BRITISH COLUMBIA | Ministry of Health

APPLICATION FOR PSYCHIATRIC MEDICATION COVERAGE

*If you have received this fax in error, please write "**MISDIRECTED**" across the front of the form and fax it back to the originator identified in Section B.*

A. TO BE SIGNED AS TRUE BY THE APPLICANT

Name: _____ Gender: ☐ M ☐ F

Address: _____

_____ Postal Code: _____

Telephone: _____ Date of Birth: ☐☐☐☐ ☐☐ ☐☐
YYYY MM DD

Personal Health Number (PHN) ☐☐☐☐☐☐☐☐☐☐ Mandatory

1. The cost of the prescribed psychiatric medication is a significant barrier to me taking my medication. I have no other financial coverage, and I believe I qualify for Premium Assistance ($30,000 family adjusted net income plus $3,000 per dependent).
2. I consent to the release of financial and clinical information about me to the mental health centre and the Ministry of Health for the sole purpose of verifying my eligibility for this program.
3. I understand that the personal information collected on this form relates directly to and is necessary for program operations. The information will be handled in accordance with the *Freedom of Information and Protection of Privacy Act.* If I have any questions about the collection and use of this information, I will contact my Health Authority.

_____ _____
Signature of Applicant Date

B. TO BE SIGNED BY THE PRESCRIBING PHYSICIAN

Check a, b or c

I certify that the patient:

a. ☐ has been hospitalized for a psychiatric condition,

OR without the medication

b. ☐ is likely to require hospitalization,

OR

c. ☐ other serious consequences are very likely (e.g. unemployment, child neglect, etc.)

Fax this form, with a cover sheet, to your local Mental Health Services Centre OR the mental health contact at your Health Authority.

FORMS SENT ELSEWHERE CANNOT BE PROCESSED

_____ _____ _____
PRINT name of prescribing physician Signature Date

_____ _____
Physican phone number Physician fax number

C. APPROVAL BY MENTAL HEALTH CENTRE / AUTHORITY

_____ _____
Signature of Director or Designate Date

Note: This authorization will expire in ☐ 1 year Date: _____

☐ or earlier Date: _____

PRINT RESET