Schedule F – Special Needs Application

Service Number	Surname	CFOne Number

Name of Beneficiary:	
Date of Birth:	
Diagnosis:	

Category of Support (check appropriate box)

Assessment ☐
*Up to $1500 (Support Our Troops 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 $1500 with receipts or estimated. Thus 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

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

If yes, which resources/benefits have you accessed?

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

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 Dependant

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

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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 you 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 Support Our Troops 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 _____

7 – Testimonial

Would you be interested in providing a testimonial for Support Our Troops in the future? Please note that by agreeing, you are simply expressing interest and a member of the Support Our Troops team may follow up with you at a later date.

Yes ☐ **No** ☐

If yes, please provide an email address to contact you at: _____

The Support Our Troops program receives requests from the news media for stories of families or interviews with families that the program has assisted. Would you be willing to participate in an interview?

Yes ☐ **No** ☐

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

Additional Information Required for the Application

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

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