SIDE A

RETURN TO:
Drug Plan and Extended Benefits Branch
3475 Albert Street
Regina, Saskatchewan S4S 6X6
PHONE: 1-800-667-7581 or 306-787-3317
FAX: 306-787-8679
EMAIL: dpeb@health.gov.sk.ca

SPECIAL SUPPORT PROGRAM APPLICATION

CRA CONSENT

- Provide a copy of your Notice of Assessment OR pages 1 to 4 of your Income Tax and Benefit Return showing Line 15000 (for both Applicant and Spouse).
- If you do not file income tax, complete Side B and provide all sources of your annual income.
- Please ensure you have provided all information. Incomplete applications will result in delays in processing.
- Coverage is effective the date complete information is received, subject to approval.

APPLICANT:		**SPOUSE:**	
LAST NAME	**FIRST NAME**	**LAST NAME**	**FIRST NAME**
CURRENT ADDRESS			
CITY	**POSTAL CODE**	**PHONE NUMBER (10 digit)**	

APPLICANT INFORMATION	**SPOUSE INFORMATION**
DATE OF BIRTH (DD / MM / YYYY)	**DATE OF BIRTH (DD / MM / YYYY)**
HEALTH SERVICES NUMBER (HSN)	**HEALTH SERVICES NUMBER (HSN)**
SOCIAL INSURANCE NUMBER (SIN)	**SOCIAL INSURANCE NUMBER (SIN)**

DECLARATION AND CONSENT

Is the Power of Attorney (POA) signing on behalf of the applicant? YES □ NO □
<u>If YES</u>, then copies of the POA documents <u>MUST be attached</u>. NOTE: If a Trustee, Guardian or POA is signing for the Applicant, a copy of the legal document must be attached to this consent form. Due to the variety of POA documents, some may not be considered acceptable for CRA, such as POA specific to or limited to a bank or financial institution.

I hereby consent to the release, by the Canada Revenue Agency to an official of the Saskatchewan Ministry of Health, of information from my income tax returns, and, if applicable, other required taxpayer information about me. The information will be relevant to, and used solely for the purpose of determining and verifying my/our eligibility and the general administration and enforcement of: the Income-Based General Coverage pursuant to *The Prescription Drugs Act* and regulations made thereunder, and will not be disclosed to any other person or organization without my approval.

This authorization is valid for the most relevant of the two taxation years prior to the year of signature. It is also valid for each subsequent consecutive taxation year during which my family unit seeks coverage under the Income-Based General Coverage requested by me or on my behalf. I understand that, if I wish to withdraw this consent, I may do so at any time by writing to Saskatchewan Ministry of Health, Drug Plan and Extended Benefits Branch.

_____ DATE _____
SIGNATURE OF **APPLICANT**, or if applicable, GUARDIAN /TRUSTEE / POWER OF ATTORNEY. A witness is necessary if Applicant signs with an "X" or a mark.

_____ DATE _____
SIGNATURE OF **SPOUSE** or if applicable, GUARDIAN / TRUSTEE / POWER OF ATTORNEY. A witness is necessary if Spouse signs with an "X" or a mark.

_____
PRINT NAME IF GUARDIAN / TRUSTEE / POWER OF ATTORNEY/ WITNESS

_____
PRINT NAME IF GUARDIAN / TRUSTEE / POWER OF ATTORNEY/ WITNESS

ADDITIONAL INFORMATION: Attach a written explanation and provide income documentation if you have changes in medication or income. For example, if you had capital gains - attach schedule 3.

Saskatchewan