Disability Assistance or a Supplement from the Ministry of Social Development and Social Innovation (SDSI)

Instructions:

- If you receive disability assistance or a supplement under the *Employment and Assistance for Persons with Disabilities Act*, complete the **Release of Information Consent** section below.
- Have an employee of the Ministry of Social Development and Social Innovation complete the **Office Use Only** section below and return the page to you.
- Send the page to us with the rest of your application.

Important:

Let us know if you no longer receive disability assistance or a supplement under the *Employment and Assistance for Persons with Disabilities Act* as this may affect your eligibility for the Fuel Tax Refund Program.

For more information, please contact the Ministry of Social Development and Social Innovation toll-free at 1 866 866-0800 or find your local office listed online at **www.sdsi.gov.bc.ca/contacts/offices.html**

Release of Information Consent

By signing below, I consent to the disclosure of my personal information between the Ministry of Finance and the Ministry of Social Development and Social Innovation for the purpose of confirming my eligibility for the Fuel Tax Refund Program. This consent will remain in place for as long as I am in the program.

I agree to inform the Ministry of Finance immediately if notified by the Ministry of Social Development and Social Innovation that I no longer qualify or receive disability assistance or a supplement under the *Employment and Assistance for Persons with Disabilities Act*.

LAST NAME	FIRST NAME	MIDDLE NAME (*if applicable*)

MAILING ADDRESS (*include street or PO box number, city and province*)	POSTAL CODE

SIGNATURE OF APPLICANT	DATE OF BIRTH YYYY / MM / DD
X	

OFFICE USE ONLY – TO BE COMPLETED BY SDSI EMPLOYEE

Applicant Information:

START DATE OF DISABILITY ASSISTANCE/SUPPLEMENT PAYMENTS YYYY / MM / DD	END DATE OF DISABILITY ASSISTANCE/SUPPLEMENT PAYMENTS (*if applicable*) YYYY / MM / DD	SDSI ICM PID NUMBER

SDSI Employee Information:

ADDRESS OF SDSI OFFICE (*please print clearly or use a stamp; include street or PO box, city, province and postal code)*	NAME OF SDSI EMPLOYEE
	TELEPHONE NUMBER ( )
	FAX NUMBER ( )

SIGNATURE OF SDSI EMPLOYEE	DATE SIGNED YYYY / MM / DD
X	