Manitoba Health

Application to Manitoba Hepatitis C Assistance Program (MHCAP) - Application Form

Send completed form to: **Manitoba Health, MHCAP 4036-300 Carlton Street, Winnipeg , Manitoba R3T 3N9**

1. Personal Health Information (to be completed by applicant)

Last Name	First Name	Middle Initial	Date of birth (day/month/year)

Address	City	Province	Postal Code

Telephone no. (home)

Telephone no. (business) - *optional*

Are you diagnosed with Hepatitis C (HCV)?

Yes ☐ No ☐

Date of diagnosis *(day/month/year) – if known*

Did you receive a transfusion in Manitoba during any or all of the following time period (s)

☐ on or before December 31, 1985 ☐ January 1, 1986 - July 1, 1990 ☐ July 2, 1990 - September 28, 1998

Reason for transfusion

Name of hospital(s) in Manitoba where transfusion(s) occurred:

Name of hospital	Date of transfusion (day/month/year)	City	Province
Name of hospital (1)	Date of transfusion (day/month/year)	City	Province
Name of hospital (2)	Date of transfusion (day/month/year)	City	Province
Name of hospital (3)	Date of transfusion (day/month/year)	City	Province

Are you a hemophiliac?

Yes ☐ No ☐

If yes, did you receive blood products in Manitoba during any or all of the following time period (s)

☐ on or before December 31, 1985 ☐ Jan. 1 , 1986 - July 1, 1990 ☐ July 2, 1990 - Sept. 28, 1998.

2. Physician Information (to be completed by applicant)

Please provide the name(s) of the physicians you have consulted who have direct knowledge of:

• Your receipt of a blood transfusion or Your HCV infection

Name of physician (1) (Physician who will be completing the Physician Form)

Business address Telephone No. ( )

Name of physician (2)

Business address Telephone No. ( )

Name of physician (3)

Business address Telephone No. ( )

3. Authorizations

To Manitoba Health

I hereby authorize Manitoba Health, including the employees, representatives and agents of Manitoba Health for the purpose of administering the Manitoba Hepatitis C Assistance Program, to collect any personal health information necessary to determine my eligibility for the Program, from any physician(s) referred to in section 2. I consent to the use and disclosure by Manitoba Health of any personal health information necessary to verify the aforementioned information for the purposes of determining my eligibility for the Program.

To the Hospital(s)

I hereby authorize the hospital(s) noted above to disclose to Manitoba Health, (including the employees, representatives and agents of Manitoba Health) for the purpose of administering the Manitoba Hepatitis C Assistance Program, any medical or other personal health information relating to my care in its possession and to provide to Manitoba Health and anyone acting on its behalf for the purpose of administering the Program with copies of such medical records or notes, charts or other personal health information that may be requested in writing by Manitoba Health relating to my care, and for so doing this is good and sufficient authority.

Collection of the personal information on this form is to determine eligibility for the Manitoba Hepatitis C Assistance Program. The authority for the collection and use of this information is the personal Health Information Act S.M. 7997, c51, ss 13(1) and 27. For information about collection practices, please contact MHCAP, 4036-300 Carlton Street, Winnipeg Mb., R3B 3M9, Tel. No. (toll free) 1-866–357-0196, in Winnipeg call 788-6339.

(Signature of applicant) (Date) (day/month/year)

If the applicant is less than 18 years of age at date of application, a parent/legal guardian must sign the form. If you are acting as a legal representative for the applicant, please sign below and indicate in which capacity. I am the parent/legal guardian/legal representative of the applicant, and confirm that I have the legal authority to sign this authorization and consent.

Signature of ☐ parent ☐ legal guardian

☐ other legal representative (specify status) __________

Date *(day/month/year)*

Upon completing this application, attach copies of any documents to support your claim of eligibility, which you currently have in your possession (e.g. letters from Canadian Red Cross/Canadian Blood Services, hospitals, or laboratory results).

Do not send originals. **(Disponible en francais)**

White – Manitoba health; Canary – Hospital; Pink - Applicant