



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.

PART 1 TO BE FILLED OUT BY THE PARENT/GUARDIAN

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

Is the child eligible for extended health benefits including optical? YES NO

If Yes, have you applied for funding through that plan? (please explain)

Three empty text boxes for explanation of funding application.

Note: The At Home Program has a funding limit of \$150 per 12 month period.

Form with fields: NAME OF OPTICAL SUPPLIER, PRICE QUOTED (\$), PHONE NUMBER, ADDRESS, CITY/TOWN, POSTAL CODE

Form with fields: NAME OF PARENT, SIGNATURE OF PARENT, DATE SIGNED (YYYY/MM/DD)

PART 2 TO BE FILLED OUT BY THE PHYSICIAN

Form with field: MEDICAL DIAGNOSIS/ DISABILITY

Please provide a clear justification for the prescription lenses and frames indicating that they are required because of the child's disability or specific medical diagnosis.

Note: Funding is limited to optical needs directly related to the child's disability or specific medical diagnosis.

Five empty text boxes for medical justification.

Form with fields: NAME OF PHYSICIAN, SIGNATURE OF PHYSICIAN, DATE SIGNED (YYYY/MM/DD)

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: 1-877-210-3332 (Toll Free)