



SIDE A

RETURN BY MAIL TO:
MINISTRY OF HEALTH
Drug Plan & Extended Benefits Branch
Operations Unit
3475 Albert Street – 2nd Floor
Regina, Saskatchewan S4S 6X6
PHONE: 1-800-667-7581 or 306-787-3317
FAX: 306-787-8679

SPECIAL SUPPORT PROGRAM APPLICATION CRA CONSENT

- ◆ Provide a copy of your Notice of Assessment OR pages 1 to 4 of your Income Tax Return showing Line 150 (for both Applicant and Spouse).
- ◆ If you do not file income tax, complete Side B and provide required income documentation.
- ◆ Incomplete applications will result in delays in processing. Please ensure you have provided all information.
- ◆ Coverage is effective the date complete information is received, subject to approval.

SURNAME / FIRST NAME APPLICANT		SURNAME / FIRST NAME SPOUSE	
CURRENT ADDRESS			
CITY		POSTAL CODE	PHONE NUMBER
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

If YES, then copies of the POA documents MUST be attached. 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 Include any written explanation or information that you feel may help for the review of this request. For example, income changes, new medication or changes in medication, capital gains. (If providing additional information about capital gains, please attach a copy of schedule 3). Ensure you include supporting documentation.