Manitoba Health

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

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

1. Name of Deceased Person

Last Name(s) (include all last names used. e.g. maiden name) | First Name | Middle Initial | Date of birth (day/month/year)

Was the deceased person diagnosed with Hepatitis C (HCV)? Yes ☐ No ☐ | Date of diagnosis *(day/month/year) – if known*

Did the deceased person 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(s)

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

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

Was the deceased person a hemophiliac? Yes ☐ No ☐

If yes, did he or she 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 the personal representative of the estate)

Please provide the name(s) of the physicians the deceased person consulted who have direct knowledge of:
• His/her receipt of a blood transfusion or His/her HCV infection and/ or cause of death

Name of physician (1) | Telephone No ( )

Business address

Name of physician (2) | Telephone No ( )

Business address

Name of physician (3) | Telephone No ( )

Business address

3. Declaration of the Personal Representative

Last Name(s) | First Name | Middle Initial

Address | City | Province | Postal Code

Telephone no. (home) | Telephone no. (business) - *optional*

4. Declaration of the Personal Representative

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 the eligibility of the estate for the Program, from any physician(s) or hospital(s) named by the physicians (s), Vital Statistics Act Registry, or Canadian Blood Services. I consent to the use and disclosure 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 the care of the deceased person 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 the care of the deceased person, 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 the person representing the estate) | **Date (day/month/year)**

As the personal representative for the estate, please sign below and indicate in which capacity you are acting on behalf of the estate. Attach documentation of your legal status as personal representative of the estate.

I am the personal representative for the estate, and confirm that I have the legal authority to sign this authorization and consent.

☐ Executor
☐ Administrator
☐ Administrator with Will Annexed

Signature | 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).

If you do not have any such documents, MHCAP will coordinate a search for them.
Do not send originals.