NOVA SCOTIA

Drug Assistance for Cancer Patients

Eligibility:

To apply for *Drug Assistance for Cancer Patients* the patient must:

- be a resident of Nova Scotia, and
- have a gross family income no greater than $15,720 per year, and
- not be eligible for coverage under other drug programs.

Application Process:

The application for *Drug Assistance for Cancer Patients* is printed on the reverse side of this form. Please answer all questions completely and accurately. Incomplete or inaccurate applications cannot be processed.

Attach a copy of the Income Tax Notice of Assessment or Re-assessment from Canada Customs and Revenue Agency for the patient, their parent(s) or guardian(s), spouse or common-law partner.

If you do not have the most recent Notice of Assessment or Re-assessment, please obtain a copy from Canada Customs and Revenue Agency by phoning 1-800-959-8281.

Forward the completed application and the Notice of Assessment to the address or fax number below.

Please allow three working days after the application is received for processing. The patient or the patient's parent or guardian will then receive a phone call to advise whether or not the patient is eligible for drug assistance.

Assessments will be conducted annually to ensure continued eligibility.

Benefits:

Drug Assistance for Cancer Patients provides approved cancer-related drug benefits, which are reviewed by the Nova Scotia Formulary Management Committee, a committee of clinicians, drug information specialists, and pharmacists. Benefit changes may occur from time to time.

If you have any questions please contact:

Nova Scotia Pharmacare Programs
PO Box 500, Halifax, Nova Scotia B3J 2S1
For assistance, call toll free at 1-800-544-6191 or locally at 429-6565
Fax: (902) 468-9402

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Drug Assistance for Cancer Patients **CONFIDENTIAL**

Patient's Name _____ Date of Birth _____/_____/_____
Day Month Year

Address _____ Postal Code _____

Telephone Number Home _____ Work _____ Other _____

NS Health Card Number (MSI) _____ (10 digit number)

If the patient is a dependent, name of parent(s) or guardian(s) _____

Parent(s) or Guardian(s) Telephone Number _____

Is the patient currently covered by a prescription drug plan/program? Yes No

INCOME INFORMATION

Provide the information requested below for the patient, their parent(s) or guardian(s), spouse or common-law partner. Enter the amount on line 150 from the most current Income Tax Return for each person.

Include a copy of the Income Tax Notice of Assessment or Re-assessment from Canada Customs & Revenue Agency for each person .

Surname, First Name	NS Health Card Number (MSI) 10 digit number	Gross Income (Line 150)
	TOTAL	

If the total gross family income is greater than $15,720, the patient does not qualify for assistance.

Statement of Information Accuracy
I declare that the information provided on this application is accurate and true and I will immediately notify the Nova Scotia Pharmacare Programs of any changes.

Statement for Release of Medical Information Related to the Patient

I hereby authorize Dr. _____ of _____
(Name) (Address)
to provide the Nova Scotia Pharmacare Programs with medical information **related to the patient** that may be required to determine eligibility.

Authorization for Release of Information
I hereby consent to the release, by the Canada Customs and Revenue Agency to the Minister of Health, or his/her designate, of information from my income tax returns. The information will be relevant to, and used solely for, the purpose of determining and verifying the family income provided on this application. The information will not be disclosed to any person without my approval. This authorization is valid for the most recent taxation year prior to signature. It is also valid for the current taxation year and subsequent consecutive taxation years for which assistance is requested. I understand that, if I wish to withdraw this consent, I may do so at any time by writing to the Nova Scotia Pharmacare Programs.

I understand and endorse the above Statement of Information Accuracy, Statement for Release of Medical Information Related to the Patient (if applicable), and the Authorization for the Release of Information, as indicated by my signature below.

Patient/Parent/Guardian's signature _____ Date _____

Spouse/Common-Law Partner's signature _____ Date _____