



The personal information collected on this form will be used for the purpose of providing At Home Program benefits and will be treated confidentially in compliance with the Freedom of Information and Protection of Privacy Act.

If you are seeking dental or orthodontic treatment under the At Home Program, the program may assist with the costs of extraordinary dental/orthodontic treatment directly related to the child's disability only.

PART 1 TO BE COMPLETED BY THE PARENT/GUARDIAN

Form with fields: NAME OF CLIENT, DATE OF BIRTH (YYYY/MM/DD), PHONE NUMBER (), ADDRESS, CITY/TOWN, POSTAL CODE

Is the child eligible for a federal/provincial or employer-sponsored dental insurance plan? [] YES [] NO

If Yes, have you applied for funding through that plan? (please explain)

Large empty text box for explanation of funding application.

Form with fields: NAME OF PARENT, SIGNATURE OF PARENT, DATE SIGNED (YYYY/MM/DD)

PART 2 TO BE FILLED OUT BY THE PHYSICIAN, NURSE PRACTITIONER, DENTIST OR ORTHODONTIST

Form with field: MEDICAL DIAGNOSIS/ DISABILITY

Form with field: DENTAL/ ORTHODONTIC TREATMENT REQUIRED *

* For dental benefits, please attach a detailed treatment plan listing fee codes and amounts, and for orthodontic benefits, provide a treatment plan and records.

Please provide a clear justification for this dental/orthodontic treatment, demonstrating how it relates to the child's medical diagnosis or disability.

Large empty text box for justification of treatment.

Form with fields: SIGNATURE OF PHYSICIAN/NURSE PRACTITIONER/ DENTIST/ ORTHODONTIST, DATE SIGNED (YYYY/MM/DD)

MAIL OR FAX COMPLETED FORM TO:

MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT
PO BOX 9763 STN PROV GOVT
VICTORIA BC V8W 9S5
FAX NUMBER: (250) 356-2159
PHONE NUMBER: 1-877-210-3332 (Toll Free)