## Schedule F - Special Needs Application

| Service Number | Surname | CF One Number |
|---|---|---|
| | | |

| | |
|---|---|
| Name of Beneficiary: | |
| Date of Birth: | |
| Diagnosis: | |

**CATEGORY OF SUPPORT (check appropriate box)**

**Assessment** ☐

*Up to $1,000 (SOT will cover residual amount not covered through PSHCP) Examples of supporting documents would be a predetermination for the insurer, or paid receipt/invoice from the provider.

**Other** ☐

*Up to $1,000 with receipts or estimates. This category includes assistive devices, respite care, therapy, medical travel (low km rate, modest meals), prescriptions etc these items/services to be supported by a report/letter/assessment from the medical field.

### THE FOLLOWING FACTORS WILL BE CONSIDERED WHEN ASSESSING APPLICATIONS

**1 - FAMILY COMPOSITION**

How large is your family? _____

How many members have "special needs" (indicate number in appropriate box)

Adult ☐

Child ☐

**2 - AVAILABILITY TO LOCAL RESOURCES**

| | Yes | No |
|---|---|---|
| Are you aware of local resources/benefits? | ☐ | ☐ |

If yes, which resources/benefits have you accessed?

| | Yes | No |
|---|---|---|
| If yes, have you been successful in obtaining the required support? | ☐ | ☐ |

If no, what resources are you lacking (including assessments)?

If no, how long is the expected wait for local services? _____

What is your action plan to address the issue in the future?

## 3 – COMPLEX NEEDS OF THE DEPENDENT

Briefly describe some of the difficulties encountered by the dependant (walking, communicating, feeding etc.)

## 4 –COSTS RELATED TO THE SPECIAL NEEDS REQUEST

Please describe how the funds will be used.

## 5 – IMPACT ON THE FAMILY

How will this financial assistance impact your family?

How does this impact the quality of life for your family?

## 6 – FAMILY INCOME

What is your gross family income? $_____

The Support Our Troops Fund works collaboratively with the Directorate Quality of Life/Military Family Services (DQOL/MFS). By signing below, you authorize the sharing of this information between the SOT and DQOL/MFS in order to: respond to your unique needs; coordinate local, regional and national support services; and help establish a continuum of support.

Applicant's signature | Date

| Current Posting Location | Anticipated New Posting Date | Location (if known) |
|---|---|---|
| | | |

## ADDITIONAL INFORMATION REQUIRED FOR THE APPLICATION

**A confirmation of the dependant's special need is required. This can be in the form of a doctor's note, letter from the CO, letter from a helping agent (social worker, padre etc.) The note/letter should include the contact coordinates for the individual signing the letter. Family references are not accepted.**

**(Ce formulaire est disponible en français)** **Protected "B" (when completed)**