BRITISH COLUMBIA | Ministry of Children and Family Development

At Home Program
Request for Medical Supplies

The personal information on this form is collected for the purpose of providing At Home Program benefits in accordance with the *Supply Act* under the authority of Section 26(c) of the *Freedom of Information and Protection of Privacy Act* (FOIPPA). Questions about the collection, use or disclosure of this information should be directed to the Medical Benefits Community Liaison/Quality Assurance Officer, toll free at 1-888- 613-3232, PO Box 9763 Stn Prov Govt, Victoria BC V8W 9S5.

Parent/Guardian Information

Last Name	First Name	Middle Initial(s)	Phone Number

Address	City/Town	Postal Code

Child/Youth Information

Last Name	First Name	Middle Name(s)

Date of Birth (yyyy-mmm-dd)	Specific Diagnosis (i.e. Type of Impairment, Location and Degree of Involvement)

Medical Supplies

Item Name	Description and Size	Amount	Frequency
			☐ Daily ☐ Monthly
			☐ Daily ☐ Monthly
			☐ Daily ☐ Monthly
			☐ Daily ☐ Monthly
			☐ Daily ☐ Monthly
			☐ Daily ☐ Monthly
			☐ Daily ☐ Monthly

Incontinence Supplies

Child's Weight in Pounds	Child's Waist Size in Inches	Child is Incontinent during the: ☐ Day ☐ Night

Item Name	Description and Size	Amount	Frequency
			☐ Daily ☐ Monthly
			☐ Daily ☐ Monthly
			☐ Daily ☐ Monthly

Justification

Please provide a clear justification for the medical supplies, indicating that the medical supplies are directly related to the child's specific diagnosis. (Attach an additional page if required)

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Delivery Information

If you are requesting a Feed Pump or Suction Unit, please use this section to provide clear delivery instructions.

Receiver Contact Name		
Address	City/Town	Postal Code
Email Address	Fax Number	Phone Number

Medical Professional Information

Full Name	Position Title	
Address	Fax Number	Phone Number
Email Address	City/Town	Postal Code

I certify the information provided is correct, and I have assessed the medical needs of the applicant, and accept responsibility for recommending the product(s) requested.

Signature of Medical Professional	Date (yyyy-mmm-dd)

Email, Mail or Fax completed form to:

Email: MCF.MedicalBenefitsProgram@gov.bc.ca

Mail: Medical Benefits Branch - At Home Program
Ministry of Children and Family Development
Po Box 9763 Stn Prov Govt
Victoria BC V8W 9S5

Fax Number: 250-356-2159
Toll Free Phone Number: 1-888-613-3232