Thalidomide Survivors Contribution Program
Extraordinary Medical Assistance Fund Instructions

Confirmed Canadian Thalidomide Survivors have access to the Extraordinary Medical Assistance Fund ("EMAF") which is intended to help cover the cost of extraordinary health support costs of Canadian Thalidomide Survivors who have needs such as specialized surgeries or home or vehicle adaptations.

Survivors are able to submit requests to the EMAF to help cover the cost of home or vehicle adaptations even if the province or territory in which he or she resides has a similar program to assist with these expenses. As such, if a Survivor has applied to a provincial or territorial program for help with the cost of an extraordinary home or vehicle adaptation and are waiting to learn if it will be covered, the Survivor can choose to submit his or her claim to the EMAF for consideration instead.

A list of potential eligible expenses is available on the website at www.tscp-pcst.ca or by calling the Administrator. While the Administrator has attempted to create a comprehensive list, there may be additional eligible expenses not contemplated. Subsequently, if you do not see your expense specifically listed, please submit an application anyway and that expense will be assessed for eligibility. If your expense is found to be eligible, that expense will be added to the list.

Please review the enclosed list of Frequently Asked Questions and Answers for more information.

Requesting EMAF funding:

You may submit your application anytime between April 1, 2019 and March 31, 2020. EMAF applications will be reviewed and payment will be issued (if assessed to be eligible) at time of submission on a first come first served basis. If there is more need in a given year then available funds, a Survivor's application will automatically be carried over to the following fiscal year and that Survivor's application will be processed first in the next fiscal year. The maximum number of times an EMAF application will be carried over is one fiscal year. *Please note that if there is greater need than available funds in a given fiscal year, extraordinary health claims (e.g. surgeries) will be given priority over other types of claims.* To date, lack of funding has not been a concern.

To request EMAF funding, you must complete the enclosed EMAF application in full and you may either submit photocopies of receipts for expenses already incurred or quotation(s) for expenses that you would like covered by the EMAF.

Survivors may continue to submit a **maximum of two** EMAF applications per fiscal year unless there is urgent need, which will be evaluated on a case by case basis.

Expenses must have been purchased or quotations must have been acquired within 1 year of the submission date of your EMAF application. Each receipt/quotation should contain a clear description of the expense incurred or to be incurred. For example, if you submit your application on June 5, 2019, then expenses/quotes acquired between June 5, 2018 and June 5, 2019 will be considered for the 2019-2020 FY. Each receipt/quotation should contain a clear description of the expense incurred or to be incurred.

When obtaining quotations, the quotation must be from a licensed professional (e.g. licensed contractor, automobile service garage, or professional medical facility etc.). The quotation should itemize in detail the work required and the associated cost of the same. If there is a requirement for a down payment/deposit before the work can be performed that should also be indicated. Only expenses from qualified/licensed professionals will be considered. **If the expense that you are requesting reimbursement of exceeds $10,000.00 CDN, please submit two detailed quotations for that expense from two different licensed professional contractors.** If that is not possible, the Survivor must provide an explanation in writing as to why he or she was unable to obtain two quotations. *The Administrator may elect to obtain a second quotation using a Crawford & Company (Canada) Inc. associated vendor for comparison purposes only*.

Requests for funding for the same expense will not be permitted within 5 years of the previous request. For example, if funding is provided for fully adapting the main floor bathroom in your home, you may not request funding to make the same changes to that same bathroom within the next 5 years unless there is an urgent need.

To have your application considered for the 2019-2020 FY, your completed application must be **RECEIVED by March 31, 2020**. Otherwise, it will be reviewed in the following fiscal year.

