Indigenous and Northern Affairs Canada
Affaires autochtones et du Nord Canada

SOCIAL PROGRAMS POLICY MANUAL

INDIGENOUS AND NORTHERN AFFAIRS CANADA

SASKATCHEWAN REGION

INAC·AANC

Canada

The federally-funded Income Assistance Program (IA) is a **program of last resort** for any on-reserve resident capable of **effectively demonstrating his/her eligibility**. This program is comparable to the Province of Saskatchewan's standards and rates.

INTENT

An outline of the basic administrative procedures required to demonstrate compliance with the federally-funded IA Program is provided in this chapter.

POLICY

1.1 GENERAL

1.1.1 Income Assistance Program Purpose

a) The purpose of the IA Program is to provide financial assistance to any eligible individual or family unit who resides on-reserve and can clearly demonstrate he/she is unable to meet his/her needs for food, shelter, personal and other items essential to his/her health and well-being.

1.1.2 Must be Eligible to Receive Benefits

a) Every individual who applies for federally-funded IA must meet conditions of eligibility in order to qualify for benefits.

1.1.3 Responsibility to Provide Complete and Accurate Information

a) Every applicant of IA and existing client in receipt of IA benefits is responsible for providing complete and accurate information to the IA Administrator (see Chapter 2, Sections 2.2, 2.3 & 2.4).

b) If a new applicant or existing client deliberately provides false information or withholds information in order to receive benefits, the IA Administrator may forward the case to the local R.C.M.P. detachment for prosecution (see Chapter 5, Section 5.9).

c) Failure to provide complete and accurate information could disqualify an individual from receiving IA benefits.

1.2 CONFIDENTIALITY

1.2.1 Confidential Service

a) All applicants and/or clients of IA have the right to confidential service.

ii) An individual who is receiving services through the *Child and Family Services Act* may apply on the day of his/her 18th birthday (This ensures continuity of care services and no disruption in financial resources).

iii) An individual who is not receiving services through the *Child and Family Services Act* and who resides on his/her own may apply on the day of his/her 18th birthday (Documentation must be provided identifying who is in receipt of the CCB for this individual prior to issuance of assistance).

b) Age 18 - Full or part-time high school student living with parents or primary caregivers

i) A high school student 18 years of age, but under the age of 19, and living with parents or primary caregivers is only **eligible as a dependent in his/her family unit**, except for:

- A student with a disability;
- A single parent;
- A student who has been financially independent of his/her parents (i.e. The student has lived away from home for a period longer than sixty (60) days or has received employment income in his/her own name for a period longer than sixty (60) days).

ii) The family unit must make an application for IA and include the 18 year old as an adult dependent. If the family unit (including the 18 year old adult dependent) is deemed eligible for IA the Adult Allowance for the 18 year old is issued to his/her parents or primary caregivers. **Employed parents/primary caregivers will be required to apply as a family unit (including the 18 year old adult dependent) and may be eligible for earned income exemptions.**

iii) It is the responsibility of the student to provide the IA Administrator with attendance records by the 20th of every month to demonstrate continued eligibility.

c) Age 18 - Not attending high school living with parents or primary caregivers (see Section 2.1.3)

i) An individual 18 years of age, but under the age of 19, not attending high school and living with parents or primary caregivers is only **eligible as a dependent in his/her family unit**, except for:

- A student with a disability;
- A single parent;
- A student who has been financially independent of his/her parents (i.e. The student has lived away from home for a period longer than sixty (60) days or has received employment income in his/her own name for a period longer than sixty (60) days).

d) Age 18 - Couple

i) Married

An application for assistance is completed and eligibility is assessed in the usual manner. Assistance may be provided only if all conditions of eligibility are met.

ii) Common-Law Couple (One age 18+ with one 16/17 year old)

A relationship is considered common-law if the couple has lived together for three (3) consecutive months.

An application is taken from the adult (age 18+). Assistance may be provided only if all conditions of eligibility are met.

The youth (and child, if any) is referred to the local Child and Family Services (CFS) Agency for an assessment of:

- The services required;
- The relationship with the adult; and
- Parental support (consent and financial).

The CFS Agency may refer the youth to the IA Program only if the referral includes:

- Written parental consent; **OR**
- Child and Family Services' recommendation that assistance be provided without parental consent; **AND**
- Information as to who is receiving the Canada Child Benefit.

iii) Common-Law Couples both less than age 18

An application for assistance is not considered until the process as defined in Section e) below is completed.

e) Youth 16 or 17 years of age

Youth 16 or 17 years of age applying for IA are referred to Child and Family Services. No benefits are provided to a 16 or 17 year old applicant regardless of his/her circumstance.

