Government of Saskatchewan

RETURN BY MAIL TO:
MINISTRY OF HEALTH
Drug Plan & Extended Benefits Branch
3475 Albert Street
Regina, Saskatchewan
S4S 6X6
PHONE: 306-787-7121
FAX: 306-798-2022

Nutritional Products Program Application

Type of Application: ☐ **Initial** ☐ **Re-assessment**

PATIENT IDENTIFICATION (to be completed by Dietitian)

Patient Surname	First Name	Date of Birth (Day/Month/Year)	
Current Address		City/Town/Village	Postal Code
Health Services Number		Phone Number ( )	

If patient is under 18 years of age, name(s) of parent/guardian: _____

Is the patient/family currently receiving assistance with their nutritional product costs through another program such as social assistance, palliative care, etc?
[ ] No
[ ] Yes
Specify:_____

CLINICAL INFORMATION (to be completed by Dietitian)

Description of medical condition indicating the need for nutritional product: (please indicate % of nutritional requirements met through nutrition product)

Formula prescribed:

Anticipated volume per month:

Anticipated duration of therapy:

Estimated cost of formula per month:

Anticipated Product Vendor :

REFERRAL INFORMATION (to be completed by Dietitian)

Dietitian:	**Telephone:** **( )**
Signature:	**Date:**
Dietitian's Address:	

DECLARATION and CONSENT (to be completed by client/family)

I consent to allow Saskatchewan Health officials access to my and my dependent(s) prescription drug costs, obtained through the Saskatchewan Health Drug Plan, for the purpose of calculating assistance with the cost of therapeutic nutrition product(s) under consideration in this application.

"I declare that all the information I have provided in this application is complete and correct in all respects and fully discloses my total income from all sources. It is a serious offense to make a false declaration. "I CONSENT TO, AND AUTHORIZE, the release to Saskatchewan Health of any documentation whatsoever, held by any party, which may be required to verify the information which I have provided on this application. I understand that such information includes, but is not limited to, information regarding my income held by Canada Customs and Revenue Agency, my employer and other government agencies. I further consent to the use of this information by Saskatchewan Health for the purposes of determining my entitlement for other Health Care benefits or programs."

_____ Signature of Applicant or Parent/Guardian	_____ Signature of Spouse
_____ Date	_____ Date
_____ Signature of Trustee/Guardian/Power of Attorney (if applicable)	_____ Signature of Trustee/Guardian/Power of Attorney (if applicable)
_____ Date	_____ Date

INCOME DECLARATION (to be completed by client/family)

Please attach the most recent Notice of Assessment form sent which clearly indicates your qualifying family income (eg: client and spouse, both parents in the case of children)

Saskatchewan Health will treat all the information provided on this application confidentially.

ADDITIONAL INFORMATION

Include any written explanation or information that may help for the review of this request. For example, income changes, new medications or nutritional products. **(If providing additional information about capital gains, please attach a copy of schedule 3). Ensure you include supporting documentation.**

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