Special Support Program Application

SIDE A: CRA Consent

- Provide a copy of your Notice of Assessment OR pages 1 to 4 of your Income Tax and Benefit Return showing Line 15000 (for both Applicant and Spouse).
- If you do not file income tax, complete SIDE B and provide all sources of annual income.
- Ensure you have provided all information. Incomplete applications will result in delays.
- Coverage is effective the date complete information is received, subject to approval.
- **Please print the form and sign**. Written signatures are required by CRA.

Please return to:
Drug Plan and Extended Benefits
3475 Albert Street
Regina, SK S4S 6X6
Phone: 306-787-3317
Fax: 306-787-8679
Email: DPEB@health.gov.sk.ca

Applicant	**Spouse**
Name:	Name:
Address:	
City: Postal Code: Phone Number:	
Date of Birth (dd/mm/yyyy):	Date of Birth (dd/mm/yyyy):
Health Services Number:	Health Services Number:
Social Insurance Number:	Social Insurance Number:

DECLARATION and CONSENT

Is the Power of Attorney (POA) signing on behalf of the applicant? ☐ **Yes** ☐ **No**

If YES, then copies of the POA documents MUST be attached. NOTE: If a Trustee, Guardian or POA is signing for the Applicant, a copy of the legal document must be attached to this consent form. Due to the variety of POA documents, some may not be considered acceptable for CRA, such as a POA limited to a bank or financial institution.

I hereby consent to the release, by the Canada Revenue Agency to an official of the Saskatchewan Ministry of Health, of information from my income tax returns, and, if applicable, other required taxpayer information about me. The information will be relevant to and used solely for the purpose of determining and verifying my/our eligibility and the general administration and enforcement of: the Income-Based General Coverage pursuant to *The Prescription Drugs Act* and regulations made thereunder, and will not be disclosed to any other person or organization without my approval.

This authorization is valid for the most relevant of the two taxation years prior to the year of signature. It is also valid for each subsequent consecutive taxation year during which my family unit seeks coverage under the Income-Based General Coverage requested by me or on my behalf. I understand that, if I wish to withdraw this consent, I may do so at any time by writing to Saskatchewan Ministry of Health, Drug Plan and Extended Benefits Branch.

Date:	Date:
Signature of APPLICANT, or if applicable, GUARDIAN / TRUSTEE / POWER OF ATTORNEY. A witness is necessary if Applicant signs with an "X" or a mark. *(digital signatures not accepted)*	**Signature of SPOUSE**, or if applicable, GUARDIAN / TRUSTEE / POWER OF ATTORNEY. A witness is necessary if Applicant signs with an "X" or a mark. *(digital signatures not accepted)*
Print name if GUARDIAN / TRUSTEE / POWER OF ATTORNEY	Print name if GUARDIAN / TRUSTEE / POWER OF ATTORNEY

ADDITIONAL INFORMATION: Attach a written explanation and provide income documentation if you have changes in medication or income. For example, if you had capital gains – attach schedule 3.