Government of Saskatchewan

Drug Plan and Extended Benefits Branch

Please return to:
Drug Plan & Extended Benefits Branch
Income Assessment - Operations Unit
3475 Albert Street
Regina, Saskatchewan S4S 6X6
Phone: 1-800-667-4884 or 306-787-5023
Fax: 306-787-8679
Website: www.saskatchewan.ca

SIDE A

Institutional Supportive Care - Income-Tested Resident Charge
CRA Consent

- Provide a copy of your Notice of Assessment OR pages 1 to 4 of your Income Tax Return showing Line 150 (for both Resident and Spouse).
- If you do not file income tax, complete Side B and provide required income documentation.
- Incomplete applications will result in delays in processing. Please ensure you have provided all information.

RESIDENT INFORMATION (Please Print)		**SPOUSE INFORMATION (Please Print)**	
Resident's Surname	First	Spouse's Surname	First
Health Services Number	Date of Birth (YY/MM/DD)	Health Services Number	Date of Birth (YY/MM/DD)
Social Insurance Number		Social Insurance Number	
CONTACT INFORMATION (Please Print)			
Surname	First	Current Mailing Address	
Home Phone Number ( )	Work Phone Number ( )	City/Town/Village	Postal Code

DECLARATION AND CONSENT

Is the Power of Attorney (POA) signing on behalf of the resident? YES☐ NO☐
If YES, then copies of the POA documents MUST be attached. NOTE: If a Trustee, Guardian or POA is signing for the Applicant, a copy of the legal document must be attached to this consent form. Due to the variety of POA documents, some may not be considered acceptable for CRA, such as POA specific to or limited to a bank or financial institution.

I hereby consent to the release, by the Canada Revenue Agency to an official of the Saskatchewan Ministry of Health, of information from my income tax returns, and, if applicable, other required taxpayer information about me. The information will be relevant to, and used solely for the purpose of determining and verifying my/our eligibility and the general administration and enforcement of: the Income Tested Resident Charge pursuant to *The Housing and Special-care Homes Act* and regulations made thereunder, and will not be disclosed to any other person or organization without my approval.

This authorization is valid for the most relevant of the two taxation years prior to the year of signature. It is also valid for each subsequent consecutive taxation year during which my family unit seeks assessment under the Income-Tested Resident Charge requested by me or on my behalf. I understand that, if I wish to withdraw this consent, I may do so at any time by writing to Saskatchewan Ministry of Health, Drug Plan and Extended Benefits Branch.

DATE

Signature of Resident, or if applicable, Guardian/Trustee/ Power of Attorney. A witness is necessary if resident signs with an "X" or a mark.

DATE

Signature of Spouse, or if applicable, Guardian/Trustee/ Power of Attorney. A witness is necessary if spouse signs with an "X" or a mark.

PRINT NAME OF Guardian/Trustee/ Power of Attorney/Witness.

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