



Schedule F - Special Needs Application

<b>Service Number</b>	<b>Surname</b>	<b>CF One Number</b>
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Name of Beneficiary:	
Date of Birth:	
Diagnosis:	

CATEGORY OF SUPPORT (check appropriate box)

<b>Assessment</b> <input type="checkbox"/> <p>*Up to \$750.00 (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.</p>	
<b>Other</b> <input type="checkbox"/> <p>*Up to \$750.00 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.</p>	

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 <input type="text"/>
Child <input type="text"/>

2 - AVAILABILITY TO LOCAL RESOURCES Yes No

Are you aware of local resources/benefits? <input type="checkbox"/>	<input type="checkbox"/>
If yes, which resources/benefits have you accessed?	
<hr style="border-top: 1px dotted black;"/>	

	<b>Yes</b>	<b>No</b>
If yes, have you been successful in obtaining the required support?	<input type="checkbox"/>	<input type="checkbox"/>
If no, what resources are you lacking (including assessments)?		
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If no, how long is the expected wait for local services? _____
What is your action plan to address the issue in the future?
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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.