NOTE TO EMPLOYMENT AND ASSISTANCE WORKERS

The purpose of the Monthly Nutritional Supplement (MNS) is to provide nutritional supplementation to recipients who are designated as a Person with Disabilities (PWD) to meet certain extraordinary needs. Eligibility for MNS is defined in the *Employment and Assistance for Persons with Disabilities (EAPWD) Act* and Regulation.

To be eligible for this supplement, the applicant must be designated a Person with Disabilities, be in receipt of disability assistance, be receiving treatment from a medical practitioner or nurse practitioner for a chronic, progressive deterioration of health due to a severe medical condition. The items requested in the application must be required to alleviate specific symptoms that are a direct result of the chronic, progressive deterioration of health and are necessary to prevent imminent danger to life. In addition, the ministry must be satisfied that there are no other resources available to the family unit to pay for the items for which the supplement may be provided. Eligibility is not based solely on the person's medical condition.

Before providing this form to a client, please ensure that:

- the client has been designated as a Person with Disabilities and is in receipt of disability assistance; and
- the client is not receiving a monthly supplement under EAPWD Regulation Section 2 (3) of Schedule C, otherwise referred to as the grandparented clause (allowance code 29).

NOTE: A client in receipt of allowance code 29 with a total value of less than $205 per month has the option of applying for MNS which would replace the currently received supplement or supplements, if eligibility is established.

Please complete Part A of the application form, including the case number, PHN number, PWD Status from the SD More Info Screen, and sign prior to issuing it to the client for completion by the medical practitioner or nurse practitioner.

When the application is returned to the Employment and Assistance Office (EAO), please ensure all parts of the form are signed and completed. Forward the completed form with any accompanying documentation to Health Assistance Branch for adjudication. Health Assistance Branch will advise both the client and EAO of the decision.

BRITISH COLUMBIA | Ministry of Social Development and Poverty Reduction

APPLICATION FOR MONTHLY NUTRITIONAL SUPPLEMENT

The personal information requested on this form will be used for the purpose of determining eligibility for a Monthly Nutritional Supplement and is collected under the authority of the *Employment and Income Assistance for Persons with Disabilities Act* and Regulation. The collection, use and disclosure of personal information is subject to the provisions of the *Freedom of Information and Protection of Privacy Act.* Any questions about this information should be directed to your local Employment and Assistance Office.

NOTE: An applicant for the Monthly Nutritional Supplement (MNS) must be a person with the Persons with Disabilities designation who is receiving disability assistance under the *Employment and Assistance for Persons with Disabilities Act* and Regulation. The ministry has the authority and discretion to review eligibility for MNS. The ministry may also, where necessary, request a second opinion for the purpose of determining eligibility for this supplement.

PART A - Must be completed by Ministry of Social Development and Poverty Reduction (please print)

Applicant's Name	Birthdate (YYYY MMM DD)	File No.	Personal Health No.

Applicant's Address	City/Town	Postal Code	PWD Status (as appears on the PE1 screen)	In Pay
			☐ Eligible	☐ 41/42

PWD Status (as appears on the PE1 screen)	Employment and Assistance Worker Signature and Worker #	Date (YYYY MMM DD)
☐ 03 ☐ 22 ☐ 28 ☐ 29		

PART B - Application Acknowledgement and Consent - Must be signed by Applicant

I am applying for the Monthly Nutritional Supplement. I understand that the Ministry of Social Development and Poverty Reduction may obtain and verify information to confirm my eligibility for this supplement. I consent to the medical practitioner or nurse practitioner identified in Part C of this application sharing and providing clarification on the medical information requested in this application form with the Ministry of Social Development and Poverty Reduction for the purposes of determining my eligibility for this supplement.

Applicant's Signature	Date (YYYY MMM DD)

PART C - Must be completed by the medical practitioner or nurse practitioner (PLEASE PRINT)

Additional documents may be attached, if necessary. Note: An incomplete application will delay processing.

