BRITISH COLUMBIA | Ministry of Children and Family Development

AT HOME PROGRAM APPLICATION

The Ministry of Children and Family Development is collecting this information under sections 26(c)(e) of the Freedom of Information and Protection of Privacy Act for the purposes of determining eligibility for the At Home Program and providing At Home Program Medical Benefits. Any questions about the collection, use or disclosure of this information should be directed to your local CYSN Office or CYSN Worker.

A. To be Completed by the Child's Physician or Nurse Practitioner

Date (MM/DD/YYYY):

Name of Applicant:	Date of Birth (MM/DD/YYYY):
Primary Diagnosis:	Secondary Diagnosis:
☐ Inpatient ☐ Outpatient	If inpatient, anticipated date of discharge (MM/DD/YYYY):
☐ Urgent Admission: Check if applicant requires equipment to be discharged from the hospital	
Translation Services Needed? ☐ Yes ☐ No	If Yes, Which Language?

Direct Admits (Please skip this section if the child or youth does not meet any of the categories below)

☐ Applicant is palliative. The At Home Program uses the same definitions as the BC Palliative Care Benefits (i.e., *is diagnosed with a life-threatening illness or condition, and has a life expectancy of up to 6 months*).

☐ Applicant has been diagnosed with Duchenne Muscular Dystrophy or Spinal Muscular Atrophy Type 1 or Type 2.

☐ Applicant has been accepted into the Self Injurious Behaviour Clinic, and a letter from the clinic is attached to this application.

☐ Applicant has Cerebral Palsy and is functioning at level 3, 4 or 5 of the Gross Motor Function Classification System (GMFCS). Please indicate GMFCS level: _____

☐ Applicant has been accepted into Nursing Support Services (NSS) Direct Care, and their NSS admission letter is attached to this application.

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Under Age 3 (Please skip this section if the child is over 3 years old)

By initialing and signing this form, you are attesting that:

- There is a strong likelihood that this child will have a severe disability. This means the child's current condition is expected to result in dependency in their functional activities of daily living (eating, dressing, toileting, washing) and there is a strong likelihood the child will continue to have these dependencies as they grow older. _____ Initial
- The child has significant care needs greater than a typical infant or young child would require (e.g., suctioning, managing aspiration risk, frequent positioning changes). _____ Initial
- The child has a permanent or consistent need for medically necessary equipment and/or specialized biomedical equipment. _____ Initial

Please describe the child's equipment needs below. A letter of attestation from the applicant's OT or PT can also be included:

Department or Clinic Contact

Name:	Position:	Department:
Telephone:	Fax:	Email:

Physician or Nurse Practitioner Signature

For children to be eligible for the At Home Program they are required to meet the Direct Admit or Under Age 3 criteria above or be assessed as dependent in three of four areas of: eating, dressing, toileting and washing in relation to or because of their disability. By signing this form you are indicating that you believe the child has probable dependencies in the above noted areas.

Signature X **Date** (MM/DD/YYYY):

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B. To Be Completed by Parent or Guardian

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Last Name of Child	First	Initial	Child's Personal Health No.	Gender	Date of Birth (MM/DD/YYYY)

Name of Parent/Guardian	Date of Birth	Gender	Phone Number	Email Address

Address	City/Town	Postal Code

Extended Health Benefits	If Yes, Name of the Insurance Company?	Preferred Form of Contact?
☐ Yes ☐ No		☐ Phone Call ☐ Text ☐ Email ☐ Mail
Translation Services Needed?	If Yes, Which Language?	Indigenous identity? ☐ First Nation ☐ Inuit
☐ Yes ☐ No		☐ Métis ☐ N/A Other:

Household Members (optional)

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

Signature of Parent/Guardian

- I am aware that the At Home Program (AHP) is intended to assist families with children with severe disabilities or complex health needs that are assessed as dependent in three of four areas of: eating, dressing, toileting and washing in relation to or because of their disability.
- 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.
- My child lives at home with me, and I am the parent/legal guardian of the child.
- My child is a resident of B.C. and is enrolled in MSP.
- 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.
- 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.
- 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 benefits for my child.
- I am aware that a nurse assessor will reach out to schedule an assessment.
- 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.

By signing this form, I acknowledge that I have read the statements above and that they are true.

Signature X **Date** (MM/DD/YYYY):