2.1.4 Family Unit

a) In family situations where a couple lives together, the head of the family, as determined by the couple, makes an application. In cases where the couple disagrees as to who is the head of the family unit, the IA Administrator may determine who should apply as head of the family unit.

ii) IA is not intended to supplement a student loan or other funding source or to replace a student loan for an individual who has defaulted on his/her payments. Student loans, Provincial Training Allowance (PTA), Employment Assistance for Persons with Disabilities (EAPD) and First Nations funding are considered the primary sources of funding for training/post-secondary education.

iii) A university student who applies for IA during semester breaks is subject to normal eligibility criteria. Christmas and Easter holidays are not considered break periods.

iv) During semester breaks not exceeding four (4) months, a student is expected to seek employment. A student who exceeds the break period of four (4) months or who graduates and is need of income assistance is able to apply for benefits and will be assessed against the eligibility criteria as any other applicant.

g) Non-Indians Residing On-Reserve

i) The cost of transportation and maintenance (i.e. meals and accommodation) to receive medical care must be provided by the IA Administrator in the same manner it is provided to other eligible on-reserve IA clients. If a Non-Indian client requires other health care services, he/she must apply to the Ministry of Social Services for supplementary health coverage (see Section 2.1.1 a) i)).

2.1.8 Persons who are <u>not eligible</u> for federally-funded IA include but are not limited to:

a) A person in a federal penitentiary, a federal halfway house or a provincial correctional centre;

b) A Young Offender in an open or closed custody facility;

c) A person who has been involuntarily committed to the Saskatchewan Hospital, North Battleford (see Chapter 4, Section 4.5);

d) An individual between 18 and 19 years old, living with parents or primary caregivers. These individuals do not qualify for IA in their own right, except for those eligible individuals identified in Chapter 2, Section 2.1.3.

e) A Registered Indian and his/her dependents that are normally resident off-reserve.

f) An individual and his/her dependents that are normally resident off-reserve.

2.4.2 Procedures

a) An applicant for federally-funded IA must apply at the office of the First Nation where he/she is living or at the location of the Funding Recipient. An off-reserve resident must apply through the MSS Client Service Centre, 1-866-221-5200.

i) The date of application is deemed to be the day upon which the applicant signs and dates the *Application for Social Assistance and Client History* form and it is subsequently received in the IA office. The IA Administrator will provide his/her signature on the *Application* form to verify the date of application. Benefits must be issued from the date of eligibility, but not prior to the date of application (see Chapter 7, Section 7.2.2.).

b) Application for IA is made following the process identified in Chapter 1, Section 1.4. All completed and signed forms are legal documents used by the applicant and the IA Administrator to enter into a contractual arrangement in which each party has rights and obligations. At the time of application, the IA Administrator must:

i) Carefully explain to the applicant the meaning of the application procedure and the declaration to ensure the applicant's rights are protected;

ii) Inform the applicant that the information he/she provides is to be true and accurate to the best of his/her knowledge and belief;

iii) Inform the applicant that if false information is given which would affect his/her eligibility; he/she may be liable for criminal prosecution;

iv) Inform the applicant that he/she is agreeing to have the IA Administrator verify all relevant information concerning his/her eligibility.

c) Every question on the "*Application for Social Assistance and Client History*" and "*Budget and Decision Sheet*" forms must be answered as outlined in Appendix 1 and Appendix 2.

d) The completed and signed forms shall be reviewed jointly by the IA Administrator and the applicant. This review should include:

i) Identification of any required, verified, or supplementary information to be provided by the applicant;

ii) An explanation of any additional conditions which must be satisfied;

iii) For a person in a rental situation, the name and address and telephone number of the landlord and relationship (if any);

iv) For a person in room and board situation, the name and relationship (if any);

5.7 RECOVERY OF OVERPAYMENT

5.7.1 Recovering Overpayments

a) Recovery rates are to be used when a decision has been made to recover from future entitlement and are not intended to preclude recovery by other means such as legal action, lump sum payments or liquid assets.

b) **Guidelines for Recovering Overpayments**

Net Income Assistance Payment	Recovery Amount
$255.00/month or less	$25.00
$256.00/month to $400.00	$40.00
$401.00/month to $550.00	$55.00
$551.00/month to $700.00	$70.00
$701.00/month to $850.00	$85.00
$851.00/month to $1,000.00	$100.00
$1,001.00/month or more	$115.00

c) A higher recovery rate may be used if requested in writing by the applicant/client. A lower recovery rate may be applied with the IA Administrator's approval.

