Health PEI

One Island Health System

Dental Health Services
152 St. Peter's Road
PO Box 2000,
Charlottetown, PE C1A 7N8

Telephone 1 (902) 368-5460
Toll Free 1 (866) 368-5460

PLEASE COMPLETE, SIGN REVERSE SIDE AND RETURN ORIGINAL APPLICATION TO THE ADDRESS ABOVE.
COPIES ARE NOT ACCEPTABLE

Provincial Dental Care Program Application Form

Office use only						
Income Verified by:						
Date Approved dd/mm/yyyy						
Approved	100%	80%	60%	40%	20%	0%

healthpei.ca/dentalhealth

APPLICANT ☐ **First-Time Applicant** ☐ **Renewal Application (July 1/20___ - June 30/20___)**

1. Applicant's Name *(Surname, First name, Initials)*		Date of Birth ***dd/mm/yyyy***	
		Personal Health Number	
		Social Insurance Number	
2. Spouse's Name *(Surname, First name, Initials)*		Date of Birth ***dd/mm/yyyy***	
		Personal Health Number	
		Social Insurance Number	
Mailing Address	Street		
	City /Town		Postal Code
Telephone Number	Home	Email	
	Alternate		
Are you or your spouse currently receiving Social Assistance?			*Yes/No*
Do you or any of your dependants have dental insurance?		*Yes/No*	*If yes, please provide*
Company Name		***Group/Policy #***	***ID/Cert. #***

APPLICANT'S DEPENDANTS

3. Dependant's Name *(Surname, First name, Initials)*	Date of Birth ***dd/mm/yyyy***	
	Personal Health Number	
	Social Insurance Number	
4. Dependant's Name *(Surname, First name, Initials)*	Date of Birth ***dd/mm/yyyy***	
	Personal Health Number	
	Social Insurance Number	
5. Dependant's Name *(Surname, First name, Initials)*	Date of Birth ***dd/mm/yyyy***	
	Personal Health Number	
	Social Insurance Number	
6. Dependant's Name *(Surname, First name, Initials)*	Date of Birth ***dd/mm/yyyy***	
	Personal Health Number	
	Social Insurance Number	

Need more space, please list other members of the family in a separate sheet

Personal health information on this application collected under section 17 of the Health Information Act and under The Freedom of Information and Privacy Protection Act and is necessary to assess eligibility.

Declaration and Consent

I /We, the undersigned, declare that the information provided on this application is true and correct to the best of my/our knowledge.

I/We, the undersigned, understand that knowingly providing false or misleading information or records is an offence under the Health and Dental Services Cost Assistance Act.

For the purpose of verifying program eligibility, I/we authorize the Department of Health and Wellness or Health PEI to obtain information from:

- *My employer, my insurer, and my plan administrator regarding private insurance coverage;*
- *The Provincial Health Plan (the Plan) regarding my eligibility for health services and release of my PHN:*
- *Retail pharmacies, to access prescription drug cost data in order to verify claims billed to the Health and Dental Services Cost Assistance Program;*

I/We, the undersigned, agree to notify the Department of Health and Wellness or Health PEI of any changes to the household, insurance coverage, or any other factor which may affect my level or eligibility of coverage.

I/We, the undersigned, hereby consent to the release by the Canada Revenue Agency (CRA), of income, expense and identifying information from income tax returns or from other sources, copies of notices of assessment or reassessment, and copies of information slips (for example, T2202A), T3, T4 and T5 slips) filed with CRA. The information will be relevant to, and used solely for the purpose of determining and verifying my eligibility and entitlement for assistance under the Health and Dental Services Cost Assistance Act, and collecting overpayments of assistance under the Freedom of Information and Privacy Protection Act identified above.

This authorization is valid for the two taxation years preceding the date of this application, the current taxation year and subsequent consecutive taxation year for which I apply for assistance under Health and Dental Services Cost Assistance Program identified above.

I understand that I may withdraw my consent from the Department or Health PEI to collect, use and disclose my information by providing written notice, but that my right to withdraw consent may be subject to limited exceptions. I may contact the Department of Health and Wellness or Health PEI for further information about how to withdraw consent, and the potential impacts if I withdraw my consent.

Applicant Name (Print)	*Signature*	*Date*
Spouse Name (Print)	*Signature*	*Date*

- *By signing above, I certify that the information given in this application and in any documents attached is correct and complete.*
- *I understand that a false statement constitutes fraud and may result in recovery of any benefits paid.*
- *I acknowledge that it is my responsibility to report any change to the information provided within 30 days of the change coming into effect.*