Institutional Supportive Care - Income-Tested Resident Charge

Side A: CRA Consent

Please return to:
Drug Plan and Extended Benefits
3475 Albert Street
Regina, SK S4S 6X6
Phone: 1-800-667-4884
Or 306-787-5023
Fax: 306-787-8679
Email: DPEB@health.gov.sk.ca

- Provide a copy of your Notice of Assessment OR pages 1 to 4 of your Income Tax Return showing Line 15000 (for both Resident 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.
- **Please print the form and sign**. Written signatures are required by CRA.

Resident Information (Please Print)

Name:

Health Services Number:

Date of Birth:

Social Insurance Number:

Spouse Information (Please Print)

Name:

Health Services Number:

Date of Birth:

Social Insurance Number:

Contact Information (Please Print)

Name:

Home Phone Number:

Work Phone Number:

Street Address or P.O. Box:

City/Town:

Province:

Postal Code:

Declaration and Consent

Is the Power of Attorney (POA) signing on behalf of the resident or spouse? **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 POA specific to or 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 Tested Resident Charge pursuant to *The Housing and Special-care Homes 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 assessment under the Income-Tested Resident Charge 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

Signature of Resident, or if applicable, Guardian/Trustee/Power of Attorney. A witness is necessary if resident signs with an "X" or a mark.

PRINT NAME OF Guardian/Trustee/ Power of Attorney/Witness.

Date

Signature of Spouse, or if applicable, Guardian/Trustee/Power of Attorney. A witness is necessary if resident signs with an "X" or a mark.

PRINT NAME OF Guardian/Trustee/ Power of Attorney/Witness.