# Doing our part

## In the Fentanyl crisis…

Financial Assistance Application

EDGEWOOD HEALTH
NETWORK INC.

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# FINANCIAL ASSISTANCE APPLICATION

1. Applicants must be 19 years of age or older and a Canadian Citizen.

2. All applicants must submit a 500-word essay explaining why they believe they would be a suitable candidate. Please provide any other supporting documentation if available, including reference letters (e.g. others in the recovery community, sponsor, counsellor, family member.)

3. Applicants will be required to participate in an interview with members of the Edgewood Health Network clinical/medical team to determine suitability.

4. Weekly check-ins may be required to maintain status while on the waiting list.

5. Financial Assistance does not cover the following items (including but not limited to):
   - Prescription medications
   - Medical costs outside of those covered by the province
   - Dental costs
   - Personal items (toiletries, cigarettes, etc.)

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Please ensure that all required information is complete and accurate. While not mandatory, completing Optional Information may further assist us in the timely process of your application.

| APPLICANT INFORMATION | | |
|---|---|---|
| Name: | | |
| Date of Birth: | Age: | Sex: ❒ Male ❒ Female |
| Marital Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Common-Law ❒ Other | | |
| Do you have dependents? ❒ Yes ❒ No | If yes, # of dependents: | |
| MSP#: | DL#: | |
| Current address: | | |
| City: | Province: | Postal Code: |
| E-mail: | Phone: | |
| Do you: ❒ Own ❒ Rent | Monthly mortgage or rent: | How long? |
| Are you a Canadian Citizen? ❒ Yes ❒ No | | |
| Prior addiction treatment? ❒ Yes ❒ No | | If yes, how many times? |
| Type of prior treatment? ❒ Inpatient ❒ Outpatient ❒ Psychiatric ❒ Day Treatment ❒ Other<br>Specify other: | | |
| Have you ever been convicted of a crime? ❒ Yes ❒ No<br>If yes, please provide details: | | |
| Current Substance(s) of Choice: | | Frequency of Use:<br>❒ Hourly ❒Daily ❒Weekly<br>❒Monthly |

| EMPLOYMENT INFORMATION | | |
|---|---|---|
| Previous or Current Employer: | | |
| Employer address: | | How long: |
| City: | Province: | |
| | | |
| Position: | ❒ Hourly ❒ Salary | Annual Income: |
| Are they aware of your need for addiction treatment? ❒ Yes ❒ No | | |
| If yes, their response: | | |
| | | |
| | | |
| | | |
| Do you have Extended Health Care Benefits? ❒ Yes ❒ No | | |
| Does it cover cost of treatment or loss of wages? ❒ Yes ❒ No ❒ Unknown | | |
| Name of Provider: | Benefits No: | |
| May we contact them? ❒ Yes ❒ No | | |

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| FAMILY INFORMATION | | |
|---|---|---|
| Name of Closest Relative: | Relationship: | |
| Relatives Address: (if known) | | |
| City: | Province: | Postal Code: |
| Phone: | Email: | Fax: |
| Are they aware of your need for addiction treatment? ❒ Yes ❒ No | | |
| If yes, their response: | | |
| | | |
| May we contact them? ❒ Yes ❒ No | | |
| Are they willing to cover the cost of treatment? ❒ Yes ❒ No ❒ Unknown<br>Please explain: | | |

| ALUMNI OR AA REFERRAL (OPTIONAL) | | |
|---|---|---|
| Have you spoken to or been in contact with anyone who is an alumnus of the Edgewood Health Network or is part of the recovery community? If yes, please provide details below: | | |
| | | |
| | | |
| | | |
| Full Name: | Phone: | ❒ PLEASE ATTACH A WRITTEN REFERENCE |

| PROFESSIONAL REFERRAL (OPTIONAL) | | |
|---|---|---|
| Have you consulted with a drug/alcohol counsellor or professional? | | |
| Name of Referral Source: | Phone No.: | ❒ PLEASE ATTACH A WRITTEN REFERENCE |

| FINANCIAL INFORMATION | |
|---|---|
| You will need the following information to complete this section: | |
| Previous years Notice of Assessment (copy only) | ❒ Copy attached |
| Last 3 months of Bank Statements (copy only) | ❒ Copies attached |
| Last 3 Pay-stubs (including assistance/disability/WCB) | ❒ Copies attached |

| INCOME AND EXPENSES | | | |
|---|---|---|---|
| T4 Gross Income Total | | Mortgage/Rent | |
| Self Employment Income | | Property Taxes | |
| Investment Income | | Heating | |
| Other Income | | Electricity | |
| | | Water | |
| | | Home Insurance | |
| | | | |
| | | | |
| | | | |
| | | | |
| ANNUAL TOTAL: | | ANNUAL TOTAL: | |

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| ASSETS AND LIABILITIES | | | |
|---|---|---|---|
| Principal Residence (if owned) | | Mortgage/Rent | |
| Vehicle (value) | | Credit Card | |
| RRSP (combined balances) | | Credit Card | |
| RESP | | Personal Loan | |
| TFSA | | Line of Credit | |
| Savings Account(s) | | Other: | |
| Chequing Account(s) | | | |
| Other: | | | |
| | | | |
| | | | |
| TOTAL: | | TOTAL: | |
| NET WORTH: | | | |

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# DISCLOSURE AND CONSENT TO THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

I warrant and confirm to you that the information given herein is in all respects true, accurate and complete. I understand that it is being used to determine eligibility for a bursary to cover treatment expenses. I authorize you to obtain any required information from any source necessary, and each source is hereby authorized to provide you with any information you require. You are hereby authorized to retain this application for Edgewood Health Network records.

_____ _____

Applicant Signature Date

_____ _____

Witness Signature Date

_____

Witness Name (please print)

**Please fax or email the completed Financial Assistance Application to:**

**Bellwood Health Services (Ontario)**
**E: info@bellwood.ca**
**F: 416-495-7943**

**OR**

**Edgewood Treatment Centre (British Columbia)**
**E: info@edgewood.ca**
**F: 250-751-2758**