Ontario

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

Ontario Seniors Dental Care Program Application

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 and your spouse (if applicable) have filed your Personal Tax Return(s) with Canada Revenue Agency (CRA) for the most recent tax year and have a valid Social Insurance Number (SIN). 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.

Alternatively, if you or your spouse, if applicable, do not have a SIN and/or have not filed your tax return(s), you will need a Guarantor to confirm you meet the eligibility requirements of the Program. If this applies to you, please complete the Ontario Seniors Dental Care Program Application through Guarantor Form (5126-20E).

You can apply to the Program through mail or online. Only one application is needed. If you wish to complete an electronic version of this form, please visit www.ontario.ca/seniorsdental.

To enroll in the Program:

1. You will need your SIN and, if applicable, your spouse's SIN.
2. Complete and sign all sections of this Application Form that apply to your situation. Please note, this form requires the applicant's signature in **two sections**: Section 4 and 6.
3. If you have a spouse, in order for you to apply, your spouse must also include their information on this form and provide their consent, regardless of their age. This information is required to properly assess your annual net income eligibility for the Program.
4. Mail your completed Application form to:
   Ministry of Health
   Ontario Seniors Dental Care Program
   Station P, PO Box 159
   Toronto ON M5S 2S7
5. 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.
6. 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.
7. Your eligibility will be automatically assessed before each benefit year. Annual notices will be sent to your mailing address regarding your enrollment status and if eligible, you will receive a new card for the benefit year. To avoid delays in the automatic assessment, it is important that you and your spouse (if applicable) file your Personal Tax Return(s) with CRA in a timely manner.

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)	Social Insurance Number or Temporary Taxation Number *

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 your 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. Tell Us About Your Spouse (if this applies to you)

If married or in a common law relationship, provide spouse information.

Last Name	First Name	Middle Name

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

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 the Ministry of Health will re-confirm that I 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 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 for the most recent tax year(s) on which eligibility is being verified and/or determined.
- 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 determining eligibility under the Ontario Seniors Dental Care Program (the "Program") and otherwise administering the Program. The Ministry of Finance collects the personal information described in this form for the purpose of assisting the Ministry of Health in determining eligibility under the Ontario Seniors Dental Care Program (the "Program"). The Ministry of Finance's authority to collect and disclose personal information with the Ministry of Health is in section 11 of the *Ministry of Revenue Act*. For more information about this collection, please contact the Ontario Seniors Dental Care Program, 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 Information

Applicant's Consent:
I consent to:

1. The collection of the information that I provide on this form by the Ministry of Health and the Program Administrator (who collects on behalf of the Ministry of Health) for the purpose of administering the Program, including determining my eligibility.
2. The disclosure of the information that I provide on this form by the Ministry of Health and the Program Administrator to the Ministry of Finance for the purpose of administering the Program, including determining my eligibility.
3. The disclosure of the information collected in this form by the Ministry of Finance, on behalf of the Ministry of Health, to the Canada Revenue Agency (CRA) for the purpose of enabling the Ministry of Finance and the Ministry of Health to administer the Program, which includes determining my eligibility under the Program.
4. The disclosure by the CRA to the Ministry of Finance, my income and expense information and related identifying information about me from the CRA tax records, on condition that the information will be used solely by the Ministry of Finance to verify my income 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.
5. The Ministry of Health, the Program Administrator, and the Ministry of Finance sharing my information that relates to eligibility under the Program with one another, for the purpose of administering and processing my file.

I understand:

- That the Ministry of Finance and the Program Administrator will act on behalf of the Ministry of Health to deliver the Program. As part of the administration of the Program, the Ministry of Finance and the Program Administrator will collect, use and disclose my personal information on behalf of the Ministry of Health;
- That the Program Administrator is an agent of the Ministry of Health as defined in the *Personal Health Information Protection Act*, 2004, S.O. 2004, c. 3, Sched. A;
- That the disclosure of my personal 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 I can withdraw my consent at any time by completing the Ontario Seniors Dental Care Program Change of Information Form (5128-20E).

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

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

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

☐ The Program applicant

☐ The Program applicant's Legal Representative (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) *

5. Spouse's Consent for the Collection, Use and Disclosure of Personal Information (If Applicable)

I consent to:

1. The collection of the information that I provide on this form by the Ministry of Health and the Program Administrator (who collects on behalf of the Ministry of Health) for the purpose of administering the Program, including determining my spouse's eligibility.
2. The disclosure of the information that I provide on this form by the Ministry of Health and the Program Administrator to the Ministry of Finance for the purpose of administering the Program, including determining my spouse's eligibility.
3. The disclosure of the information collected in this form by the Ministry of Finance, on behalf of the Ministry of Health, to the Canada Revenue Agency (CRA) for the purpose of enabling the Ministry of Finance and the Ministry of Health to administer the Program, which includes determining my spouse's eligibility under the Program.
4. The disclosure by the CRA to the Ministry of Finance, my income and expense information and related identifying information about me from the CRA tax records, on condition that the information will be used solely by the Ministry of Finance to verify my income and to determine my spouse's 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 my spouse's eligibility under the Program is determined.
5. The Ministry of Health, the Program Administrator, and the Ministry of Finance sharing my information that relates to eligibility under the Program with one another, for the purpose of administering the Program and processing my Spouse's file.

I understand:

- That the Ministry of Finance and the Program Administrator will act on behalf of the Ministry of Health to deliver the Program. As part of the administration of the Program, the Ministry of Finance and the Program Administrator will collect, use and disclose my personal information on behalf of the Ministry of Health;
- That the Program Administrator is an agent of the Ministry of Health as defined in the *Personal Health Information Protection Act,* 2004, S.O. 2004, c. 3, Sched. A;
- That the disclosure of my 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 my spouses eligibility under the Program;
- That I can withdraw my consent at any time by completing the Ontario Seniors Dental Care Program Change of Information Form (5128-20E).

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

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

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

☐ Spouse of the Program applicant

☐ The Spouse's Legal Representative, (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 Spouse/Common Law Partner	Contact Telephone Number
Signature of Spouse/Common Law Partner or Legal Representative	Date (yyyy/mm/dd)

6. 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) *