

New Start Digital Youth Intensive Outpatient Program Application

New Start Foundation envisions a world where all Canadians can receive effective, equitable and timely mental health and addiction treatment

Eligibility will be based on both clinical and financial need

Application Process

Each applicant must:

1. Complete clinical assessment
2. Complete the financial application form
3. Provide proof that all resources have been exhausted
4. Provide information regarding income, income tax, assets and bank information

Date Application Submitted: _____

Name of the applicant: _____

Age of applicant: _____

Caregiver/Payer Information

Caregiver/Payer Name: _____

Marital Status: _____

Birth date: _____ Age: _____ Number of Dependents: _____

Current address: _____

Street Address

City

Province

Postal Code

Past Address: _____

Street Address

City

Province

Postal Code

Caregiver/Payer Employment Information

Occupation: _____

Current Employer: _____ Employment Date: _____

Do you have group benefits/employee benefits through your employer? Yes No

Health insurance information

Name of insurer: _____

Policy Number: _____ Certificate Number: _____

Paramedical / specific practitioner coverage: \$ _____

Health spending account coverage: \$ _____

Do you have an individual health / dental plan that covers professional services? Yes No

Health insurance information

Name of insurer: _____

Policy Number: _____ Certificate Number: _____

Paramedical / specific practitioner coverage: \$ _____

Health spending account coverage: \$ _____

Co-Payer Information

Caregiver/Payer Name: _____

Marital Status: _____

Birth date: _____ Age: _____ Number of Dependents: _____

Current address: _____

Street Address

City

Province

Postal Code

Past Address: _____

Street Address

City

Province

Postal Code

Co-Payer Employment Information

Occupation: _____

Current Employer: _____ Employment Date: _____

Does the Co-payer have group benefits/employee benefits through your employer? Yes No

Health insurance information

Name of insurer: _____

Policy Number: _____ Certificate Number: _____

Paramedical / specific practitioner coverage: \$ _____

Health spending account coverage: \$ _____

Does the Co-payer have an individual health / dental plan that covers professional services? Yes No

Health insurance information

Name of insurer: _____

Policy Number: _____ Certificate Number: _____

Paramedical / specific practitioner coverage: \$ _____

Health spending account coverage: \$ _____

Income Statement

| Combined Payer and Co-Payer Income Description | |
|--|----|
| Line 150 from Notice of Assessment | |
| T4 slip income | |
| | |
| | |
| Total Income | \$ |

Please provide backup for the above

Please list any other treatment the applicant is currently getting or has had in the past three years

In addition to the specific financial information requested, please explain why you and your family cannot pay for treatment:

Does the applicant identify as a BIPOC or visible minority? Yes No Prefer not to say

Are you requesting full or partial funding? Full Partial

If partial, please suggest amount of funding requesting: _____

DISCLOSURE AND CONSENT TO THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

I warrant and confirm to you that the information given herein is in all respects true, accurate and complete. I understand that is being used to determine credit worthiness. I authorize you to obtain any information you may require from any source and each source is hereby authorized to provide you with any information you require. You are hereby authorized to retain this application for New Start Foundation records.

If any part of this statement is incorrect or if there is a breach of this agreement, then I agree to pay the full cost of the program.

I have attached the following documentation:

- Income Tax Notice of Assessment for the last three years
- Insurance Policy coverage back-up
- Federal and provincial government social assistance (welfare, housing, child tax benefits etc.)

I consent to and accept this as written notice of your obtaining, disclosing, or exchanging any credit, personal or other information about me (including information contained in my personal information file) at any time from, to or with any credit bureau, personal information agent, credit grantor or insurer, my employer, or other person in connection with any relationship between us or those which you or I may wish to establish.

Payer Signature: _____

Co-Payer signature: _____

Witness: _____

Witness: _____

Date: _____

Date: _____