Ontario

Ministry of Health and Long-Term Care

Station P, PO Box 2286
Toronto ON M5S 3J8
Fax: 416-354-2354
Toll-free Fax: 1-877-258-3392

Healthy Smiles Ontario

Ontario Works First Nations Verification Form

If you are in receipt of Ontario Works, your children 17 years of age and younger who are residing with you are eligible to receive dental benefits under Healthy Smiles Ontario.

If you are a youth 17 and under receiving Ontario Works, you (and your spouse if they are 17 years of age or younger) are also eligible to receive dental benefits under Healthy Smiles Ontario.

How to Apply

To enrol your children in the Healthy Smiles Ontario Program, please:

1. Complete and sign the Verification Form. Please ensure that you provide information in **Section 2** for all of your children who are residing with you (Note: Multiple children can be identified on the same form).
2. Mail or fax your completed Verification Form to the Ministry of Health and Long-Term Care to the address noted above.

After You Apply

Once enrolled in the Healthy Smiles Ontario Program, you will be mailed a Healthy Smiles Ontario Welcome Package which includes a dental card for each eligible child and information about the Program.

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

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Ontario Works First Nations Verification Form

Ministry Use Only – Date Received	Version

Please read the instructions before completing the Ontario Works First Nations Verification Form. Fields marked with an asterisk (*) are mandatory. Complete all required information to avoid processing delays.

Section 1 Ontario Works Recipient Information – (Parent/Guardian/Youth applying on their own)

Indicate if you are a parent or guardian enrolled in Ontario Works **OR** a youth who is enrolled on your own behalf. Youth who are applying on their own behalf only need to fill out this section. *(please choose one)*

☐ Custodial Parent ☐ Youth – applying on your own behalf

☐ Legal Guardian

Last Name*

First Name* Middle Name

Date of Birth* (YYYY/MM/DD) Sex* ☐ Male ☐ Female Telephone Number (incl. area code)*

Mailing Address*

Unit/Apt/Suite* Street Number and Name (PO Box, Rural Route, Postal Station)*

City/Town* Province/State*▼ Postal/Zip Code*

Country*

If joint custody ONLY, please provide other parents information:

Last Name*

First Name* Telephone Number (incl. area code)*

Mailing Address*

Unit/Apt/Suite* Street Number and Name (PO Box, Rural Route, Postal Station)*

City/Town* Province/State*▼ Postal/Zip Code*

Country*

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Section 2 Children/Youth Information

Please complete for all eligible children/youth within the benefit unit.

			Is this child/youth eligible for Non-Insured Health Benefits (NIHB)?
Children/Youth 1*	Last Name	Sex* ☐Male ☐Female	Yes ☐ No ☐
	First Name	Date of Birth*	
Children/Youth 2	Last Name	Sex ☐Male ☐Female	Yes ☐ No ☐
	First Name	Date of Birth (YYYY/MM/DD)	
Children/Youth 3	Last Name	Sex ☐Male ☐Female	Yes ☐ No ☐
	First Name	Date of Birth (YYYY/MM/DD)	
Children/Youth 4	Last Name	Sex ☐Male ☐Female	Yes ☐ No ☐
	First Name	Date of Birth (YYYY/MM/DD)	
Children/Youth 5	Last Name	Sex ☐Male ☐Female	Yes ☐ No ☐
	First Name	Date of Birth (YYYY/MM/DD)	
Children/Youth 6	Last Name	Sex ☐Male ☐Female	Yes ☐ No ☐
	First Name	Date of Birth (YYYY/MM/DD)	
Children/Youth 7	Last Name	Sex ☐Male ☐Female	Yes ☐ No ☐
	First Name	Date of Birth (YYYY/MM/DD)	
Children/Youth 8	Last Name	Sex ☐Male ☐Female	Yes ☐ No ☐
	First Name	Date of Birth (YYYY/MM/DD)	
Children/Youth 9	Last Name	Sex ☐Male ☐Female	Yes ☐ No ☐
	First Name	Date of Birth (YYYY/MM/DD)	

Section 3 Application Type

Please indicate whether you are applying for a new HSO child/youth, updating the information for an existing HSO child/youth or re-applying.*

- ☐ New Application for child/youth
- ☐ Child/youth Information Update
- ☐ Renewal for child/youth

Section 4 Ontario Works Delivery Partner Information

Name of Ontario Works Administrator/Caseworker:

Last Name* First Name*

Ontario Works Office:

Site Name* Phone Number*

Unit/Apt/Suite* Street Number and Name (PO Box, Rural Route, Postal Station)*

City/Town* Province ON Postal Code*

Section 5 Terms and Conditions

Applicants must accept the **Terms and Conditions** below.

I **declare that:**

- The child/youth for whom this Ontario Works First Nations Verification Form for Healthy Smiles Ontario is being submitted is within an Ontario Works Benefit Unit.
- I have not misrepresented information about the child/youth, myself or my household and understand that any misrepresentation may result in the immediate removal of the child/youth from the Program, and that the Government of Ontario may seek reimbursement for any services that were rendered while the child/youth was ineligible for the Program.
- I understand that the information on this application may be subject to audit and verification and that I must immediately report any changes that may affect the eligibility of the child/youth to the Ministry of Health and Long-Term Care.
- I understand that the dental card that may be provided to the child/youth if the child/youth is eligible for the Program is valid for up to one benefit year (January 1 - December 31) from the registration date and will expire at the end of each benefit year (December 31) or the 18th birthday of the client(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 consent to the collection, use and disclosure of any of the information included on this form or submitted in connection with this form by and among my dental service provider(s) and the Ministry of Health and Long-Term Care. I also consent to the collection use and disclosure of related treatment information between my dental service provider(s) and the Ministry of Health and Long-Term Care for the purpose of: follow up and case management; program administration, and evaluation under the Healthy Smiles Ontario Program.

	Signature of Parent/Guardian/Youth*	Date (YYYY/MM/DD)*
X		

If joint custody,

	Signature of Parent/Guardian/Youth*	Date (YYYY/MM/DD)*
X		