



## Drug Assistance for Cancer Patients

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### Eligibility:

To apply for drug coverage through the *Drug Assistance for Cancer Patients* you must have a diagnosis of cancer and:

- be a resident of Nova Scotia and have a valid Nova Scotia Health Card;
- have a gross family income no greater than \$15,720 per year; and
- not be eligible for coverage under other drug programs, except Family Pharmacare.

### Benefits:

*Drug Assistance for Cancer Patients* provides coverage for certain cancer-related drug benefits listed in the Nova Scotia Formulary.

### Application Process:

The application for the *Drug Assistance for Cancer Patients* is printed on the reverse side of this form. Please answer all questions completely and accurately. Incomplete or inaccurate applications cannot be processed.

Attach a copy of the Income Tax Notice of Assessment or Reassessment from Canada Revenue Agency for the patient, their parent(s) or guardian(s), spouse or common-law partner.

If you do not have the most recent Notice of Assessment or Reassessment, you will have to obtain a copy from Canada Revenue Agency by phoning 1-800-959-8281.

Forward the completed application and the Notice of Assessment to the address or fax number below. Once deemed eligible, there is no renewal process.

Please allow three working days after the application is received for processing. You or your guardian will then receive a phone call to confirm the outcome of the application.

If you have any questions regarding the assistance provided or the application process, please call 496-7001 or toll free 1-800-305-5026, or visit the website at [www.nspharmacare.ca](http://www.nspharmacare.ca).

**Nova Scotia Pharmacare Programs**  
**PO Box 500, Halifax, Nova Scotia B3J 2S1**

**Fax: (902) 468-9402**

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Day Month Year

Address \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone Number Home \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

NS Health Card Number (MSI) \_\_\_\_\_ (10 digit number)

If the patient is a dependent, name of parent(s) or guardian(s) \_\_\_\_\_

Parent(s) or Guardian(s) Telephone Number \_\_\_\_\_

Is the patient currently covered by a prescription drug plan/program? Yes  No

**INCOME INFORMATION**

Provide the information requested below for the patient, their parent(s) or guardian(s), or spouse. Enter the amount on line 150 from the most current income tax return for each person.

**Enclose a copy of the Income Tax Notice of Assessment or Reassessment from Canada Revenue Agency for each person.**

Surname, First Name	Nova Scotia Health Card Number	Gross Income (Line 150)

**TOTAL**

**If the total gross family income is greater than \$15,720, the patient does not qualify for assistance.**

**Statement of Information Accuracy**

I declare that the information provided on this application is complete. I understand that a false statement constitutes fraud and may result in recovery of any benefits paid by the Nova Scotia Department of Health.

**Statement for Release of Medical Information Related to Patient**

I hereby authorize Dr. \_\_\_\_\_ of \_\_\_\_\_  
(Name) (Address)

to provide the Nova Scotia Pharmacare Programs with medical information **related to the patient** that may be required to determine eligibility for the *Drug Assistance for Cancer Patients* Program.

**Authorization for Release of Information**

I/we hereby consent to the release, to the Nova Scotia Department of Health by the Canada Revenue Agency, of information from my income tax returns and other required taxpayer information and, if applicable, information from my parent or guardian's/spouse's income tax returns. This information will be relevant to and used solely for the purpose of determining and verifying eligibility for and the general administration and enforcement of the *Drug Assistance for Cancer Patients* Program, and will not be disclosed to any person without my approval. This consent is valid for the most recent tax year prior to signature. It is also valid for the current taxation year and subsequent consecutive taxation years for which assistance is requested. I understand that if I wish to withdraw this authorization, I may do so at any time by writing to the Nova Scotia Pharmacare Programs.

I understand and endorse the above Statement of Information Accuracy and support both of the above Authorizations for the Release of Information, as indicated by my signature below.

Patient/Parent/Guardian's signature \_\_\_\_\_ Date \_\_\_\_\_  
 Spouse's signature \_\_\_\_\_ Date \_\_\_\_\_