DARTMOUTH SENIORS SERVICE CENTRE
WHERE OLD FRIENDS MEET NEW FRIENDS

Medical Expense Assistance Program

Receipts may be submitted from one of the following categories per application:

- Dental Care - one receipt may be submitted per application
- Hearing Care - one receipt may be submitted per application
- Vision Care - both Eye Exam and Glasses receipts may be submitted per application
- Prescription Medications - multiple receipts may be submitted per application
- Incontinence Products - multiple receipts may be submitted per application
- Meal Replacement Products - multiple receipts may be submitted per application Applicant must be a current member of the DSSC.

Submitted claims must have been paid in full by member and proof of payment provided at time of application.

Application may be made twice a calendar year.

Assistance will be 25% of submitted receipts to a maximum of $250 per application.

Eligible expenses may date no earlier than 90 days from commencement of membership.

The DSSC reserves the right to deny any application.

The DSSC reserves the right to deny applications once the funds for this program are depleted.

DSSC Membership Number: _____

Name: _____ Phone Number: _____

Do you have any private insurance coverage? Yes ___ No ___

If yes, insurance company name: _____Policy #: _____

How much have you received or expect to receive from your insurance company?

_____

Have you received any other financial assistance towards the submitted receipts? If so, from whom and approximately how much?

I am voluntarily releasing the information contained in this application to the DSSC in order to demonstrate my eligibility for the Medical Assistance Program. I understand my information will only be collected, used and distributed for the purposes of administering the Medical Assistance Program.
I hereby confirm that the information provided herein is accurate, correct and complete and that the documents submitted along with this application form are genuine.

Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Date Received: _____

Amount Approved: _____

Date Paid to Member: _____

Cheque #: _____

Signature of Processing Staff Member:

_____

Name (please print):

_____