Ontario

Ministry of Health
Ontario Seniors Dental Care Program
Station P, PO Box 159
Toronto ON M5S 2S7

Ontario Seniors Dental Care Program Application Through Guarantor

Instructions

The **Ontario Seniors Dental Care Program** ("the Program") provides comprehensive dental care to eligible low-income seniors. The benefit year for the program is August 1st to July 31st. A senior is eligible for the Program if they:

- Are 65 years of age or older;
- Are a resident of Ontario;
- Meet the income eligibility requirements (available at www.ontario.ca/seniorsdental); and
- Have no other form of dental benefits, apart from the Canadian Dental Care Plan (CDCP). This includes private insurance or dental coverage through other government programs such as Ontario Works, Ontario Disability Support Program or Non-Insured Health Benefits. Clients may qualify for the CDCP and may still be eligible for the OSDCP provided the client meets the eligibility criteria.

As a senior, you may use this application form to apply for the Program if you do not have a valid Social Insurance Number (SIN) and/or if you have not filed your Personal Tax Return(s) with Canada Revenue Agency (CRA) for the most recent tax year. If you have a spouse (married or common law partner) who would also like to apply for the Program, they must complete their own Application Form.

This Application through Guarantor form may be completed for up to three application cycles (3 years). Any Guarantor application that is submitted for a third or more consecutive year will result in the ministry following up with the Applicant to ensure that the Guarantor application is still needed and to educate the applicant on applying to the Ontario Seniors Dental Care Program (non-Guarantor stream). Failure to apply to the Ontario Seniors Dental Care Program (non-Guarantor stream) after this time period of three years may result in your Application through the Guarantor application being declined.

Alternatively, if you or your spouse, if applicable, have a SIN and have filed your tax return(s), please complete the Ontario Seniors Dental Care Program Application Form (5125-20E).

To enroll in the Program:

1. Complete and sign all sections of this Application Form that apply to your situation.
2. Mail your completed Application form to:
   Ministry of Health
   Ontario Seniors Dental Care Program
   Station P, PO Box 159
   Toronto ON M5S 2S7
3. The Program Administrator will contact you or your legal representative (including a substitute-decision maker, power of attorney for personal care, or a court appointed guardian of the person) if there are any issues with the application. You will be notified of the status of your application by letter once it has been reviewed.
4. If your application is approved, you will receive a welcome package and dental card in the mail with an expiration date of July 31 of the current benefit year.
5. Your eligibility will not be automatically assessed before each benefit year. In order to continue your enrollment in the Program, you must re-apply to the Program for each subsequent benefit year.

For more information, please visit www.ontario.ca/seniorsdental. If you have additional questions, please contact the **Program**: 416-916-0204 **Toll-free**: 1-833-207-4435 **TTY toll-free**: 1-800-855-0511.

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

1. Applicant Information – Tell Us About You

Last Name *	First Name *	Middle Name

Preferred Name

Date of Birth * (yyyy/mm/dd)	Telephone Number *	Alternative Telephone Number ext.

Residential Address

Unit Number	Street Number *	Street Name *	PO Box

City/Town *	Province *	Postal Code *
	Ontario	

☐Select if your Residential Address differs from you Mailing Address

Mailing Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Marital Status *

☐Married/Common Law ☐Single ☐Separated

☐Divorced ☐Widowed

2. Program Eligibility for Non-Tax Filers

This application form requires applicants to obtain a guarantor to confirm the identity and program eligibility requirements of the applicant(s).

Applicants who have applied with a Guarantor will have to re-apply to the Program for each subsequent benefit year.

2a. Income Declaration

I confirm that due to extenuating circumstances, my income cannot currently be verified through tax information, however, I confirm that my income meets the eligibility requirements. *

☐Yes ☐No (If no, Program eligibility cannot be granted)

2b. Guarantor Information

Complete if you are the Guarantor. As Guarantor, you must sign the declaration below. Important: A "Guarantor" must be a person that:

- Is a Canadian Citizen and 18 years of age or older.
- Can confirm the identity of the applicant and if applicable, their spouse/common law partner and the identity, age and Ontario residency of the client(s).
- Is a member of a regulated profession (e.g., dentist, teacher, nurse, doctor, lawyer) or other specified profession (e.g., mayor, professor). Please visit www.ontario.ca/seniorsdental for a list of acceptable guarantors.

