

Low Income Drug Program Application Form

*If you currently have a NLPDP Drug Card for either of the following reasons, you are **NOT** required to complete this application for assistance under the Low Income Drug Program as your benefits will remain the same:*

- *You are registered under the Income Support Program; Home Support Program; Child Youth & Family Services Program; or Community Youth Corrections Program*
- *You are a Government Subsidized Resident of a Long Term Care Facility*
- *You are in receipt of the Guaranteed Income Supplement*

SECTION A PERSONAL INFORMATION

APPLICANT	SPOUSE (if applicable)
Surname	Surname
First Name	First Name
MCP Number	MCP Number
Date of Birth (yyyy - mm - dd)	Date of Birth (yyyy - mm - dd)
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

MAILING ADDRESS

Street / P.O. Box	City / Town	
Province	Postal Code	Phone Number

SECTION B FAMILY STATUS

- Single
 Couple - with no children
 Family - with children (includes single parent families)

SECTION C DEPENDENT INFORMATION - Include all dependent children living with you under the age of 18 or aged 18 to 20 and still attending high school. Please attach a confirmation letter from the school. (If more space is required, please attach a separate sheet)

Surname	First Name	Gender		Date of Birth			MCP Number
		M	F	Year	Month	Day	

PLEASE COMPLETE BOTH SIDES OF THIS FORM

SECTION D PRIVATE DRUG INSURANCE/COVERAGE	
Do you, your spouse or dependent children have drug insurance coverage with a private insurer? <input type="checkbox"/> No (If no, go to Section E) <input type="checkbox"/> Yes	
Name of Insurance Company (e.g. Blue Cross)	
Policy Number	Family Members Covered
Terms of Coverage (e.g. insurance pays 80% of costs of prescription drugs)	

SECTION E EMPLOYER INFORMATION			
APPLICANT		SPOUSE (if applicable)	
Employer Name		Employer Name	
Street / P.O. Box		Street / P.O. Box	
City / Town		City / Town	
Province	Postal Code	Province	Postal Code
Phone Number		Phone Number	

SECTION F DECLARATION AND CONSENT	
<p>I declare that the information provided on this application is true and correct to the best of my knowledge. I understand that this information will be used to determine eligibility for a drug card with the Low Income Drug Program and may be subject to verification by officials of the Department of Health and Community Services.</p> <p>For the purpose of verifying my eligibility for a drug card, and of auditing use of the drug card, I authorize the Department of Health and Community Services to obtain information from:</p> <ul style="list-style-type: none"> • My Employer regarding private insurance coverage. • The Medical Care Plan (MCP) regarding my eligibility for provincial health benefits and release of my MCP number to be used for identification purposes on my drug card. • Pharmacies, to access copies of prescriptions in order to verify claims billed to the NLPDP. <p>I agree to notify the Low Income Drug Program of any change in my financial circumstances so that my level of coverage can be adjusted accordingly.</p> <p>In order to verify financial information provided, I hereby consent to the release, by the Canada Revenue Agency to an official of the Department of Health and Community Services, of information from my income tax returns, and, if applicable, other required taxpayer information about me, including my dependent children, to be used solely for the purpose of determining and verifying my eligibility, entitlement for and the general administration and enforcement of the Low Income Drug Program and will not be disclosed to any other person or organization without my approval.</p> <p>This authorization is valid for the current taxation year and each subsequent consecutive taxation year for which I will be in receipt of assistance under the Low Income Drug Program. I understand that if I wish to withdraw this consent, I may do so at any time by writing to the Regional Director at the address identified below.</p>	
_____	_____
Printed Name of Applicant	Printed Name of Spouse
_____	_____
Signature of Applicant	Signature of Spouse
_____	_____
Social Insurance Number	Social Insurance Number
_____	_____
Date	Date

<p>Please mail completed applications to: NLPDP – Low Income Drug Program P.O. Box 510 Stephenville, NL, A2N 3B4</p>	<p>Contact Information: Toll free: 1-888-859-3535 Toll free fax: 1-888-272-2444 E-mail: LIDPinfo@gov.nl.ca</p>
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PLEASE COMPLETE BOTH SIDES OF THIS FORM