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 $1000 (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 $1000 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 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 ______________

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.