ASSISTANCE FOR CANCER PATIENTS PROGRAMS

Drug Assistance for Cancer Patients Program; and Boarding, Transportation and Ostomy Program

ELIGIBILITY

To be eligible for the ***Drug Assistance for Cancer Patients Program*** and the ***Boarding, Transportation and Ostomy Program***, the patient must have a diagnosis of cancer and:

- Be a resident of Nova Scotia and have a valid Nova Scotia health Card
- Have a gross family income no greater than $25,500 per year
- Not be eligible for coverage under other drug programs

Does the patient have a cancer diagnosis? Yes ❑ No ❑
Does the patient have private insurance that will cover the cost of cancer medication? Yes ❑ No ❑

PATIENT INFORMATION

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

Address _____ Postal Code_____

Preferred Telephone Number _____ Married ❑ Single ❑

Nova Scotia Health Card Number _____ (10-digit number)

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

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

Will the patient require a travel escort? Yes ❑ No ❑ (If yes, please call 1-866-553-0585 for more information)

INCOME INFORMATION

I have included a copy of the Notice of Assessment or Re-assessment from Revenue Canada for each person in the family (e.g. the patient, their parent(s) or guardian(s), spouse or common-law partner). Yes ❑ No ❑

STATEMENT FOR RELEASE OF MEDICAL INFORMATION RELATED TO PATIENT

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

AUTHORIZATION FOR RELEASE OF INFORMATION

I/we hereby consent to the release, to the Nova Scotia Department of Health and Wellness by the Canada Revenue Agency, of information from my income tax returns and other required taxpayer information. This information will be relevant to, and used solely for the purpose of, determining and verifying eligibility for, and the general administration and enforcement of, the Assistance for Cancer Patients programs and will not be disclosed to any person without my approval. This consent is valid for two taxation years 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 authorization, I may do so at any time by writing to the Nova Scotia Pharmacare Programs.

I understand and endorse the Release of Information, as indicated by my signature below. I also acknowledge that by completing this application, I will be enrolled in both programs.

Patient/Parent/Guardian's Signature_____ Date_____

Spouse/Common-Law Partner's signature_____ Date _____

Assistance for Cancer Patients Programs
PO Box 500, Halifax, Nova Scotia B3J 2S1
Toll Free: 1-866-553-0585 Fax: 902-490-2275