Submitting applications and documentation during COVID-19

Seniors Co-Payment Program (SCP) application

To submit a Seniors Co-Payment Program application or supporting documentation, you can **either**:

- fax the documents to 416-642-3034
- e-mail the documents to trillium@ontariodrugbenefit.ca
- mail the documents to:

  Ontario Drug Benefit Program
  Ministry of Health
  PO Box 384, Station D
  Etobicoke ON M9A 4X3

If faxing or emailing, you must **mail the original signed form** to the SCP by Canada Post when the pandemic is over. We will update the ministry website to tell you when you have to mail us your documents.

When you mail us the original application, please write in bold letters "Resubmit Originals" on the application form.

Ontario

Ministry of Health

Formulaire français

Seniors Co-Payment Program Application Guide

General Information

Once you turn 65 years of age, you automatically qualify to have your eligible prescription drug costs covered through the Ontario Drug Benefit **(ODB)** program. Your ODB coverage starts on the first day of the month after your 65th birthday, if you live in Ontario **and** have a valid Ontario Health Card.

Under the ODB program, you pay a yearly set amount of up to $100 towards your drugs, called a deductible. You pay off your deductible by buying prescription drugs covered under the ODB. Once you pay the yearly deductible, you will pay up to the maximum ODB dispensing fee of $6.11 for each prescription drug. This fee is called a "co-payment."

Seniors can apply for help with these costs through the Seniors Co-Payment Program (SCP) by completing this form. Under this program, your co-payment will be $2 or less and you pay no yearly deductible. To qualify, you must be either:

- A senior living alone with a net annual income that is less than or equal to $22,200, or
- A senior living with a spouse whose combined net annual income is less than or equal to $37,100

Please do NOT complete this form, if:

- Your net yearly income is above these income levels, as you do not qualify for the $2 or less co-payment and zero deductible.
- You live in a long-term care home or in a home for special care or Community Home for Opportunity, or are receiving professional home and community care services. You automatically receive the $2 or less co-payment and $0 deductible and, therefore, you do not need to apply.

What You Pay

Once you join the Seniors Co-Payment Program, your pharmacy will charge you up to $2 for filling each ODB eligible prescription. To be eligible, your prescriptions must be:

- **Covered under the ODB Program**. To find out if your prescription medication is covered, please check online at https://www.ontario.ca/page/get-coverage-prescription-drugs
- **Dispensed in an Ontario pharmacy**

Program Timelines

The Seniors Co-Payment Program is a yearly program. It covers your ODB prescriptions over the program year, which starts on August 1st and ends on July 31st in the next calendar year. You must be 65 years of age or over to be enrolled; however, you can apply up-to 3 months in advance of your 65th birthday.

To apply — You can apply any time in the program year and up to 2 months after it ends (that is, by September 30th). If you have already paid for any ODB eligible prescription drugs since you turned 65, you can apply for reimbursement.

To get reimbursed — Please send us your original prescription receipts for reimbursement up to 3 months after the end of the program year (that is, by October 31st).

Sample key dates (2021/2022 program year)

Program year begins	Program year ends	Deadline to apply for program year just ended	Deadline to send receipts for program year just ended
August 1, 2021 ►	July 31, 2022 ►	September 30, 2022 ►	October 31, 2022

Before You Begin

1. Please complete all sections of the application form that apply to your situation. If completed by hand, PRINT clearly in capital letters using a blue/black pen.
2. If you live with a spouse **(married or common law partner)** you must include all their information and signatures on the application, regardless of their age, or have their legal representative do so.

   The person who fills out the application will be our contact if we have to call or write for more information.
3. If you are the legal representative of the applicant(s), please ensure all the information you provide is correct. Sign Section C, fill out Section D, and attach the required supporting documents.

Important: Before You Send Your Application

1. Make sure you/your legal representative and your spouse/their legal representative sign your application in both places in Section C. We cannot process your application unless it is signed in **all** signature areas.
2. You and your spouse (if applicable), **must consent to the disclosure of income information from the Canada Revenue Agency (CRA) to the Ministry ("CRA consent")**, regardless if you file an income tax return annually. This allows the ministry to verify your household's net income with the CRA electronically in order to determine SCP eligibility, which is the quickest and simplest way to enroll and stay enrolled each year. (Your household means you and, if applicable, your spouse)
3. The ministry will verify your household's net income **from the taxation year prior to the program year** in which you join. For example, to join in the 2021/22 program year starting on August 1, 2021, we will be verifying your household's net income from the 2020 taxation year.
4. If you or your spouse do not file an income tax return annually, then send us other proof of your income documentation with the application, such as:
   - T4 and/or T5 slips for all income
   - Documents that show your Canada Pension Plan (CPP), Old Age Security (OAS), and/or disability payments
   - A letter from your employer showing your current pay
   - Goods and Services Tax (GST) Notice of Determination (showing you and your spouse's net income)
   - Documents from any other source of income
5. Check if any of these situations apply to you. To avoid processing delays, send the required documents with your application.
   - **If you have no income**

