Ontario

Ministry of Health and Long-Term Care

Co-Payment Application for Seniors

You are automatically eligible for Ontario Drug Benefits if you:

- are 65 or older, *(i.e. the first day of the month past your 65th birthday)* **and**
- live in Ontario, **and**
- have a valid Health Card

Application

Before you begin:

1. There are two types of co-payments: a $2 co-payment and a higher co-payment.
   Please complete this application ONLY if you believe you are eligible for the $2 co-payment.
   Read the enclosed *Guide to Your Application* before completing this application.
2. You should complete this application for the $2 co-payment if:
   - your net income is less than $16,018 *(for a single senior)*
   - your combined net income is less than $24,175 *(for a couple)*
3. If you are 65 or older and live with a spouse or partner, decide which one of you will fill out the application. The person who fills out the application will be our contact if we have to call or write for more information.

Please PRINT clearly in capital letters using a blue or black pen.
Please remember that you must both sign the application in all signature areas which are lightly shaded.

A. Tell us about you – the applicant

■ You must complete this section, even if you have no income.
See the *Guide to Your Application* for information about your net income.

Last name

First name | Middle name

Health Number | Version Code* | Sex: [X] male [X] female | Date of birth: Y Y Y Y / M M / D D

Social Insurance Number | Telephone number: ( ) – | What language do you prefer? [X] English [X] French

Which of these best describes your living situation? Mark (X) one box only.
[X] married or living with partner [X] single, separated, divorced, or widowed

Net Income (see #3 in Guide): $, . 00

Mailing address (street number, street name) | Apt. #

City or town | Province: O N | Postal Code

* Complete this box if there are any letters after your Health Number.
If your mailing address above is different than your residence address, give us your full residence address.

Street number and name, lot, concession or township

City or town | Province: O N | Postal Code

B. Tell us about your spouse or partner

Complete this section if you are married or living with a partner. If you are single, separated, divorced or widowed, please go to **Section C.**

Last name of spouse or partner

First name | Middle name

Health Number | Version Code* | Sex: [X] male [X] female | Date of birth: Y Y Y Y / M M / D D

Social Insurance Number | Relationship to you

Net Income (see #3 in Guide): $, . 00

Total Income: $, . 00 ■

Add your net income to your spouse's or partner's income.

B. Tell us about your spouse or partner *(continued)*

Please send us a copy of your *Notice of Assessment* from the Canada Revenue Agency, or other proof of income for both you and your partner.

C. Please read and sign this agreement

Make sure you and your spouse or partner sign this application in all signature areas which are lightly shaded.

By signing this application you confirm that:

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- the information provided in this application is true, correct and complete to the best of my knowledge;
- the Ministry of Health and Long-Term Care or its agents may collect any information from any source to verify the information in this application. All information is kept strictly confidential;
- you will tell the Ministry of Health and Long-Term Care about any increase or decrease in your income or your spouse's/partner's income.

Your signature	Date	**Your spouse's or partner's signature**	Date
X	Y Y Y Y / M M / D D	X	Y Y Y Y / M M / D D

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I authorize the Canada Revenue Agency to release to the Ministry of Health and Long-Term Care information from my income tax returns and other required taxpayer information whether supplied by me or a third party. The information will be relevant to, and used solely for the purpose of determining and verifying eligibility, including determining appropriate co-payment amounts, and for the administration and enforcement of the Ontario Drug Benefit Program under the *Ontario Drug Benefit Act*, and will not be disclosed to any other person or organization without my approval, except as required or permitted by law. This authorization is valid for the most recently available of the two taxation years prior to signing this consent and each subsequent consecutive taxation year for which assistance under the *Ontario Drug Benefit Act* may be requested and determined. I understand that, if I wish to withdraw this consent, I may do so at any time by writing to the Ontario Drug Benefit Program, 5700 Yonge Street, 3rd Floor, Toronto ON M2M 4K5

Applicant

Signature of applicant or applicant's representative	Date
X	Y Y Y Y / M M / D D

Please mark (X) appropriate box to identify above signatory, and attach supporting documents, as appropriate.

☐ applicant ☐ applicant's Guardian of Property ☐ applicant's Guardian of the person
☐ applicant's Attorney under continuing power of attorney ☐ applicant's Attorney under power of attorney for personal care

If the signature above is ***not*** that of the applicant, print the signatory's information.

First name Last name

Applicant's Spouse/Partner

Signature of spouse/partner or representative	Date
X	Y Y Y Y / M M / D D

Please mark (X) appropriate box to identify above signatory, and attach supporting documents, as appropriate.

☐ spouse / partner ☐ spouse's/partner's Guardian of Property ☐ spouse's/partner's Guardian of the person
☐ spouse's/partner's Attorney under continuing power of attorney ☐ spouse's/partner's Attorney under power of attorney for personal care

If the signature above is ***not*** that of the applicant's spouse/partner, print the signatory's information.

First name Last name

Please check again that you / your representative and your spouse / partner / their representative have signed in all areas which are lightly shaded. If any signatures are missing, we will have to return your application.

When you have completed the application:

1. Make sure that you / your representative and your spouse / partner / their representative have signed in all areas which are lightly shaded.
2. Collect the documents you'll need for proof of income (see #3 of the enclosed guide for a list of the documents).
3. If applicable, collect any supporting documents you will need (see section above)
4. Send everything to us in the return envelope. The address is Ontario Drug Benefit Program, Ministry of Health and Long-Term Care, PO Box 384, Etobicoke D ON M9A 4X3
5. We'll notify you by mail once we've processed your application.

This information is collected under the authority of the *Personal Health Information Protection Act*, 2004, S.O. 2004, c.3, Sched. A (PHIPA) and Section 13 of the *Ontario Drug Benefit Act*, R.S.O. 1990, c.O.10. This information is collected for the purpose of administering the Ontario Drug Benefit Program. It may be used and disclosed in accordance with PHIPA, as set out in the Ministry of Health and Long-Term Care "Statement of Information Practices" which may be accessed at www.health.gov.on.ca. For more information, please contact the Director, Ontario Drug Benefit Program, Ministry of Health and Long-Term Care, 5700 Yonge Street, 3rd floor, Toronto ON M2M 4K5 or call 416 503–4586 in the Toronto area or toll-free at 1 888 405–0405.

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