d) When an overpayment occurs, a written report which contains the reason, the amount, the recovery plan, and action taken (reprimand, legal action instituted) must be placed on file. Detailed calculation must also be included.

e) The client is advised in writing of the reason, the amount and the specific details concerning the overpayment.

f) When assistance is based on fluctuating circumstance, the resulting underpayment/overpayment, is considered an adjustment (e.g. income, utilities, etc.) and reconciled at regular intervals. The adjustment is assessed on the next monthly entitlement.

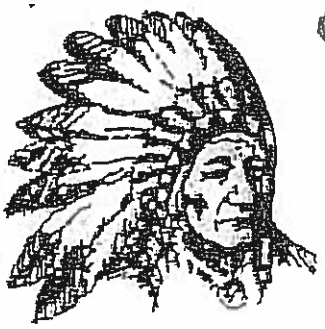
5.8 UNDERPAYMENTS

5.8.1 Due to Administrative Error or Unanticipated Change in Circumstances

a) When an underpayment occurs due to an administrative error or unanticipated change in circumstances, a benefit should be granted for the difference.

5.8.2 Due to Unidentified Needs

a) Where an underpayment occurs because needs were unidentified a benefit should be granted.



COTE FIRST NATION #366

Cote Income Assistance Program
P.O. BOX 66
KAMSACK, SK S0A 1S0

TELEPHONE: (306) 542-2694
FAX: (306) 542-3735

Fax Cover Sheet

To: HRDC **FROM: TARA CADOTTE A/O CLAUDINE SHINGOOSE**

URGENT: INCOME ASSISTANCE ADMINISTRATOR

FAX: (780) 495-7717 A/O (780) 495-6037

PAGES: ____

DATE: _____

RE: _____

SIN NUMBER: _____ **DATE OF BIRTH:** _____

PLEASE DO AN EI CLAIM AND WORKERS COMPENSATION CHECK ON THE ABOVE INDIVIDUAL.
SEE COPY OF CONSENT FORM ATTACHED

RECEIVING EI BENEFITS: **YES** **NO**

COMMENTS: _____

_____

_____

IF YES: START DATE FOR EI BENEFITS: _____

WORKERS COMPENSATION: **YES** **NO**

LAST DAY WORKED: _____

SIGNATURE OF HRCD REP: _____ **DATE:** _____

COTE FIRST NATION #366

Cote Income Assistance Program
P.O. BOX 66
KAMSACK, SK S0A 1S0

TELEPHONE: (306) 542-2694
FAX: (306) 542-3735

CLIENT NAME:_____

SIN NUMBER:_____

DATE OF BIRTH:_____

I, _____, authorize the Issuing Authority to obtain any information from any person, agency or organization to determine and/or verify my eligibility for benefits or services under the Cote Band Income Assistance Program. I understand that this authorization includes information such as source and amount of my needs, Income, financial resources, assets, employment records, marital status, medical records and the amount of benefits or my entitlement to benefits under other programs.

I also understand that it is my responsibility to inform the Issuing Authority immediately of any changes whatsoever in the information provided. I understand that it is a serious matter to provide false information and/ or fail to report any changes in the information provided.

I declare that all the information provided is true and complete and I make this solemn declaration believing it to be true and knowing that it is of the same force and effect as if made under oath.

_____ Applicants Signature

_____ Issuing Authorities Signature

_____ Date

COTE FIRST NATION #366

Cote Income Assistance Program
P.O. BOX 66
KAMSACK, SK S0A 1S0

TELEPHONE: (306) 542-2694
FAX: (306) 542-3735

Cote First Nation: Caseplan

Please fill this out the best that you can, no answer is wrong however every box needs to be completed.

Name:_____

Date:_____

My Achievements: Skills, Interests, Experiences & Leisure Activities

-
-
-
-

My Personal Characteristics (What makes me, me)

-
-
-
-

My Aim (School, Employment, Training ETC)

-
-
-
-

How will I get there? What Could I do to help myself attain my aim?

-

Personal Challenges (Barriers)

-
-
-
-

Client Signature:_____

COTS AND SOCIAL ASSISTANCE

House Number :_____

Head Of Household. __ _____.

Client name and/or Spouse_____.

Name of Children / Adults living within the home:

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

11._____

12._____

13._____

14._____

15._____

16._____

Signature of Client_____

Signature of Spouse_____.

