REQUIRED*

Incontinence Supplies Required: (age 3 or older):

Child's Weight: _____

Child is incontinent Day Night

Table with 4 columns: ITEM NAME, DESCRIPTION/SIZE/PRODUCT NUMBER, QUANTITY (per day, per month), LENGTH OF TIME REQUIRED*

* Please note that unless otherwise indicated, the Medical Benefits Program will set a one year time limit on supplies.

Please provide a clear justification for the medical supplies, indicating that the supplies are directly related to the child's specific disability/diagnosis. (Attach additional pages if required).

Large empty box for justification text

Form with fields: NAME OF HEALTH CARE PROFESSIONAL, SIGNATURE OF HEALTH CARE PROFESSIONAL, PROFESSION, DATE SIGNED (YYYY/MM/DD)

AREA CODE AND PHONE NUMBER ()

MAIL OR FAX COMPLETED FORM TO:

MEDICAL BENEFITS PROGRAM - AT HOME PROGRAM
MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT
PO BOX 9763 STN PROV GOVT
VICTORIA BC V8W 9S5
FAX NUMBER: (250) 356-2159
PHONE NUMBER: 1-888-613-3232 (Toll Free)