To apply for EMAF funding, the Survivor must:

1. Complete the attached Extraordinary Medical Assistance Fund application in full.
2. Provide a photocopy of your Notice of Assessment for 2018 unless you have chosen not to submit it. If you choose not to submit your Notice of Assessment, you will be assessed at the highest income level for the purposes of the Financial Needs Test.
3. Provide the additional supporting documentation as requested including receipts and/or quotations.
4. Provide a photocopy of Government issued photo identification for the Survivor.
5. Provide a photocopy of Government issued photo identification for legal appointed representative(s) if applicable.
6. Return the completed Extraordinary Medical Assistance Application, receipts/quotations, supporting documentation, and identification to the Administrator **by mail, email or fax as follows:**

Thalidomide Survivors Contribution Program
c/o Crawford Class Action Services
3-505 133 Weber St N
Waterloo ON N2J 3G9
tscp-pcst@crawco.ca; 1-888-842-1332

2019-2020 FY EMAF Application Deadline:
Received by March 31, 2020

Thalidomide Survivors Contribution Program
EMAF Application

Privacy Statement:

The information requested in this Thalidomide Survivors Contribution Program Extraordinary Medical Assistance Fund ("EMAF") Application is being collected, used and retained by the Thalidomide Survivors Contribution Program Administrator ("Administrator") and its Agents for the purpose of operating and administering the Thalidomide Survivors Contribution Program Administration pursuant to the *Personal Information Protection and Electronic Documents Act*, S.C. 2000, c. 5 ("PIPEDA"). The information will be provided to the Government of Canada in order to facilitate the administration of the Thalidomide Survivors Contribution Program. Personal information is protected under federal legislation, including PIPEDA and the *Privacy Act*, and personal information may be used or disclosed in accordance with applicable legislation. You have the right to request access to your personal information. To do so, call 1-877-507-7706 or 1-877-627-7027 (TTY).

I am applying for EMAF Funding for the 2019-2020 fiscal year

APPLICATION DEADLINE – RECEIVED BY MARCH 31, 2020

Section 1: Thalidomide Survivor Contact Information	
First Name:	
Middle Name(s):	
Last Name:	
Date of Birth (mm/dd/yyyy):	
Sex at Birth:	☐ Male ☐ Female
Gender Identity:	☐ Male ☐ Female ☐ Other: _____
Mailing Address:	
City/Town:	
Province/Territory/State/Country:	
Postal Code/Zip Code:	
Primary Telephone Number:	( ) –
Alternate Telephone Number:	( ) –
Email Address:	

Section 2: Legally Appointed Personal Representative Information **(Leave this section blank if the Survivor does not have a Legally Appointed Personal Representative)**	
This section is to be completed **only** if you have been **legally** appointed to administer the Survivor's affairs. You MUST provide proof of your authority to act as the Personal Representative of the Thalidomide Survivor. Please complete all boxes in both Section 1 on the previous page for the Survivor and Section 2 below for yourself.	
I have enclosed a **certified true** photocopy of one (1) of:	Please check (✓) the applicable box: ☐ Authority to Act ☐ Court Order ☐ Other: _____ ☐ Authority to Act was previously submitted to the Administrator and has not changed (If this box is checked, no need to resend Authority to Act).
First Name:	
Last Name:	
Mailing Address:	
City/Town:	
Province/Territory/State/Country:	
Postal Code/Zip Code:	
Primary Telephone Number:	( ) –
Alternate Telephone Number:	( ) –
Email Address:	
Relationship to Survivor	

Section 3: Person who helped complete this form ☐ **Same as Section 2 (If this box checked, no need to complete Section 3 boxes below)**	
First Name:	
Last Name:	
Mailing Address:	
City/Town:	
Province/Territory/State/Country:	
Postal Code/Zip Code:	
Primary Telephone Number:	( ) –
Alternate Telephone Number:	( ) –
Email Address:	
Relationship to Survivor:	

Section 4: EMAF Expenses

Survivors are able to submit requests to the Extraordinary Medical Assistance Fund ("EMAF") to help cover the cost of home or vehicle adaptations even if the province or territory in which he or she resides has a similar program to assist with these expenses. As such, if a Survivor has applied to a provincial or territorial program for help with the cost of an extraordinary home or vehicle adaptation and are waiting to learn if it will be covered, the Survivor can choose to submit his or her claim to the EMAF for consideration instead.

