Ontario

Ministry of Health
Healthy Smiles Ontario
33 King St W
PO Box 645
Oshawa ON L1H 8X1

Healthy Smiles Ontario Change of Information

Ministry Use Only – Date Received

Complete and mail the Change of Information Form to the address shown above. Print clearly using black or blue ink. Fields marked with an asterisk (*) are mandatory.

Note: If you are in receipt of Social Assistance or enrolled in the Healthy Smiles Ontario Emergency and Essential Services stream, and need to update your information, please visit ontario.ca/healthysmiles or call ServiceOntario at 1-844-296-6306.

Existing Applicant Information – Tell Us About You

Provide the details from your existing account. This information is mandatory for your Change of Information Form to be processed.

Last Name* First Name*

Date of Birth* (yyyy/mm/dd) Social Insurance Number

Section 1 Change of Information

Indicate what change(s) you want to make in the check boxes below.

- ☐ Change your existing information (complete Sections 2 and 6)
- ☐ Add or change current children/youth(s) information (complete Sections 3, 6 and 9)
- ☐ Change of marital status and/or spousal information (complete Sections 4, 6 and 9)
- ☐ Withdraw program consent (complete Sections 5 and 6)

Section 2 Change Your Existing Information

Complete to change the first name, the last name, the address or the phone number on the account.
You must also sign Section 6.

Last Name First Name

Telephone Number Alternate Telephone Number (optional)

Residential Address
Unit/Apt/Suite Street Number and Name

City/Town Province Postal Code
ON

Mailing Address ✓ ☐ select this box if same as Residential Address, or complete
Unit/Apt/Suite Street Number and Name (PO Box, Rural Route, Postal Station)

City/Town Province Postal Code

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Section 3 Children/Youth Information

Complete if you are changing, adding or removing a child/youth from the Program. If you are adding a new child/youth to your account, you must sign the Declaration in Section 6 and the Certification and Consent in Section 9 of this Form.

Note: Insurance coverage does not disqualify the child/youth from the Program. You may be asked to send further information from the Insurance carrier if any children/youth(s) listed have dental insurance coverage. See Terms and Conditions for more information.

Please list the total number of dependent children/youth in your household 17 years of age or younger at the time of completing this Form:

Total number of dependent children/youth

Children/Youth Information				Adding Child/Youth Does this child/youth have insurance that includes dental benefits?	Currently Enrolled Child/Youth Is there a change in insurance coverage for this child/youth?
Child/Youth 1	☐ Add	☐ Change	☐ Remove	☐ Yes ☐ No	☐ Add ☐ Remove Effective date (yyyy/mm/dd)
Last Name					
First Name		Date of Birth (yyyy/mm/dd)			
Child/Youth 2	☐ Add	☐ Change	☐ Remove	☐ Yes ☐ No	☐ Add ☐ Remove Effective date (yyyy/mm/dd)
Last Name					
First Name		Date of Birth (yyyy/mm/dd)			
Child/Youth 3	☐ Add	☐ Change	☐ Remove	☐ Yes ☐ No	☐ Add ☐ Remove Effective date (yyyy/mm/dd)
Last Name					
First Name		Date of Birth (yyyy/mm/dd)			
Child/Youth 4	☐ Add	☐ Change	☐ Remove	☐ Yes ☐ No	☐ Add ☐ Remove Effective date (yyyy/mm/dd)
Last Name					
First Name		Date of Birth (yyyy/mm/dd)			
Child/Youth 5	☐ Add	☐ Change	☐ Remove	☐ Yes ☐ No	☐ Add ☐ Remove Effective date (yyyy/mm/dd)
Last Name					
First Name		Date of Birth (yyyy/mm/dd)			

Note: Complete a new form if you need to list more than 5 children/youths.

Section 4 Change of Marital Status and/or Spouse/Common Law Partner Information

When you are adding a spouse/common-law partner to your account, you and your spouse/common law partner must sign the Declaration in Section 6 and the Certification and Consent in Section 9 of this Form.

Marital Status: ☐ Married/Common Law ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

☐ Add Spouse/Common Law Partner ☐ Remove Spouse/Common Law Partner

Last Name First Name

Date of Birth (yyyy/mm/dd) Social Insurance Number

Section 5 Withdraw Program Consent

Complete if you no longer consent to have the Ontario Ministry of Finance verify your tax information with the Canada Revenue Agency to verify eligibility and consent to the collection, use and disclosure of personal health information. You must also sign Section 6.

