BRITISH COLUMBIA | Ministry of Children and Family Development

AT HOME PROGRAM APPLICATION

The personal information collected on this form will be used for the purposes of determining At Home Program eligibility and providing benefits and will be treated confidentially in compliance with the *Freedom of Information and Protection of Privacy Act*. Any questions about the collection, use or disclosure of this information should be directed to the Director, Child and Youth with Special Needs Branch, (250) 952-6044, PO Box 9719 Stn Prov Govt, Victoria BC V8W 9S5.

A. TO BE COMPLETED BY PARENT OR GUARDIAN

LAST NAME OF CHILD	FIRST	INITIAL	CHILD'S PERSONAL HEALTH NUMBER	GENDER ☐ M ☐ F	DATE OF BIRTH (YYYY/MM/DD)

NAME OF PARENT(S)/GUARDIAN(S)	DATE OF BIRTH (YYYY/MM/DD)	DAYTIME PHONE NUMBER
		( )

ADDRESS	CITY/TOWN	POSTAL CODE	EVENING PHONE NUMBER
			( )

EXTENDED HEALTH BENEFITS ☐ YES ☐ NO	IF YES, NAME OF INSURANCE COMPANY

REGISTERED INDIAN ☐ YES ☐ NO	IF YES, REGISTRATION NUMBER	IF YES, BAND NAME AND NUMBER

All Household Members (excluding the child) USE BACK OF PAGE IF YOU REQUIRE MORE SPACE.

Last Name	First Name	Relationship to Child	Gender	Date of Birth (YYYY/MM/DD)

Signature of Parent/Guardian (please ✔ appropriate box(es), initial each true statement and then sign in the signature area below)

- If my child is eligible for the At Home Program, I require: (if your child is eligible for one benefit, please indicate your preferred benefit) ☐ respite benefits and/or ☐ medical benefits — INITIAL
- I am aware that the At Home Program (AHP) is intended to assist families who are facing extraordinary costs and care demands because of their children's severe disabilities or complex health needs. — INITIAL
- I am aware that any information I provide in relation to this application will be used by the Ministry of Children and Family Development to determine initial and continuing eligibility for AHP benefits. — INITIAL
- My child lives at home with me and I am the parent/legal guardian of the child. — INITIAL
- My child is a resident of B.C. and has a legal right to reside permanently in Canada. — INITIAL
- My child is not the beneficiary of or in receipt of a Court award or settlement and there has not been a Court judgment, award or settlement, arising from a personal injury claim, in favour of my child. — INITIAL
- I agree to inform the AHP Regional Contact when there is a Court judgment, award or settlement, in favour of my child, arising from a personal injury claim. — INITIAL
- I consent to the release of information contained in this application and related assessments to members of the Regional Eligibility Committee, to the local Health Authority and staff of the Ministry of Children and Family Development, who are responsible for providing medical or respite benefits for my child. — INITIAL
- I will inform the AHP Regional Contact of any change in any of the information provided in this application on the occurrence of the change. — INITIAL

SIGNATURE X **DATE** (YYYY/MM/DD):

B. TO BE COMPLETED BY THE CHILD'S PHYSICIAN

PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS

SIGNATURE	NAME (PLEASE PRINT)	DATE (YYYY/MM/DD)

C. ELIGIBILITY DECISION - this section for Government Office use only

REGION	☐ ELIGIBLE ☐ RESPITE ☐ MEDICAL	☐ NOT ELIGIBLE	EFFECTIVE DATE (YYYY/MM/DD)	AM NUMBER

REGIONAL CONTACT SIGNATURE	NAME (PLEASE PRINT)	DATE SIGNED (YYYY/MM/DD)

AT HOME PROGRAM APPLICATION (CONTINUED)

D. REGIONAL ELIGIBILITY COMMITTEE RECOMMENDATION

CHILD'S NAME	PARENT(S) NAME(S)

MEETING DATE(YYYY/MM/DD)

☐ Initial Application
☐ Reassessment
☐ Appeal

REVIEW DATE(YYYY/MM/DD)

MEMBERS PRESENT

☐ NOT ELIGIBLE

ELIGIBLE

- ☐ RESPITE BENEFITS
- ☐ MEDICAL BENEFITS
- ☐ CHOICE

FUNCTIONAL CRITERIA

Indicate whether the child is dependent, close to dependent or not dependent in each area of daily living.

EATING: _____

DRESSING: _____

TOILETING: _____

WASHING: _____

DISCUSSION

INDICATE THE FACTORS OR OTHER CRITERIA CONSIDERED IN MAKING THE ELIGIBILITY DECISION.