Ontario Works Program
Housing and Social Services Department

Discretionary Health Benefit Request

Name: Member ID:

Date of Birth (m/d/yyyy): Phone Number:

Case Manager Name:

Please briefly outline the reason why you are requesting these funds.

☐ **Dental** - *(*indicate Dentist Name, contact information and time and date of appointment)

☐ **Vision** – (copy of quote and prescription must be attached)

☐ **Other** (provide additional details below)

Details:

Please list the items that you are requesting help with:

	Item(s):	**Estimated Cost(s):**
1.		$
2.		$
3.		$
	Total Amount Requested**:**	**$**

Signature: _____ **Date:** _____

Notice with Respect to the Collection of Personal Information
(Freedom of Information and Protection of Privacy Act)
(Municipal Freedom of Information and Protection of Privacy Act)

This information is collected under the legal authority of the *Ontario Works Act,* 1997, section 7, 8, 57 & 58 of the *Ontario Disability Support Program Act,* 1997, sections 5, 10, 45 & 46 for the purposes of administering Government of Ontario social assistance programs.

For Office Use Only

☐ Approved ☐ Not granted _____ Criteria _____ Funding

Case Manager Signature:_____ Date:_____

Supervisor Authorization:_____ Date: _____

Please complete form in full, sign and deliver to:

Ontario Works, 362 Montreal Street, Kingston, ON K7K 3H5

Inquiries can be directed to:

Phone: 613-546-2695

FAX: 613-546-9658