Applicant

☐ I withdraw consent to disclose my tax information to the Ontario Ministry of Finance and consent for collection, use and disclosure of personal health information to the Ministry of Health.

Signature of Applicant	Date (yyyy/mm/dd)

Spouse/Common Law Partner

☐ I withdraw consent to disclose my tax information to the Ontario Ministry of Finance and consent for collection, use and disclosure of personal health information to the Ministry of Health.

Signature of Spouse/Common Law Partner (if applicable)	Date (yyyy/mm/dd)

Note: By withdrawing your consent, we can no longer administer the program and the child/youth will no longer be eligible to receive dental services under the Program.

Section 6 Declaration

I declare that all information provided on this Change of Information Form is accurate and complete and that I have not misrepresented information about myself, any dependent(s), or my household. I declare that I understand that the Ontario Ministry of Finance will keep this Change of Information Form on record for the purpose of updating information on my account. I understand that unless a change of address is indicated in Section 2, the addresses provided on my original Application Form will be used for all household members listed on this Form. I understand that eligibility for the Program is dependent on compliance with the Terms and Conditions for the Program (see Section 7 for the Terms and Conditions of the Healthy Smiles Ontario Program).

Signature of Applicant*	Date* (yyyy/mm/dd)

Section 7 Terms and Conditions

I declare that:

- The children/youth(s) for whom this Healthy Smiles Ontario Application form is being made meet the following eligibility requirements for the Healthy Smiles Ontario Program ("the Program"):
    - 17 years of age or under
    - A resident of Ontario, and
    - A member of a household that meets the income eligibility requirements as indicated at ontario.ca/healthysmiles
- I have not misrepresented information about myself or my household and understand that any misrepresentation may result in the immediate removal of children/youth(s) from the Program, and that the Government of Ontario may seek reimbursement for any services that were rendered while the children/youth(s) were ineligible for the Program. I understand that the information on the Application form may be subject to audit and verification. **I must immediately report any changes** that may affect the eligibility of the children/youth(s) to the Ministry of Health. The mailing address given on the Application form will be the address used for all household members listed.
- I understand that only certain dental procedures are covered under the Program, as listed in the Healthy Smiles Ontario Program Schedules of Dental Services and Fees. I am responsible for paying for services not covered or paid for under the Program, and for any services rendered after the end date of the children/youth(s) eligibility period.
- I understand that any existing public or private dental insurance coverage for children/youth(s) listed must be utilized before resorting to the Program. I understand that if any children/youth(s) listed have other insurance coverage, I may be asked to send further information from the Insurance carrier.
- I understand that the children/youth(s) eligibility end date is the earlier of the following: either July 31 following the date of the application or the 18th birthday of the children/youth(s). I understand that the Ontario Ministry of Finance will re-confirm that the children/youth(s) continue to meet the eligibility requirements of the Program following the Program eligibility period end-date each benefit year (July 31).
- I understand that the Ontario Ministry of Finance, on behalf of the Ministry of Health, will keep my Application information on record for the purpose of annual eligibility verification.
- I understand that I must re-apply to the Program if I did not file taxes in the most recent tax year(s) based on which eligibility is being verified. Upon completion of the verification process, the Ministry of Health will issue the eligible children/youth(s) a renewed dental card.
- I understand that the dental card is valid for up to one benefit year (August 1 – July 31) from the registration date and will expire at the end of each benefit year (July 31) or the 18th birthday of the children/youth(s) listed.
- I understand that the dental card must be presented to the dental provider at each visit in order to obtain services under the Program. Dental providers will not render services under the Program unless a valid dental card is presented.
- I also understand that the Ministry of Health collects the information I have provided on the Application form for the purpose of evaluation to ensure that the Program meets the needs of eligible children and youth.

Notice of Collection: The personal information collected on this form will be used by the Ontario Ministry of Health, Ontario Ministry of Finance, and ServiceOntario for the purpose of determining eligibility under the Healthy Smiles Ontario Program (the "Program") and otherwise administering the Program. The Ontario Ministry of Finance's authority to collect and share personal information with the Ministry of Health and ServiceOntario is in section 11 of the *Ministry of Revenue Act* which authorizes the Ontario Ministry of Finance to assist other ministries in administering a government assistance program. The personal information collected on this form will only be used and disclosed for the purpose of administering the Program, or otherwise in accordance with applicable law. For more information about this collection, please contact the Director, Health Promotion and Prevention Policy and Programs Branch, Ministry of Health, 393 University Avenue, Suite 1802, Toronto ON M7A 2S1 or call 416-314-2257.

