BRITISH COLUMBIA | Ministry of Social Development and Poverty Reduction

Persons With Disabilities Designation Application - Prescribed Class

The personal information requested on this form is collected by the Ministry of Social Development and Poverty Reduction pursuant to sections 26(c) of the *Freedom of Information and Protection of Privacy Act* for the purpose of administering the *Employment and Assistance for Persons with Disabilities Act*. If you have any questions about the collection, use or disclosure of this information, please contact the Ministry of Social Development and Poverty Reduction at 1-866-866-0800.

Personal Information

Last Name	First Name	Middle Name(s)
Birth Date (YYYY MMM DD)	Personal Health Number	Case Number (for office use only)

The purpose of this form is to collect the information necessary to determine eligibility for the Person with Disabilities designation as a member of a prescribed class of persons under the *Employment and Assistance for Persons with Disabilities Act.*

Declaration and Notification

I, _____ , am applying for designation as a Person with Disabilities under the *Employment and Assistance for Persons with Disabilities Act* and I declare that the information provided on this form is true and complete. I understand that the Ministry of Social Development and Poverty Reduction may verify the information on this form, as necessary to determine and confirm my eligibility for the designation.

To apply for this designation, one of the following statements must be true. Check the box beside the one that applies to you:

- ☐ I am enrolled in BC Palliative Care Benefits - PharmaCare Plan P of the Ministry of Health
- ☐ I have been determined to be disabled for the purposes of the Canada Pension Plan (CPP) and am eligible to receive CPP Disability Benefits from Employment and Social Development Canada
- ☐ I have been determined eligible (now or in the past) to receive community living supports from Community Living British Columbia
- ☐ I have been determined eligible (now or in the past) to receive benefits as a child under the Ministry of Children and Family Development's At Home Program. Choose benefit type:
  - ☐ Medical Benefits
  - ☐ Respite Benefits Only – Children and Youth with Special Needs worker name and contact:

_____

Authorization and Consent

I consent to the Ministry of Social Development and Poverty Reduction disclosing a copy of this document, including the personal information about me contained in it, to any agency I have identified above.

I consent to any agency I have identified above disclosing to the Ministry of Social Development and Poverty Reduction all personal information about me and my eligibility for and receipt of benefits or supports under the program operated by that agency.

I authorize the Ministry of Social Development and Poverty Reduction to indirectly collect from any agency I have identified above all personal information about me and my eligibility for and receipt of benefits or supports under the program operated by that agency for the purpose of assessing my eligibility for designation as a Person with Disabilities and for assistance under the *Employment and Assistance for Persons with Disabilities Act.*

_____ _____

Applicant Signature* | Date Signed

* If the Applicant does not have the necessary capacity to sign this Application, it may be signed by a person who has legal authority to act on behalf of the Applicant under section 3 or 4 of the Freedom of Information and Protection of Privacy Regulation. A guardian may act for a child if the authority to make the application described in this document and provide the consents and authorization set out above are within the scope of the guardian's duties or powers. A committee appointed under the *Patients Property Act*, a person acting under a power of attorney, a litigation guardian or a representative acting under a representation agreement, as defined in the *Representation Agreement Act* may act for an adult if the authority to make the application described in this document and provide the consents and authorization set out above are within the scope of that person's duties or powers.

If you are signing this document on behalf of the Applicant, you must state your legal authority to act on behalf of the Applicant and you must attach proof of that legal authority to this Application.

My legal authority to act for the applicant is _____ .

Note: Proof of Committee, Power of Attorney, Litigation Guardian, Representation Agreement Representative or Guardian status must accompany this Application

Eligibility Verification (for office use only)

I confirm the person noted above is receiving or has been determined eligible to receive benefits or supports from or under the program or agency indicated below, (please check applicable box):

- ☐ BC Palliative Care Benefits (PharmaCare Plan P), Ministry of Health
- ☐ Canada Pension Plan – Disability Benefits Program, Employment and Social Development Canada
- ☐ Community Living BC (Developmentally Disabled or Personal Supports Initiative)**
- ☐ At Home Program, Ministry of Children and Family Development** (check benefit type below):
  - ☐ Medical Benefits
  - ☐ Respite Benefits Only

**If the person noted above has received or was determined eligible to receive benefits or supports under the At Home Program or from Community Living BC, but is not currently receiving those benefits or supports, please also check the applicable box above.

- ☐ Applicant **not** eligible for the program indicated above

Program Authority Signature _____ Date Signed _____

Print Name _____ Office/Department/Branch Name _____