Guarantor's Last Name *	Guarantor's First Name *
Guarantor's Title *	Relationship to Applicant *

Address

Unit Number	Street Number *	Street Name *	PO Box

City/Town *	Province *	Postal Code *

Country *

Telephone Number *	Alternative Telephone Number ext.

Declaration of Guarantor

I verify that, to the best of my knowledge:

1. The identity of the applicant is as reflected on the application.
2. The applicant is 65 years of age or older.
3. The applicant is a resident(s) of Ontario.

I have not misrepresented myself or any information as listed above. I understand that the information on this Application form may be subject to audit and verification by the Ministry of Health. I hereby acknowledge that the applicant, and if applicable, their spouse/common law partner listed meet the eligibility requirements identified in

1-3 above for the Ontario Seniors Dental Care Program.

Signature	Date (yyyy/mm/dd) *

3. Terms and Conditions of the Program

This Application form requires you to agree to the Terms and Conditions below.

I declare that:

- I meet the following eligibility requirements for the Ontario Seniors Dental Care Program:
  - 65 years of age or older;
  - Resident of Ontario;
  - The Program income eligibility requirements as indicated at www.ontario.ca/seniorsdental; and
  - Have no other form of dental benefits, apart from the Canadian Dental Care Plan (CDCP). This includes private insurance or dental coverage through other government programs such as Ontario Works, Ontario Disability Support Program or Non-Insured Health Benefits. Clients may qualify for the CDCP and may still be eligible for the OSDCP provided the client meets the eligibility criteria.
- I have not misrepresented information about myself and understand that any misrepresentation may result in immediate removal from the Program, and that the Government of Ontario may seek reimbursement for any services that were rendered while ineligible for the Program.
- I understand that the information on this Application form may be subject to audit and verification by the Ministry of Health. I must immediately report any changes that may affect my eligibility to the Ministry of Health through the Ontario Seniors Dental Care Program Change of Information Form (5128-20E). The mailing address given on Section 1 of this Application form will be the address used for correspondence.
- I understand that only certain dental procedures are covered under the Program, as listed in the Ontario Seniors Dental Care Program Schedules of Dental Services. 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 my eligibility period.

- 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). I understand that I must re-apply to the Program in order to be assessed for eligibility for the next program year.
- I understand that I must present the dental card 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.

Notice of Collection: The information collected in this form will be used by the Ministry of Health for the purpose of administering the Program. For more information about this collection, please contact the Ontario Seniors Dental Care Program, Ministry of Health, Station P, PO Box 159, Toronto, ON, M5S 2S7 or call 1-833-207-4435.

4. Applicant Consent for Collection, Use and Disclosure of Personal Health Information

This section asks for your consent to allow the Ministry of Health, your dental service providers and local public health units to collect, use and disclose certain personal health information (i.e. treatment data) about you related to the Seniors Dental Care Program ("the Program") in order for the Ministry of Health to administer and evaluate the Program.

If you do not consent to the collection of your personal health information you cannot obtain dental services under the Program. You can withdraw your consent at any time by completing a Change of Information Form (5128-20E). 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.

Applicant's Consent:

I consent to:

1. The Ministry of Health disclosing my enrollment status to my dental service provider and local public health unit for the purpose of confirming my enrollment in the Program, where approved.
2. The Ministry of Health disclosing my name, date of birth, and client identification number to my dental service provider and local public health unit, as applicable, so that:
   a. my dental service provider and local health public health unit, as applicable, can locate my treatment information for this Program and provide it to the Ministry of Health.
3. My dental service provider and my 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:
   a. My treatment information such as services provided to me, my tooth and surface number, the name of my dental provider, and service date.

I understand:

- That the disclosure of my 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 my personal health information as permitted or required by the *Personal Health Information Protection Act,* 2004;
- That I can withdraw my consent at any time by completing the Ontario Seniors Dental Care Program Change of Information Form (5128-20E); 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.

If you consent to the collection, use and disclosure of your personal health information as described on this Form, please complete and sign below.

I consent to the collection, uses and disclosures of my personal health information described in this form.

I have the legal authority to consent to this disclosure as I am: *

☐ The Program applicant

☐ The Legal Representative of the Program applicant (including a substitute-decision maker, power of attorney for personal care, or a court appointed guardian of the person). You must attach a copy of the legal document that authorizes you to act on their behalf.

Name of Legal Representative

Relationship to Applicant	Contact Telephone Number
Signature of Applicant or Legal Representative	Date (yyyy/mm/dd) *