BRITISH COLUMBIA | Ministry of Health

APPLICATION FOR PSYCHIATRIC MEDICATION COVERAGE

A. TO BE SIGNED AS TRUE BY THE APPLICANT

Name: _____ Gender: ❒ M ❒ F

Address: _____

_____ Postal Code: _____

Telephone: _____ Date of Birth: | | | | | | | | |
YYYY MM DD

Personal Health Number (PHN) | | | | | | | | | | | Mandatory

1. The cost of the prescribed psychiatric medication is a significant barrier to me taking my medication. I have no other financial coverage, and I believe I qualify for Premium Assistance ($28,000 family adjusted net income plus $3,000 per dependent).
2. I consent to the release of financial and clinical information about me to the mental health centre and the Ministry of Health for the sole purpose of verifying my eligibility for this program.
3. I understand that the personal information collected on this form relates directly to and is necessary for program operations. The information will be handled in accordance with the *Freedom of Information and Protection of Privacy Act.* If I have any questions about the collection and use of this information, I will contact my Health Authority.

_____ _____
Signature of Applicant Date

B. TO BE SIGNED BY THE PRESCRIBING PHYSICIAN - Send to local Mental Health Centre/Authority. (Do NOT send to MSP/PharmaCare or Mental Health & Addictions Headquarters.)

Check a, b or c

I certify that the patient:

a. ❒ has been hospitalized for a psychiatric condition,

OR without the medication

b. ❒ is likely to require hospitalization,

OR

c. ❒ other serious consequences are very likely (e.g. unemployment, child neglect, etc.)

_____ _____ _____
Name of prescribing physician *(print)* Signature Date

C. APPROVAL BY MENTAL HEALTH CENTRE / AUTHORITY

_____ _____
Signature of Director or Designate Date

Note: This authorization will expire in ❒ 1 year Date: _____

❒ or earlier Date: _____