BRITISH COLUMBIA | Ministry of Children and Family Development

Application for At Home Program Medical Benefits (CYSN Pilot Areas)

What is this for?

Parents and guardians use this form to apply for At Home Program Medical Benefits for their child or youth, with the support of the child or youth's physician or nurse practitioner. You may fill it in your web browser or by hand.

This form is intended for families living in Kelowna, Prince Rupert, Terrace and Smithers. For more information, see Medical benefits in the pilot areas`

Information collection, use or disclosure

The personal information collected on this form will be used for the purposes of determining At Home Program Medical Benefits eligibility and providing benefits. This information 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 Community Liaison Quality Assurance Officer, Specialized Provincial Services, 1 888-613-3232, PO Box 9763 Stn Prov Govt, Victoria BC V8W 9S5.

How to submit this application

1. Ensure all the following items are included with your application:

- ☐ Section A is completed and signed by a parent or guardian
- ☐ Section B is completed and signed by the child or youth's doctor, pediatrician, nurse practitioner or pediatric specialist
- ☐ Copies of any required assessments referenced in Section B are attached
- ☐ A copy of the parent or guardian’s government-issued identification
- ☐ A copy of the child or youth’s government-issued identification or BC Services Card

2. Submit by email, fax or mail:

- Email: MCF.MedicalBenefitsProgram@gov.bc.ca
- FAX: 250-356-2159
- Mail: PO Box 9763 STN PROV GOVT Victoria, BC V8W 9S5

If you have any questions, please call us at 1-888-613-3232 or 250-387-9649.

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Section A

To be completed by parent or guardian

Ensure all information matches the child or youth's and parent or guardian's photo ID (e.g. spelling of name, date of birth).

Email or bring the form to the child or youth's doctor, pediatrician, nurse practitioner or pediatric specialist to complete Section B.

Child or Youth

First name	Middle name(s)	Last name

Date of birth (YYYY-MM-DD)	Personal Health Number	Gender
		◯ Boy ◯ Girl ◯ Non-Binary ◯ Prefer not to say

Does this child or youth have Extended Health Benefits?	If yes, what is the name of the insurance company that provides health coverage?
◯ Yes ◯ No ◯ I don't know	

Is this child or youth currently receiving services from a local family connection centre?	If yes, what is the name of the family connection centre?
◯ Yes ◯ No	

This child or youth is:

◯ First Nations ◯ Métis ◯ Inuit ◯ Nisga ◯ None of these options

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Parent or Guardian

First name	Last name	
Relationship to child or youth ◯ Parent ◯ Guardian	Date of birth (YYYY-MM-DD)	
Primary phone	Secondary phone	
Email	Preferred contact method ◯ Email ◯ Phone	
Street address	City	Postal code

Household

If anyone else is living in your home besides you and the child, list them here.

First name	Last name	Date of birth (YYYY-MM-DD)	Relationship to child or youth

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Please confirm that the following statements are true:
☐ I am aware that if my child or youth is 3-17 years of age they require the Pediatric Evaluation of Disability Inventory Computer Adaptive Test (Pedi-CAT) (PEDI), Vineland-3 or be classified with the Gross Motor Functioning Classification System (GMFCS) to be eligible for At Home Program Medical Benefits.
☐ My child or youth lives at home with me and I am the parent or legal guardian of the child or youth.
☐ My child or youth is a resident of British Columbia and is enrolled in the Medical Services Plan (MSP).
☐ My child or youth 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 or youth.
☐ I agree to inform At Home Program Medical Benefits if there is a Court judgment, award or settlement, in favour of my child or youth, arising from a personal injury claim.
☐ I consent to the release of information contained in this application and related assessments to the local Health Authority, family connection centre and staff of the Ministry of Children and Family Development, who are responsible for providing Medical Benefits for my child or youth.
☐ I will inform At Home Program Medical Benefits of any change in any of the information provided in this application on the occurrence of the change. This includes a change in diagnosis.
☐ 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.

Parent or Guardian signature (Typed signatures are not accepted)	Date signed (YYYY-MM-DD)

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Section B

To be completed by **the child or youth's doctor, pediatrician, nurse practitioner, or pediatric specialist**

Medical Practitioner	
Name	Qualifications ◯ Physician ◯ Pediatrician ◯ Nurse practitioner ◯ Pediatric specialist
Email	Phone
Work address	

Diagnosis
Child or youth's primary diagnosis:
Child or youth's secondary diagnosis (if applicable):

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To assess eligibility for At Home Program Medical Benefits at least one of the following assessments must be completed: Vineland-3, PEDI-CAT, or GMFCS. Please review the eligibility requirements in the At Home Program Guide prior to submission.

Assessments are not required if the child or youth has a palliative condition, is receiving Nursing Support Services or has been diagnosed with Duchenne Muscular Dystrophy or Spinal Muscular Atrophy Type 1 or Type 2.

If this application is submitted without an assessment and one is required, At Home Program Medical Benefits staff will contact the parent or guardian directly to advise on how to receive an assessment from their local family connection centre.

Assessment(s) included as part of this application:

- ☐ Vineland-3
- ☐ Pediatric Evaluation of Disability Inventory Computer Adaptive Test (PEDI-CAT)
- ☐ Gross Motor Function Classification System (GMFCS)
- ☐ No assessment included (child or youth is under 3 years of age or is a direct admit category)

OR

Which of the following circumstances apply for this child or youth? (check all that apply)

- ☐ Receiving Nursing Support Services Direct Care
- ☐ Diagnosed with Duchenne Muscular Dystrophy or Spinal Muscular Atrophy Type 1 or Type 2
- ☐ Considered to have a palliative condition and have a life expectancy of up to six months
- ☐ Has a likely prolonged disability with moderate to severe impact on their abilities

For children **under 3 years of age** to be eligible, there must be strong likelihood that they will have a long-term disability. This means the child or youth's current condition is expected to result in significant limitations in their adaptive functioning, mobility and or daily living activities and there is a strong likelihood they will continue to have these limitations as they get older.

By signing this form, I am indicating that the child or youth:

- ☐ Has limitations and significant difficulty with their mobility and or daily living activities
- ☐ Is functioning well below age-level expectations
- ☐ Requires consistent and or permanent need for medical equipment to support their mobility, positioning, and or assist life sustaining functions

Note: If you do not know the full scope of the child or youth's medical equipment needs, a letter of attestation from the child or youth's Occupational Therapist/Physiotherapist can be included.

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Describe the child or youth's consistent and permanent need for medical equipment to support their mobility, positioning, and/or life-sustaining functions:
Is there anything else about the Child or youth medical diagnosis or condition which you think we should be aware of?
☐ I confirm that this child or youth will likely have a prolonged disability with moderate to severe impact on their abilities.

Signature	Date signed (YYYY-MM-DD)

Once complete, return the form to the parent or guardian.