Signature of Head of Household_____

DECLARATION OF ASSETS AND INCOME

ng Authority

PRIVACY ACT STATEMENT

The information you provide on this document is collected under the authority of T.B. Minute 627879 for the purpose of social assistance application and will be stored in personal information bank number INA/P-PU-020. Personal information that you provide is protected under the provisions of the Privacy Act.

_____ declare that I, and my spouse, _____

ave the following assets:

	Cash value
ıney:	
1. Owing from other persons	$ _____
2. In trust with other persons	$ _____
3. Savings	$ _____
4. Life insurance	$ _____
5. Stocks / Bonds	$ _____
roperty other than home	$ _____
hattels:	
1. Livestock	$ _____
2. Farm equipment	$ _____
3. Crop	$ _____
4. Nets	$ _____
5. Boats	$ _____
6. Motors	$ _____
7. Trapping equipment	$ _____
8. Other	$ _____
☐ Truck ▶ Make	Year
☐ Car ▶ Make	Year
Income during the previous month	$ _____

	Income	Totals
Earned Income		
1. Income from employment (monthly)	$ _____	
	$ _____	$ _____
2. Income from trapping (gross)	$ _____	
Less expenses	$ _____	
Net Income	$ _____	$ _____
3. Income from fishing (gross)	$ _____	
Less expenses	$ _____	
Net Income	$ _____	$ _____
4. Income from small business	$ _____	
Less expenses	$ _____	
Net Income	$ _____	$ _____
5. Income from farming Less expenses	$ _____	$ _____
Total earned income		$ _____
Less exemption		$ _____
Total deductible earned income A		$ _____
Unearned Income		
1. Family allowance	$ _____	
2. Unemployment insurances	$ _____	
3. Workers compensation	$ _____	
4. Pension / OAS / GIS, CIPP., D.V.A.	$ _____	
5. Training / Education allowance	$ _____	
6. Rental and property revenue (Less exemption if applicable)	$ _____	
7. Band fund distribution	$ _____	
8. Maintenance payments	$ _____	
Total deductible unearned income B		$ _____
TOTAL DEDUCTIBLE (A + B) ▶		$ _____

The statement made herein are true to the best of my knowledge and belief and I have not concealed or omitted any information required to be given

_____ Signature of Issuing Authority

_____ Signature of applicant

_____ Date

_____ Signature of spouse (where applicable)

Consent to inspect assets:

I, _____ consent that the Issuing Authority or his authorized representative may secure information in respect to my or my spouse's assets. This may involve access to any account or safety deposit box held by me alone or jointly, in any bank, trust company or other financial institution or to any assets held by me or on my behalf by any person, or any records relating to any of them.

_____ Witness

_____ Signature of applicant

_____ Witness

_____ Signature of spouse (where applicable)

_____ Date

501-13 (3-86)

White copy ▶ Client Yellow copy ▶ Client file Pink copy ▶ District

Indian and Northern Affairs Canada / Affaires indiennes et du Nord Canada

STATUTORY DECLARATION – DÉCLARATION STATUTAIRE

Canada

Province of
Province de _____

In the matter of
Dans l'affaire _____

To wit:
À savoir:

I,
Je, _____ of the
de _____

of
in the Province of
dans la province d _____

Do Solemnly Declare as follows:
déclare solennellement ce qui suit: _____

And I make this solemn Declaration conscientiously believing it to be true, and knowing that it is of the same force and effect as if made under oath, and by virtue of the Canada Evidence Act.
et je fais solemment cette déclaration solonnelle, la croyant vraie et sachant qu'elle a la même valeur et la même effet que si elle était faite sous serment et sous l'empire de la Loi sur la preuve au Canada.

Declared before me at the
Déclaré devant moi dans l _____

of
d _____

in the Province of
dans la province d _____

this day of
ce _____ jour d _____, 19 _____

Canada

APPLICATION FOR SPECIAL NEED ALLOWANCE

Issuing Authority

PRIVACY ACT STATEMENT

The information you provide on this document is collected under the authority of T.B. Minute 627879 for the purpose of social assistance application and will be stored in personal information bank number INA/P-PU-020. Personal information that you provide is protected under the provisions of the Privacy Act.

Note ▶ This form must be completed for all special needs (Recurring or one-time only).

Name of head of household

Address

Treaty no. | Band name and membership no.