A schedule of possible expenses is available on the website at www.tscp-pcst.ca or by calling the Administrator. This list is not all inclusive; however, routine eye exams, routine dental check-ups, routine eye glasses, and ongoing services such as home or garden maintenance and recurring medications, massage or chiropractic treatments are not eligible expenses under the EMAF. If you are unsure if an expense would be covered, please submit your application for consideration.

Instructions:

1. Please answer the questions in Parts 1 and 2 of Section 4 starting on the next page.

   Part 1 – Description of Expenses
   Part 2 – Additional Information

2. Please provide a photocopy of your Notice of Assessment from your income tax return from the previous year. **Please check (✓) the applicable box below:**

   ☐ I am applying for EMAF Funding for the 2019/2020 fiscal year and have enclosed a photocopy of my Notice of Assessment from 2018.

   ☐ I elect NOT to submit a copy of my Notice of Assessment and understand that by doing so I will be assessed at the highest income level for the purposes of the Financial Needs Test.

3. Please provide a photocopy of any additional documents requested or that you think may be helpful to support your request for funding.

Section 4: Part 1 – Description of Expenses

To help the Administrator assess your request for EMAF funding, please provide a brief description of the expense(s) that you are requesting EMAF funding for and check the applicable box(es) to indicate what supporting documentation you have submitted in regard to each expense. If more space is needed, you may photocopy page 5 as required. Please write the Survivor's full name at the top of each additional page and on each supporting document submitted. Please number reach receipt/quote in reference to Section 4: Part 1 for easy identification.

If the expense that you are requesting reimbursement of exceeds $10,000.00 CDN, please submit two detailed quotations for that expense from two different licensed professional contractors. If that is not possible, the Survivor must provide an explanation in writing as to why he or she was unable to obtain two quotations.

If you choose to submit medical documentation, it may be in the form of a note from your Healthcare Provider explaining the importance of this adaption/need/expense. The note is helpful, but is not required. You may also submit photographs documenting the basis for the need, but again submission of the same is optional.

No.	Description of Expense	Amount Requested	Supporting Documentation Enclosed
			☐ Photocopy of Receipt(s) ☐ Notice of Assessment from 2018 ☐ Detailed Estimate(s)/Quotation(s) ☐ Medical Note/Report ☐ Other (please specify): _____
			☐ Photocopy of Receipt(s) ☐ Notice of Assessment from 2018 ☐ Detailed Estimate(s)/Quotation(s) ☐ Medical Note/Report ☐ Other (please specify): _____

No.	Description of Expense	Amount Requested	Supporting Documentation Enclosed
			☐ Photocopy of Receipt(s) ☐ Notice of Assessment from 2018 ☐ Detailed Estimate(s)/Quotation(s) ☐ Medical Note/Report ☐ Other (please specify): _____
			☐ Photocopy of Receipt(s) ☐ Notice of Assessment from 2018 ☐ Detailed Estimate(s)/Quotation(s) ☐ Medical Note/Report ☐ Other (please specify): _____
			☐ Photocopy of Receipt(s) ☐ Notice of Assessment from 2018 ☐ Detailed Estimate(s)/Quotation(s) ☐ Medical Note/Report ☐ Other (please specify): _____
	Total:		

Please note the application of the cap: A Survivor may receive a maximum of $40,000 per fiscal year indexed at 2% per year from the EMAF subject to EMAF fund availability. In other words, if a Survivor's total expenses submitted in the same fiscal year exceed $40,000, regardless if he or she submits one application or more than one application prior to the deadline for that fiscal year, the maximum amount a Survivor can receive for all applications submitted in that given fiscal year will not exceed $40,000 indexed at 2% per year.

The cap for the 2019-2020 FY is $41,616.00 CDN per fiscal year.

