Disability Assistance or a Supplement from the Ministry of Social Development and Poverty Reduction (SDPR)

Instructions:

- If you receive disability assistance or a supplement under the *Employment and Assistance for Persons with Disabilities Act*, complete the **Release of Information Consent** section below.
- Have an authorized representative of the Ministry of Social Development and Poverty Reduction (SDPR) complete the **Office Use Only** section below and return this page to you. **Note:** Some Service BC representatives are authorized representatives of SDPR. Check with Service BC to find out if a location can assist you with this form.
  - Service BC Centre locations: **servicebc.gov.bc.ca/locations** or
  - SDPR office locations: **www.sdsi.gov.bc.ca/contacts/offices.html**
- Send this page to us with the rest of your application.

Important:

Let us know if you no longer receive disability assistance or a supplement under the *Employment and Assistance for Persons with Disabilities Act* as this may affect your eligibility for the Fuel Tax Refund Program.

For more information, contact Service BC toll-free at 1 800 663-7867 or the Ministry of Social Development and Poverty Reduction toll-free at 1 866 866-0800.

Release of Information Consent

By signing below, I consent to the disclosure of my personal information between the Ministry of Finance and the Ministry of Social Development and Poverty Reduction for the purpose of confirming my eligibility for the Fuel Tax Refund Program. This consent will remain in place for as long as I am in the program.

I agree to inform the Ministry of Finance immediately if notified by the Ministry of Social Development and Poverty Reduction that I no longer qualify or receive disability assistance or a supplement under the *Employment and Assistance for Persons with Disabilities Act*.

LAST NAME	FIRST NAME	MIDDLE NAME (*if applicable*)

MAILING ADDRESS (*include street or PO box number, city and province*)	POSTAL CODE

SIGNATURE OF APPLICANT	DATE OF BIRTH YYYY / MM / DD
X	

OFFICE USE ONLY – TO BE COMPLETED BY SDPR REPRESENTATIVE

Applicant Information:

START DATE OF DISABILITY ASSISTANCE/SUPPLEMENT PAYMENTS YYYY / MM / DD	END DATE OF DISABILITY ASSISTANCE/SUPPLEMENT PAYMENTS (*if applicable*) YYYY / MM / DD	SDPR ICM PID NUMBER

SDPR Representative Information:

ADDRESS OF OFFICE PROVIDING SDPR INFORMATION (*print clearly or use a stamp; include street or PO box, city, province and postal code)*	NAME OF SDPR REPRESENTATIVE
	TELEPHONE NUMBER ( )
	FAX NUMBER ( )

SIGNATURE OF SDPR REPRESENTATIVE	DATE SIGNED YYYY / MM / DD
X	

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