Pharmacare Application and Consent Authorization

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Manitoba
Health, Seniors and Long-Term Care

Please Print – One application per family unit | **Application Deadline – March 31 of Current Benefit Year**

Applicant's Surname	Given Name	Current Marital Status:	Spouse's Surname	Given Name
Manitoba Health Registration Number		❑ Married/ Common Law	Manitoba Health Registration Number	
Personal Health Identification Number (PHIN)		❑ Separated	Personal Health Identification Number (PHIN)	
Social Insurance Number (SIN)		❑ Single/ Widowed	Social Insurance Number (SIN)	
Current Address		City/ Town		
Telephone Number		Postal Code		

Note: This information is collected under the authority of section 13 (1) of *The Personal Health Information Act* and will be used for the purpose of determining Pharmacare benefit eligibility

Eligible prescription purchases are applied to the annual deductible for each benefit year from April 1 to March 31.

Is the Power of Attorney signing on behalf of the applicant and/or spouse? ❑ Yes ❑ No
(If Yes, copies of Power of Attorney documents must be attached)

If applicable, does the Applicant or Spouse reside in a Personal Care Home? ❑ Yes ❑ No

One Time Program Enrolment

- ✔ One time application form completion.
- ✔ Deductible is automatically set on April 1 each benefit year.
- ✔ Automated application process.
- ✔ Deductible Confirmation letter will automatically be provided at beginning of each benefit year.
- ✔ Income tax information from two years prior to the beginning of the benefit year is supplied by Canada Revenue Agency.

CONSENT

I hereby consent to the release, to the Manitoba Department of Health by the Canada Revenue Agency, of income, expense and identifying information, including name, marital status, and birthdate, from my income tax returns and from other sources, and if applicable, similar information respecting my spouse. This information will be relevant to and used solely for the purpose of verifying my eligibility and determining the amount of benefits established under *The Prescription Drugs Cost Assistance Act* and regulations made thereunder, and will not be disclosed to any person without my approval.

This authorization is valid for the two previous taxation years, the current taxation year and for each subsequent consecutive taxation year during which my family unit seeks coverage under the Pharmacare program or someone seeks such coverage on behalf of my family unit. I understand that, if I wish to withdraw this authorization, I may do so at any time by writing to the Pharmacare program.

Signature of Applicant _____ Date _____

Signature of Spouse _____ Date _____

DECLARATION

I declare that all the information I have provided in this form is complete. I also certify that the prescription drug costs for which I am or will be claiming benefits are not covered by another federal/provincial/municipal program. I understand that a false statement constitutes fraud and may result in recovery of any benefits paid by Manitoba Health.

Signature of Applicant _____ Date _____

Signature of Spouse _____ Date _____

The completed form can be forwarded to Manitoba Health, 300 Carlton Street, Winnipeg MB, R3B 3M9 or faxed to 204-786-6634.
For additional information, please contact our office at 204-786-7141, toll free 1-800-297-8099 or www.gov.mb.ca/health/pharmacare.

Reminder: Signatures are required in both the Consent & Declaration

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