Section 8A Consent for Ministry of Health, Ontario Ministry of Finance and ServiceOntario to collect, use and disclose my personal information

I understand that the personal information that I provide on this form is collected by the Ministry of Health, the Ontario Ministry of Finance and ServiceOntario, for the purpose of administering the Healthy Smiles Ontario program (The Program). I understand that the Ontario Ministry of Finance and ServiceOntario are assisting the Ministry of Health with the administration of this government program.

I consent to the Ministry of Health, the Ontario Ministry of Finance and ServiceOntario, sharing information that relates to eligibility under the Program with one another, for the purpose of administering and processing my file.

Section 8B Consent for the Ontario Ministry of Finance to disclose my personal information to the Canada Revenue Agency and Consent for the Canada Revenue Agency to release my tax information to the Ontario Ministry of Finance

I consent to the disclosure of this personal information by the Ontario Ministry of Finance, on behalf of the Ministry of Health, to the Canada Revenue Agency, for the purpose of enabling the Ontario Ministry of Finance and the Ministry of Health to administer the Program, which includes determining eligibility, issuing letters and notices, and responding to inquiries about my file.

I consent to the disclosure by the Canada Revenue Agency to the Ontario Ministry of Finance, my income and expense information and related identifying information about me from the Canada Revenue Agency tax records, on condition that the information will be used solely by the Ontario Ministry of Finance to verify my income and eligible dependents, and to determine eligibility under the Program. This authorization is valid for the two taxation years immediately preceding the date of application and each subsequent taxation year(s) for which eligibility under the Program is determined.

I understand that this consent will remain in effect until it is withdrawn, that it can be withdrawn in writing, and that if the consent is withdrawn this may end eligibility under the Program.

Section 9 Consent for Collection, Use and Disclosure of Personal Health Information

This section asks for your consent to allow the Ministry of Health, the children/youth(s) dental service providers and local public health units to collect, use and disclose certain personal health information (i.e. treatment data) about the children/youth(s) related to the Healthy Smiles Ontario Program (“the Program”) in order for the Ministry of Health to administer and evaluate the Program.

The children/youth(s) cannot obtain dental services under the Program if you do not consent to the collection of the children/youth(s) personal health information. You can withdraw your consent at any time in writing. Please note that your withdrawal will have no effect on the personal health information disclosed to the Ministry of Health before the date of the withdrawal; however, the Ministry of Health will only use or disclose that personal health information as permitted or required by the *Personal Health Information Protection Act, 2004*.

I consent to:

1. The Ministry of Health disclosing the children/youth(s) enrollment status to the children/youth(s) dental service provider and local public health unit for the purpose of confirming the children/youth(s) enrollment in the Program, where approved.
2. The Ministry of Health disclosing the children/youth(s) name, date of birth, and children/youth(s) identification number to the children/youth(s) dental service provider and local public health unit, as applicable, so that:
    - the children/youth(s) dental service provider and local public health unit, as applicable, can locate the children/youth(s) treatment information for this Program and provide it to the Ministry of Health.
3. The children/youth(s) dental service provider and the children/youth(s) local public health unit, as applicable, disclosing the following personal health information to the Ministry of Health so that the Ministry can use the personal health information to administer, audit and evaluate the Program:
    - The children/youth(s) treatment information such as services provided to the children/youth(s), the children/youth(s) tooth and surface number, the name of the children/youth(s) dental provider, and service date.

I understand:

- That the disclosure of the children/youth(s) personal health information will continue until I withdraw my consent;
- This consent will remain in effect until it is withdrawn, and that if the consent is withdrawn, this will affect eligibility under the Program;
- That the Ministry of Health will collect, use and disclose the children/youth(s) personal health information as permitted or required by the *Personal Health Information Protection Act, 2004*;
- That I can withdraw my consent at any time in writing; and
- That my withdrawal will have no effect on the personal health information collected by the Ministry of Health before the date of my withdrawal.

I consent for all the purposes listed above (Sections 7, 8A, 8B and 9).

Signature of Applicant	Date (yyyy/mm/dd)

Signature of Spouse/Common Law Partner (if applicable)	Date (yyyy/mm/dd)

Please sign and return all 6 pages of this form for it to be processed.