Length of time applicant has been in receipt of social assistance | Total number of dependents

Type of special need required

Have special needs allowances been issued previously ▶ ☐ No ☐ Yes | If "Yes" specify purpose | Date | Amount

Have advances been issued previously in current year ▶ ☐ No ☐ Yes | If "Yes" state amount outstanding

Request for special needs (identify requirements and amount).

Explain request

What alternative sources of meeting this need have been explored?

Signature of applicant | Date

Duration ▶ ☐ One time only ☐ Continuous | From ▶ | To ▶

Cost | Estimates attached ▶ ☐ Yes ☐ No | Verified by home visit ▶ ☐ Yes ☐ No

Recommended by

Signature of Issuing Authority | Date

Amount approved ▶

Comments

District Superintendent of Social Development | Date

Regional Director of Social Development | Date

601-12 (3-86)

■ T ■ Northern Development Canada Développement du Nord Canada

Medical Report

Assessment of Level of Care (Services)

Notes to Examining Physician

1. Unless specifically requested by Aboriginal Affairs and Northern Development Canada, the cost of this examination is the responsibility of the applicant/client.
2. Please return the completed form to: _____

Date issued:►				IA Administrator to provide name above (▲) and indicate on (◄) the left the date this form was issued to the client.
	Year	Month	Day	

Client Consent:

I give my consent for the release of the information contained in this Medical Report to Aboriginal Affairs and Northern Development Canada and the individual identified above (note #2), to confirm my eligibility for federally-funded income assistance.

Date: ►					
	Year	Month	Day	▲Signature ▲	▲Trustee (where applicable) ▲

▲Name of Patient ▲		▲Age ▲	▲Sex ▲
▲ Address ▲	Date examined: ► Year Month Day		
▲ Examining Physician ▲	▲How long has this patient been under your care?▲		

Diagnosis:
History:
Diet:
Special Problems/or Needs: (e.g. Tube feedings, Oxygen therapy, Skin care, Physiotherapy, Occupational therapy, frequent episodes of acute illness, etc.)
Treatment and Management:

Activity of Daily Living	Full Assistance Needed	Partial Assistance Needed	Supervision Only	No Assistance Needed
Washing face and hands	☐	☐	☐	☐
Grooming, shaving	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Bathing	☐	☐	☐	☐
Walking with safety	☐	☐	☐	☐
Walking with an aid	☐	☐	☐	☐
Using a wheelchair	☐	☐	☐	☐
Transferring from bed to wheelchair & vice versa to toilet	☐	☐	☐	☐
Transferring from bed to chair & vice versa	☐	☐	☐	☐
Positioning in bed or chair	☐	☐	☐	☐
Feeding	☐	☐	☐	☐
Toileting	☐	☐	☐	☐

	Catheter	Complete	Partial	Occasional	None
Bladder Incontinence	☐	☐	☐	☐	☐
Bowel Incontinence		☐	☐	☐	☐

Is there difficulty in communication: Yes ☐ No ☐ If yes, this is due to: ☐ Mental Causes ☐ Deafness Partial/Total ☐ Speech Difficulty ☐ Language Barriers

Is vision seriously impaired? Yes ☐ No ☐

Mental Condition:

Is the patient	Yes	At Times	No		Yes	At Times	No
Cooperative?	☐	☐	☐	Confused?	☐	☐	☐
Aggressive?	☐	☐	☐	Destructive?	☐	☐	☐
				Unpleasant habits?	☐	☐	☐

	Yes	At Times	No
Are there any tendencies to wander?	☐	☐	☐

Please check off the Level of Care (Services) you feel is most appropriate for the applicant/client:

☐ **No Level**

☐ **Level I Care (Services):**
Essentially independent but may need some guidance or supervision in the activities of daily living. Staff time for care averages 20 minutes a day.

☐ **Level II Care (Services):**
Supervision and assistance may be needed with personal hygiene and grooming. Safety ambulant with or without mechanical aids or independent at wheelchair level. Usually continent. Able to feed self. Some supervision and direction may be needed for behavioral problems. Staff time for care averages 45 minutes a day.

☐ **Level III Care (Services):**
All degrees of supervision and assistance may be needed in the activities of daily living. Basic nursing care is usually required. Supervision and direction may be given for emotional or behavioral problems which do not endanger life or property. Care at this level is carried out under the supervision of a Registered Nurse or Registered Psychiatric Nurse as directed by the attending physician. Staff time for care averages 2 hours a day.

☐ **Level IV (Services):**
All patient care is carried out under continuing medical supervision and all nursing care is carried out under professional supervision. Emergency and consultative medical services and highly skilled technical nursing services must be readily available when required. Staff time for care averages more than 2 hours a day.