Section 4: Part 2 – Additional Information

Please explain how receiving funding for the expense(s) listed in Section 4: Part 1 will help you. If additional pages are needed, please write the Survivor's full name at the top of each additional page.

Section 5: Photo Identification and Privacy

To protect your privacy and to help confirm your identity when receiving documents from you, proof of identification is required by **ALL** eligible Survivors whenever a new application form is submitted. Legally appointed Personal Representatives must provide identification for **both** the Survivor and the Personal Representative.

Please submit a photocopy of one (1) of the following government issued pieces of identification for proof of identity purposes. The identification **must include your date of birth**:

- Birth Certificate
- Baptismal Certificate
- Valid Provincial Driver's License
- Valid Provincial Photo ID Card (must include date of birth)
- Canadian Passport

Section 6: Declaration and Signature

Section 6 must be completed by the Thalidomide Survivor or the Personal Representative with the legal authority to act on behalf of the Survivor. Please read the following declaration carefully before signing.

Declaration:

1. I have completed the Thalidomide Survivors Contribution Program Extraordinary Medical Assistance Fund ("EMAF") Application and I understand that the Administrator will be reviewing my Application for completeness and may need to contact me to request additional information. I understand that the information provided in this application and the supporting documentation will be used to assess my request for funding under the EMAF.

2. **I also understand that by signing this Declaration I confirm that I have not received funding from any other provincial or territorial program or other organization in regard to the expenses being requested in this application.**

3. I understand that my claim may be selected by random to undergo a review of the work completed to help the Administrator better understand the specialized needs of Thalidomide Survivors and for quality assurance purposes.

4. I agree to the sharing of my personal information, including but not limited to my contact information, with the Administrator, the Government of Canada and necessary authorized third parties, only for the purpose of processing my request for assessment.

By signing below, I indicate my agreement to the contents of this Declaration.

Thalidomide Survivor/Personal Representative:

Print Name: _____

Signature: _____

Date: _____
(mm/dd/yyyy)

Section 6: Declaration and Signature continued…		
All Thalidomide Survivors or legally appointed Personal Representatives must sign or sign with a mark in Section 6 in the presence of a witness who may be a relative. The witness must complete the Witness information below and sign the Witness Declaration on the next page.		
Witness' First Name	Witness' Last Name	
City/Town	Province/Territory/State	Country
Relationship to Thalidomide Survivor/Personal Representative		

Witness Declaration: I have witnessed the signature or mark of the Thalidomide Survivor or legally appointed Personal Representative. Where the Thalidomide Survivor or legally appointed Personal Representative signed with a mark, I have read the content of this Thalidomide Survivors Contribution Program Extraordinary Medical Assistance Fund ("EMAF") Application to the Thalidomide Survivor and/or his/her Personal Representative, who signed with a mark, who understands and confirms the information.

Print Name: _____

Signature: _____

Date: _____
(mm/dd/yyyy)

Please make sure the following have been included with your completed application when returning it to the Administrator:

- ☐ Photocopies of receipts, estimates/quotations, medical notes/reports, and other documentation as applicable.
- ☐ Photocopy of your Notice of Assessment for 2018 unless you have chosen not to submit it.
- ☐ Photocopy of government issued identification for Survivor.
- ☐ Photocopy of government issued identification for legally appointed Representative(s) (if applicable).
- ☐ Certified true copy of their authority to act on behalf of the Survivor (if applicable). If Authority to Act was previously submitted to the Administrator and has not changed there is no need to resend Authority to Act.
- ☐ Signed and dated Declaration for Survivor/Personal Representative in Section 6.
- ☐ Completed, signed and dated Witness section by Witness in Section 6.

Return completed application by mail, email or fax to:

Thalidomide Survivors Contribution Program
c/o Crawford Class Action Services
3-505 133 Weber St N
Waterloo ON N2J 3G9
tscp-pcst@crawco.ca; 1-888-842-1332

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