NOTE: This form should not be completed if your patient only requires nutritional supplements for a short term (3 months or less) or where a diet supplement is sufficient to meet the patient's needs as other ministry programs are available to assist with these situations. The ministry provides the following diet supplements: high protein diet, gluten free diet, reduced sodium diet, kidney dialysis diet, dysphasia diet, ketogenic diet, phenylalanine (PKU) diet and a diet for Cystic Fibrosis.

The Monthly Nutritional Supplement is only available to an applicant receiving treatment from a medical practitioner or nurse practitioner for a chronic, progressive deterioration of health on account of a SEVERE medical condition(s), and who, as a direct result of the chronic, progressive deterioration of health, displays two or more of the symptoms set out in Question 3 of the application, and where the items requested in the application will alleviate those specific symptoms AND prevent imminent danger to the applicant's life.

1. Please list and describe the applicant's **severe** medical condition(s): (PLEASE PRINT)

Diagnosis	Description

2. As a direct result of the **severe** medical condition(s) noted above, is the applicant being treated for a chronic, progressive deterioration of health? If so, please provide details and any information on treatments including any relevant clinical or diagnostic reports.

BRITISH COLUMBIA | Ministry of Social Development and Poverty Reduction

APPLICATION FOR MONTHLY NUTRITIONAL SUPPLEMENT

Applicant's Name: _____ Applicant's File Number: _____

3. As a direct result of the chronic, progressive deterioration of health noted above, does the applicant display two or more of the following symptoms? If so, please describe in detail.

Malnutrition _____

Underweight status _____

Significant weight loss _____

Significant muscle mass loss _____

Significant neurological degeneration _____

Moderate to severe immune suppression _____

Significant deterioration of a vital organ (please specify) _____

_____

4. Please specify the applicant's height _____ **and weight** _____ **.**

Height and weight will assist in determining your patient's Body Mass Index (BMI)

5. VITAMIN OR MINERAL SUPPLEMENTATION:

Vitamins and minerals are only available to an applicant to alleviate one or more of the symptoms specified in Question 3, if those symptoms are a direct result of a chronic, progressive deterioration of health, and to prevent imminent danger to the applicant's life. This supplement does not include homeopathic, naturopathic or herbal remedies.

- Specify the vitamin or mineral supplement(s) required and expected duration of need:

_____

_____

_____

- Describe how this item will alleviate the specific symptoms identified:

_____

_____

_____

- Describe how this item or items will prevent imminent danger to the applicant's life.

_____

_____

_____

6. NUTRITIONAL ITEMS:

Nutritional items are only available to an applicant to alleviate one or more of the symptoms specified in Question 3 if those symptoms are a direct result of a chronic, progressive deterioration of health and the nutritional items are medically essential, will provide caloric supplementation to a regular dietary intake and are required to prevent imminent danger to the applicant's life.

- Specify the additional nutritional items required and expected duration of need:

_____

_____

_____

Ministry of Social Development and Poverty Reduction

APPLICATION FOR MONTHLY NUTRITIONAL SUPPLEMENT

Applicant's Name: _____ Applicant's File Number: _____

6. NUTRITIONAL ITEMS: continued

- Does this applicant have a medical condition that results in the inability to absorb sufficient calories to satisfy daily requirements through a regular dietary intake? If yes, please describe:

_____

_____

_____

- Describe how the nutritional items required will alleviate one or more of the symptoms specified in Question 3 and provide **caloric** supplementation to the regular diet:

_____

_____

_____

- Describe how the nutritional items requested will prevent imminent danger to the applicant's life:

_____

_____

_____

Additional Comments:

_____

_____

_____

_____

_____

_____

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_____

_____

_____

Medical Practitioner or Nurse Practitioner Name (Please Print)	Medical Practitioner or Nurse Practitioner Number	Telephone
Date (YYYY MMM DD)	Medical Practitioner or Nurse Practitioner Signature	

Payment:
The $25.00 fee for completing Part C of this form may be billed through MSP under Fee Item 96400
If you have any questions, please contact: Health Assistance Branch at 1-888-221-7711

Medical Practitioner or Nurse Practitioner Office Stamp