     Provide a letter declaring no income earned from any source for the applicable taxation year **signed and dated** by the individual making the declaration
   - **If your income has recently changed**

     Provide proof of your current income if it is different than stated on your Notice of Assessment (NOA) from the CRA
   - **If you are the legal representative of the person(s) applying**

     Provide copies of the legal documents that show you are the legal Guardian or Power of Attorney for the applicant(s)
   - **If you are newly widowed and have not filed a tax return that states this change**

     Provide a copy of the death certificate for your spouse
   - **If you are newly separated/divorced and have not filed a tax return that states this change**

     Include a copy of your legal separation agreement or divorce papers

Questions

Call (in the Toronto area)	416-503-4586
Toll free	1-888-405-0405
Email	seniors@ontariodrugbenefit.ca

Ontario Ministry of Health

Seniors Co-Payment Program Application

Where To Send Your Application

Send the original completed application with any supporting documents to:

Ontario Drug Benefit Program
Ministry of Health
PO Box 384, Station D
Etobicoke ON M9A 4X3

Note: We'll notify you by mail once we've processed your application.

Section A. Tell Us About You – The Applicant

Last Name	First Name	Middle Name

Health Card Number	Version Code	Complete this field if there are any letters after your Health Card Number

Date of Birth (Y Y Y Y M M D D)	Social Insurance Number

Spousal Status

☐ Single ☐ Married/Common Law ☐ Separated ☐ Divorced ☐ Widowed

Mailing Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone Number

Home	Alternate(s)

Preferred Language

☐ English ☐ Français

Residential Address (Provide your physical address if the mailing address is a rural PO box or general delivery)

Unit Number	Street Number	Street Name

City/Town	Province	Postal Code

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

Complete this section if you live with a spouse **(married or common law partner).** If you are single, separated, divorced or widowed, go to Section C.

Last Name	First Name	Middle Name

Health Card Number	Version Code	Complete this field if there are any letters after your spouse's Health Card Number

Date of Birth (Y Y Y Y M M D D)	Social Insurance Number

Relationship to the Applicant ☐ Married ☐ Common law partner

Section C. Please Read and Sign This Agreement

Make sure you and your spouse (if applicable) sign this application in both signature areas below. Or, have your legal representative sign for you. Indicate who is representing you legally in Section D.

By signing this application you confirm that:

1

- The information provided in this application is true, correct and complete to the best of my knowledge.
- The Ministry of Health or its agents may collect any information from any source to verify the information in this application. All information is kept strictly confidential.
- I will tell the Ministry of Health about any change to my household, marital status, address and/or my income or my spouse's income.

Signature of Applicant or Representative	Signature of Spouse or Representative
Date (yyyy/mm/dd)	Date (yyyy/mm/dd)

2

I authorize the Canada Revenue Agency to release to the Ministry of Health information from my income tax returns and other required taxpayer information whether supplied by me or a third party. The information will be related to, and used solely for the purpose of determining and verifying eligibility, including determining appropriate co-payment amounts, and for the administration and enforcement of the Ontario Drug Benefit Program under the *Ontario Drug Benefit Act*. This information will not be disclosed to any other person or organization without my approval, except as required or permitted by law. This authorization is valid for the most recently available of the 2 taxation years prior to signing this consent and each subsequent consecutive taxation year for which I require assistance under the *Ontario Drug Benefit Act*.

I understand that, if I wish to withdraw this consent, I may do so at any time by writing to the:

Ontario Drug Benefit Program
Ministry of Health
PO Box 384, Station D
Etobicoke ON M9A 4X3

Signature of Applicant or Representative	Signature of Spouse or Representative
Date (yyyy/mm/dd)	Date (yyyy/mm/dd)

Section D. Tell Us If You Are a Legal Representative

Select the appropriate option below if you are signing this form for the applicant and/or their spouse.
You must attach a copy of the legal document that authorizes you to act on their behalf.

I am authorized to sign for the applicant as their:

- ☐ Guardian of property
- ☐ Guardian of person
- ☐ Power of Attorney (financial)
- ☐ Power of Attorney (personal care)

I am authorized to sign for the applicant's spouse as their:

- ☐ Guardian of property
- ☐ Guardian of person
- ☐ Power of Attorney (financial)
- ☐ Power of Attorney (personal care)

Notice of Collection of Personal Information

This information is collected under the authority of the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Schedule A (PHIPA) and Section 13 of the *Ontario Drug Benefit Act*, R.S.O. 1990, c. O.10. This information is collected for the purpose of administering the Ontario Drug Benefit Program. It may be used and disclosed in accordance with PHIPA, as set out in the Ministry of Health "Statement of Information Practices" which may be accessed at www.health.gov.on.ca. For more information, please contact the Director, Delivery and Eligibility Review Branch, Ministry of Health, 5700 Yonge Street, 3rd floor, Toronto ON M2M 4K5 or call 416-503-4586 in the Toronto area or toll-free at 1-888-405-0405.

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