☐ A. **Specialized Supervisory Care** – where the emphasis lies on the management of advanced mental deterioration with its attendant problems. Physical conditions requiring continuing medical supervision are likely to co-exist.
☐ B. **Supportive Care** – where the emphasis lies on skilled nursing care and specialized techniques to arrest or retard deterioration.
☐ C. **Restorative Care** – where the emphasis lies on a slow paced restorative program designed to improve functional ability to the extent that care at home or Levels I to III may be achieved.

▲ Physician's Signature ▲	Year	Month	Day
▲ Address ▲			

Aboriginal Affairs and Northern Development Canada
Affaires autochtones et Développement du Nord Canada

Medical Report

Notes to Examining Medical Practitioner or Health Care Professional

1. Unless specifically requested by Aboriginal Affairs and Northern Development Canada, via an Income Assistance Administrator, the cost of this examination is the responsibility of the applicant/client.
2. Please return the completed form to: _____

Date issued:►

Year	**Month**	**Day**

IA Administrator to provide name above (▲) and indicate on (◄) the left the date this form was issued to the client.

Client Consent:

I hereby authorize any health care professional who has observed or attended me, to give full information regarding my condition including history, consultation reports, and diagnosis, to Aboriginal Affairs and Northern Development Canada and the individual identified above (note #2), for the purpose of determining my eligibility for federally-funded income assistance benefits.

Date: ►					
Year	**Month**	**Day**	**▲Signature of Client ▲**	**▲Trustee (where applicable) ▲**	

▲Name of Patient ▲			**▲Age ▲**	**▲Sex ▲**
▲ Address of Patient▲	**Date examined: ►**	**Year**	**Month**	**Day**
▲ Examining Medical Practitioner ▲	**▲How long has this patient been under your care?▲**			

Diagnosis and History

1. Does this patient have a **short term** illness or condition (under 12 months)? ☐ **Yes** ☐ **No**

   Diagnosis: _____

   OR

2. Does this patient have a **prolonged** physical or mental condition (over 12 months) as defined in Chapter 7, Section 7.7.2 a) of the Social Programs Policy Manual? ☐ **Yes** ☐ **No**

   If **YES** to either question above, please explain below.

   _____

   _____

3. Does the patient's condition limit employment or training capacity? ☐ **Yes** ☐ **No**

   Treatment: _____

   _____

   Prognosis: _____

   _____

4. Present medication: _____

   If any of the above medications affect the patient's activities, please explain below:

   _____

5. If the patient is not able to work at this time, when can he/she be expected to be ready for work? (Approximate number of days, weeks, or months) _____.

Can the patient return to former occupation? ☐ Yes ☐ No

If Yes, are there any restrictions? Please describe below:

_____

_____

If No, please indicate the reason below:

_____

_____

6. Is the patient capable of any other work? ☐ Yes ☐ No

If Yes, what type of work?

_____

_____

If No, why is the patient not capable of work?

_____

_____

7. Does the patient have an addiction problem? ☐ Yes ☐ No

Do you believe the patient would benefit from addiction treatment? ☐ Yes ☐ No

If Yes, please indicate where you will be referring him/her: _____

Special Diet

8. If the patient is pregnant, expected birth date: _____

9. Does the patient's child require infant formula? ☐ Yes ☐ No

If Yes, name of formula: _____ Number of months required: _____

If No, does the patient require a lactation diet: ☐ Yes ☐ No

10. The following list includes commonly prescribed special diets where expenses exceed normal food costs.

If a special diet is required, please check **one** of the following:

☐ High Protein for **acute conditions where treatment is intensive** and for a specific time period.
Number of months required: _____

☐ Caloric Level (**Please circle reason**) diabetes, weight reduction, modified fats.
Daily Calories: ☐ **1900 - 2499** ☐ **2500 - 2999** ☐ **3000 +** **Length of time required** _____

☐ Food Supplement (Boost, Ensure, etc.) **for specific condition and time period.**
Name of supplement: _____
Number of cans/day: _____ Length of time required: _____

☐ Dialysis

☐ Chronic Disease – includes Hepatitis C, HIV, AIDS, Sickle Cell Anemia, Cystic Fibrosis.

☐ Other (describe) _____

I _____ am a _____ licensed to practice in Saskatchewan.
(print health professional's name) (professional discipline)

Address: _____

This report contains my clinical assessment and considered opinion at this time.

Signature: _____