Manitoba
www.manitoba.ca/fs/dhsu

MEDICAL SUPPLIES REQUEST AND JUSTIFICATION

This request is in support of an individual enrolled in the following program(s):

RESET FORM

☐ Employment and Income Assistance
☐ Manitoba Supports for Persons with Disabilities
☐ Children's disABILITY Services
☐ Community Living disABILITY Services

Family Services is authorized to collect personal information and personal health information under section 36(1)(b) of *The Freedom of Information and Protection of Privacy Act* ("FIPPA") and section 13(1) of *The Personal Health Information Act* ("PHIA") respectively, as the information is directly related to and necessary for the purposes of administering eligible supports provided by the programs identified at the top of this document and facilitating the procurement and delivery of medical supplies and equipment. We have limited the information we are collecting about you to the minimum amount necessary for these purposes. Your information is protected by the protection of privacy provisions of FIPPA and PHIA. We cannot use or disclose it for any other purpose, unless you consent or we are authorized or required to do so by FIPPA and PHIA. If you have any questions about your information, please contact the FIPPA Coordinator at (204) 945-2013 or 2nd floor 114 Garry Street, Winnipeg MB, R3C 4V4

- Section 1: to be completed on behalf of all applicants.
- Section 2: to be completed only by Regulated Health Professional.
- Section 3: includes instructions for Assessment Professionals on information that must accompany this request.
- Section 4: to be completed by office staff.

PROGRAM OBJECTIVE: To provide the most basic, cost effective medical supplies to meet a medically essential need.

SECTION #1: CLIENT INFORMATION

CLIENT SURNAME	GIVEN NAME	MIDDLE INITIAL	BIRTHDATE (DD MM YY)	
ADDRESS:	TOWN/CITY	POSTAL CODE	TELEPHONE/CONTACT NUMBER	
DELIVERY ADDRESS (if different from above)	TOWN/CITY	POSTAL CODE	GENDER: ☐ M ☐ F	PHIN:
PARENT/GUARDIAN/AGENCY (if applicable)	CASE NUMBER (if applicable)		DATE OF REQUEST (DD MM YY)	
HEIGHT and WEIGHT: HEIGHT: WEIGHT:	ARE ANY OF THESE BENEFITS COVERED UNDER ANY OTHER PUBLIC OR PRIVATE HEALTH CARE PLAN (i.e. RHA, MPI, BLUE CROSS, WCB, FNIHB or OTHER) ☐ NO ☐ YES IF YES WHICH BENEFIT(S):			

SECTION #2: PRESCRIBER / REGULATED HEALTH PROFESSIONAL INFORMATION (IF APPLICABLE)

PARENTS/GUARDIANS OF CHILDREN'S disABILITY SERVICES CLIENTS NEED ONLY COMPLETE THE DIAGNOSIS AND TYPE OF SUPPLY SECTION.

SURNAME	GIVEN NAME		ORGANIZATION
ADDRESS	TOWN/CITY	POSTAL CODE	TELEPHONE/CONTACT NUMBER
FAX NUMBER	E-MAIL ADDRESS	SIGNATURE	
DESCRIBE THE IMPACT OF THE CLIENT'S MEDICAL CONDITION INCLUDING DIAGNOSIS			
WHAT TYPE OF SUPPLIES ARE RECOMMENDED TO MEET THE CLIENT'S BASIC NEEDS?			

SECTION #3: SUPPLIES BEING REQUESTED

DESCRIPTION OF SUPPLY	OFFICE USE ONLY MDA SAP # IF APPLICABLE	# PER DAY (IF APPLICABLE)	SIZE (IF APPLICABLE)

SECTION #4: ADDITIONAL INFORMATION / COMMENTS

PLEASE FORWARD COMPLETED REQUEST ELECTRONICALLY, E-MAIL , FAX OR MAIL TO:

Disability and Health Supports Unit – Provincial Services / 100 – 114 Garry Street, Winnipeg MB R3C 1G1

TELEPHONE INQUIRIES, PLEASE PHONE (204) 945-4393 or FAX (204) 945-1436 or E-MAIL disandhealthsupports@gov.mb.ca

FOR OFFICE USE ONLY

CASE MANAGER'S NAME		REGIONAL OFFICE / COMMUNITY AREA
DATE COMPLETED	INFACT CLIENT IDENTIFIER	ASSESSMENT OFFICER / SERVICE ADVISOR INITIALS
DELIVERY METHOD ☐ Courier ☐ Mail ☐ Client Pickup ☐ Bus		ORDER FREQUENCY ☐ One- Time Order ☐ On-call ☐ On-Going (automatic) Repeats: _____ Expiry Date: _____

This information is available in alternate formats upon request.
Ces renseignements sont offerts dans de multiples formats sur demande.

PRINT FORM

SUBMIT FORM