Ontario

Ministry of Health

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

Healthy Smiles Ontario
General Application

Instructions

For more information please visit ontario.ca/healthysmiles. If you have questions, please contact the ServiceOntario INFOline: **Toll-free**: 1-844-296-6306, **TTY toll-free**: 1-800-387-5559, **TTY Toronto only**: 416-327-4282

The **Healthy Smiles Ontario Program** provides eligible children and youth with access to free dental care. Children and youth are eligible if:

- they are 17 years of age or under
- they live in Ontario, and
  - the household they live in meets the income eligibility requirements as indicated at ontario.ca/healthysmiles

Note: Children 17 and under are automatically enrolled in the Healthy Smiles Ontario Program if they or their family are in receipt of Ontario Works, Temporary Care Assistance, Ontario Disability Support Program, or Assistance for Children with Severe Disabilities.

To enroll a child or youth in the Healthy Smiles Ontario Program:

Complete this **Application** form if you and your spouse or common law partner, if applicable, currently reside in Ontario, have a Social Insurance Number (SIN) or a Temporary Taxation Number (TTN), and have filed your taxes.

If you and your spouse or common law partner, if applicable, do not have a SIN or TTN and/or have not filed taxes, you must apply using the **Application through Guarantor** form. A guarantor is someone who can confirm the identity, age and residency of the individuals applying to the program.

1. Complete all pages and sign this Application form at the end of Section 5 (page 5).
2. Mail all pages of your completed Application form to:

   Healthy Smiles Ontario
   33 King Street West
   PO Box 645
   Oshawa ON L1H 8X1

3. You will receive a response once your Application form has been processed.
4. Applicants who are eligible and enrolled will be automatically re-evaluated for each subsequent benefit year. We will send you a notice on enrollment status. Make sure you file your taxes on time to avoid delays.

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Ministry of Health
Healthy Smiles Ontario
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PO Box 645
Oshawa ON L1H 8X1

Healthy Smiles Ontario General Application

Ministry Use Only – Date Received	Version

Please read the instructions before completing your application for the **Healthy Smiles Ontario Program**.
Fields marked with an asterisk (*) are mandatory. Complete all required information to avoid processing delays.

Section 1 Applicant Information – Tell Us About You

Indicate if you are a parent or guardian applying on behalf of your child/youth, or a youth living on your own and applying on your own behalf.*

☐ Custodial Parent/Legal Guardian ☐ Youth – living on your own and applying on your own behalf

Last Name*

First Name* Date of Birth* (yyyy/mm/dd)

Telephone Number* Alternate Telephone Number (optional) Social Insurance Number*

Residential Address
Unit/Apt/Suite Street Number and Name*

City/Town* Province ON Postal Code*

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

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

If married or in a common law relationship, provide spouse or common law partner information:
Last Name Social Insurance Number

First Name Date of Birth (yyyy/mm/dd)

Section 2 Children/Youth Information - Tell Us About the Children/Youth(s) You Are Applying For

Total number of dependent children/youth*
in your household **17 years of age or younger** at the time of application

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Child/Youth 1*

Last Name*

First Name* | Date of Birth* (yyyy/mm/dd)

Child/Youth has insurance coverage that includes dental benefits?* Yes ☐ No ☐

Child/Youth 2

Last Name

First Name | Date of Birth (yyyy/mm/dd)

Child/Youth has insurance coverage that includes dental benefits? Yes ☐ No ☐

Child/Youth 3

Last Name

First Name | Date of Birth (yyyy/mm/dd)

Child/Youth has insurance coverage that includes dental benefits? Yes ☐ No ☐

Child/Youth 4

Last Name

First Name | Date of Birth (yyyy/mm/dd)

Child/Youth has insurance coverage that includes dental benefits? Yes ☐ No ☐

Child/Youth 5

Last Name

First Name | Date of Birth (yyyy/mm/dd)

Child/Youth has insurance coverage that includes dental benefits? Yes ☐ No ☐

Child/Youth 6

Last Name

First Name | Date of Birth (yyyy/mm/dd)

Child/Youth has insurance coverage that includes dental benefits? Yes ☐ No ☐

Child/Youth 7

Last Name

First Name | Date of Birth (yyyy/mm/dd)

Child/Youth has insurance coverage that includes dental benefits? Yes ☐ No ☐

Child/Youth 8

Last Name

First Name | Date of Birth (yyyy/mm/dd)

Child/Youth has insurance coverage that includes dental benefits? Yes ☐ No ☐

Section 3 Terms and Conditions

This Application form requires the applicant, and if applicable the spouse/common law partner, to accept the **Terms and Conditions** below.

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 this 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 Section 1 of this 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 this 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 this 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 4A 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 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 4B 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 affect eligibility under the Program.

Section 5 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 3, 4A, 4B and 5).

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

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

Please sign above and return all 5 pages of this application for it to be processed.