New Start Foundation for Addiction & Mental Health

New Start Foundation Program Funding 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:

Program applying for:

- ☐ Digital youth outpatient program
- ☐ Bellwood youth day-patient program

Caregiver/Payer Information

Caregiver/Payer Name:

Marital Status:

Birth date: Age: Number of Dependants:

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 Dependants:

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 hereby agree with you that all of my present and future indebtedness to New Start Foundation shall become due and payable without notice or demand.

I have attached the following documentation:

- Income Tax Notice of Assessment for the last three years
- Bank account statements for the last 12 months
- Disability income statements for the last 12 months (if applicable)
- 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:** _____