BRITISH COLUMBIA | Ministry of Children and Family Development

At Home Program
Request For Optical Benefits

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*. Any questions about the collection, use or disclosure of this information should be directed to the Director, Children and Youth with Support Needs Branch, (250) 952-6044, PO Box 9719 Stn Prov Govt, Victoria, B.C. V8W 9S1.

Part 1 To Be Filled Out By The Parent/Guardian

Name of Child	Date of Birth (YYYY/MM/DD)	Phone Number
		( )

Address	City/Town	Postal Code

Is the child eligible for extended health benefits including optical? ☐ Yes ☐ No

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

Note: The At Home Program has a funding limit of $150 per 12 month period.

Name of Optical Supplier	Price Quoted	Phone Number
	$	( )

Address	City/Town	Postal Code

Name of Parent	Signature of Parent	Date Signed (YYYY/MM/DD)

Part 2 To Be Filled Out By The Physician or Nurse Practitioner

Medical Diagnosis/Disability

Please provide a clear justification for the prescription lenses and frames indicating that they are required because of the child's disability or specific medical diagnosis.

Note: Funding is limited to optical needs directly related to the child's disability or specific medical diagnosis.

Name of Physician or Nurse Practitioner	Signature of Physician or Nurse Practitioner	Date Signed (YYYY/MM/DD)

Mail or Fax Completed Form to:

Medical Benefits Program - At Home Program
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)