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Monthly Nutritional Supplement Application

Note: An applicant for the Monthly Nutritional Supplement (MNS) must be a recipient of Disability Level II (DBL II). The Administering Authority has authority and discretion to review eligibility for MNS. The Administering Authority may also, where necessary, request a second opinion for the purposes of determining eligibility for this supplement.

Part A - Must be completed by the Administering Authority to verify eligibility for DBL II		
Applicants Name	Birthdate (YYYY-MMM-DD)	SIN
Address:		DBL II Status ☐ Eligible

Part B - Applicant acknowledgement and consent (Must be signed by Applicant)	
I am applying for the Monthly Nutritional Supplement. I understand that the Administering Authority may obtain and verify information to confirm eligibility for this supplement. I consent to the medical practitioner or nurse practitioner identified in Part C of this application sharing and providing clarification on the medical information requested in this application form with the Administering Authority for the purpose of determining eligibility.	
Applicant Signature:	Date: (YYYY-MMM-DD)

Part C - Must be completed by the medical practitioner or nurse practitioner (Please print). Additional documents may be attached, if necessary. Note: an incomplete application will delay processing.

Note: This form should not be completed if your patient only requires nutritional supplements for a short term (3 months or less) or where a diet supplement is sufficient to meet the patient's needs. Social Development provides the following supplements: high protein diet; gluton free diet; reduced sodium; kidney dialysis; dysphasia diet; ketogenic diet; phenylalanine diet and a diet for cystic fibrosis.
The Monthly Nutritional Supplement is only available to an applicant receiving treatment from a medical practitioner or nurse practitioner for a chronic, progressive deterioration of health on account of a SEVERE medical condition or conditions, and who is as a result of the chronic progressive deterioration of health, displays two or more symptoms set out in Question 3 of the application and where the items requested in the application will alleviate those specific symptoms AND prevent imminent danger to the applicant's life.

1. Please list and describe the applicant's SEVERE medical condition(s):	
Diagnosis	Condition

2. As a direct result of the SEVERE medical condition(s) noted above, is the applicant being treated for a chronic progressive deterioration of health? If so, please provide details and any information on treatments including any relevant clinical or diagnostic reports:

3. As a direct result of the chronic, progressive deterioration of health noted above, does the applicant display two or more of the following symptoms? If so, describe in detail.

Malnutrition	
Underweight status	
Significant weight loss	
Significant muscle mass loss	
Moderate to severe immune suppression	
Significant deterioration of a vital organ (Please specify)	

4. Vitamin or mineral Supplementation

Vitamins and minerals are only available to an applicant to alleviate one or more of the symptoms specified in question 3, if those symptoms are a direct result of a chronic progressive deterioration of health, and to prevent imminent danger to the applicant's life. This supplement does not include homeopathic, naturopathic or herbal remedies.

Specify the vitamin or mineral supplement(s) required and expected duration of need:

Describe how this item or items will alleviate the specific symptoms identified:

Describe how this item or items will prevent imminent danger to the applicant's life:

5. Nutritional Items

Nutritional items are only available to an applicant to alleviate one or more of the symptoms specified in question 3 if those symptoms are a direct result of a chronic, progressive deterioration of health and the nutritional items are medically essential, will provide caloric supplementation to a regular dietary intake and are required to prevent imminent danger to the applicant's life.

Specify the additional nutritional items required and expected duration of need:

Does this applicant have a medical condition that results in the inability to absorb sufficient calories to satisfy daily requirements through regular dietary intake? If yes, please describe.

Describe how the nutritional items requried will alleviate one or more of the symptoms specified in Question 3 and provide caloric supplementation to the regular diet

Describe how the nutritional items requested will prevent imminent danger to the applicant's life:

Additional Comments:

Medical Practitioner or Nurse Practitioner Name	Medical Practitioner or Nurse Practitioner Number	Telephone #

Medical Practitioner or Nurse Practitioner Signature	Date (YYYY-MMM-DD)