Today's Date

Case #: Click here to enter
MIS Case #: Click here to enter

Client Name
Address

Dear Client Name:

To make sure you receive all the assistance you are eligible for, we need the following medical information.

☐ **Diet Supplement:** Please take the attached information sheet to your doctor, nurse practitioner or registered dietitian and request written confirmation that includes your diagnosis, need for a specialized diet and duration of need. [attach diet supplement information sheet]

☐ **Persons with Persistent Multiple Barriers (PPMB):** Please have your health professional complete the attached form (HR2892). [attach form, if required]

☐ **Work Restrictions:** Please have your doctor complete the attached form (HR3069).

☐ **Medical Supplies:** Please get a medical note from your doctor or nurse practitioner that includes your diagnosis, a list of what you need each month (specify amount), and how long you will need it for. Please see Health Supplement Info Sheet – Medical Supplies for detailed information.

Please return this information by Date. You can mail it to us or drop it off at our office at local office address. You can also fax it to us at local office fax number.

If you have any questions, please call the Ministry of Social Development and Poverty Reduction Choose an item

Sincerely,

Enter Name
Ministry Choose an item
Enclosures: Choose an item.

HR3237 (19/06/17)
Security Classification: MEDIUM

The Ministry of Social Development and Poverty Reduction operates under the authority of the *Employment and Assistance Act* and Regulations, and the *Employment and Assistance for Persons with Disabilities Act* and Regulations.

Ministry of Social Development and Poverty Reduction

Office Name

Mailing Address
Enter address

Telephone: (###) ###-####
Facsimile: (###) ###-####