How to apply for a Special Diet Allowance:

Step 1

Complete Section I.

Step 2

Take the application form to a health professional to complete.
Only health professionals who are listed in Section II of the form can complete it for you.

Step 3

The person applying for the Special Diet Allowance, or someone lawfully authorized to sign on their behalf, for example a trustee, must sign Section IV after the health professional completes the form.

If the Special Diet Allowance is for a child under 16, then Section IV must be signed by the social assistance applicant/recipient or other individual who is lawfully authorized to sign on behalf of the child, for example the child's parent or guardian.

Important: The application will not be approved if Section IV is not signed.

Step 4

Once the form is completed, return the original to your local Ontario Works or ODSP office.
You can drop it off in person or you can mail it.

Ontario

Ministry of Community and Social Services

Ontario Disability Support Program
Ontario Works

Application for Special Diet Allowance

For Local Office Use Only
Date Received:

OHIP Fee Code
K055

Section I - To be completed by applicant

Applicant Information

Last Name	First Name	Initial

Date of birth (Y M D)	Member ID	Relationship to recipient
		☐ self ☐ spouse ☐ dependent child or dependent adult

Section II - To be completed by an approved health professional [see list below]

This application must be completed by one of the following approved health professionals:

- A Physician
- A Registered Nurse in the Extended Class
- A Registered Dietitian
- A Registered Midwife or a Traditional Aboriginal Midwife recognized and accredited by her or his Aboriginal community. **[Note:** a Registered Midwife or a Traditional Aboriginal Midwife, who is recognized and accredited by her or his Aboriginal community, may only confirm that a special diet is required for the medical condition *insufficient lactation to sustain breast-feeding or breast-feeding is contraindicated.]*

Instructions:

1. When completing Section III, i) place a check mark next to the applicant's medical condition that requires a special diet, ii) indicate the length of time the diet is required and iii) initial in the space provided to confirm the medical condition.
2. Complete the information below and sign.

Last Name	First Name

Street Number	Unit/Suite/Apt.	Street Name

City/Town/Municipality	Province	Postal Code

Telephone Number	Stamp

I am a legally qualified:

- ☐ Physician
- ☐ Registered Nurse in the Extended Class
- ☐ Registered Dietitian
- ☐ Registered Midwife or a Traditional Aboriginal Midwife recognized and accredited by her or his Aboriginal community

and I confirm that I have indicated a total of _____ *(e.g. one, two, etc.)* medical condition(s) on this application form for which the applicant requires a special diet and that the information I have provided is true in my professional opinion.

_____ _____

[Signature of Approved Health Professional] *[Date]*

Note: The Criminal Code of Canada s.s. 380 (1) states that everyone who by deceit, falsehood or other fraudulent means defrauds the public of any property, money or valuable security, is guilty of an offence. The *Ontario Works Act, 1997*, Sec. 79/*Ontario Disability Support Program Act, 1997*, Sec. 59 states a person who knowingly aids or abets another person to obtain or receive assistance to which the other person is not entitled under this Act and the regulations is guilty of an offence.

Payment - If you are a Registered Nurse in the Extended Class, a Registered Dietitian, a Registered Midwife or a Traditional Aboriginal Midwife recognized and accredited by her or his Aboriginal community, please forward your invoice in the amount of $20.00 to the appropriate local Ontario Works office or ODSP office noted at the top of the application form. Please be sure to include the applicant's name and Member ID on the invoice.

Section III - Special Diet Allowance

MEDICAL CONDITION that requires a Special Diet	Length of time the Special Diet is required for the MEDICAL CONDITION	Confirmation of Medical Condition
☐ Allergy to Wheat	☐ 6 m ☐ 12 m ☐ Indefinite	Health Professional's Initials
☐ Celiac Disease *Note: Where both of the above conditions are indicated only one allowance amount will be provided.*	☐ 6 m ☐ 12 m ☐ Indefinite	Health Professional's Initials
☐ Diabetes	☐ 6 m ☐ 12 m ☐ Indefinite	Health Professional's Initials
☐ Extreme Obesity: Class III BMI>40	☐ 6 m ☐ 12 m ☐ Indefinite	Health Professional's Initials
☐ Gestational Diabetes *(Note: Allowance will be provided during pregnancy and for 3 months post partum)*	Expected Delivery Date (yyyy/mm/dd)	Health Professional's Initials
☐ Hypercholesterolemia/Hyperlipidemia	☐ 6 m ☐ 12 m ☐ Indefinite	Health Professional's Initials
☐ Hypertension *Note: Where more than one of the above 5 conditions is indicated only one allowance (the highest) will be provided*	☐ 6 m ☐ 12 m ☐ Indefinite	Health Professional's Initials
☐ Dysphagia requiring thickened fluids	☐ 6 m ☐ 12 m ☐ Indefinite	Health Professional's Initials
☐ Allergy to Milk/Milk Products	☐ 6 m ☐ 12 m ☐ Indefinite	Health Professional's Initials
☐ Lactose Intolerance *Note: Where both of the above conditions are indicated the allowance amount for Allergy to Milk/Milk Products will be provided*	☐ 6 m ☐ 12 m ☐ Indefinite	Health Professional's Initials
☐ Insufficient Lactation to Sustain Breast-feeding or Breast-feeding is Contraindicated *Note: A Special Diet Allowance will be paid during the first 12 months of an infant's life if formula is necessary due to inadequate quantity of breast milk or breast-feeding is contraindicated and the infant requires supplementation to maintain weight*	Infant's Date of Birth (yyyy/mm/dd)	Health Professional's Initials
☐ Osteoporosis	☐ 6 m ☐ 12 m ☐ Indefinite	Health Professional's Initials
☐ Renal Failure - Pre-Dialysis (GFR<30)	☐ 6 m ☐ 12 m ☐ Indefinite	Health Professional's Initials
☐ Renal Failure - Peritoneal/Hemodialysis	☐ 6 m ☐ 12 m ☐ Indefinite	Health Professional's Initials

MEDICAL CONDITION that requires a Special Diet	Length of time the Special Diet is required for the MEDICAL CONDITION	Confirmation of Medical Condition
☐ Stage 1 & 2 chronic wounds or burns 1-10% body surface area	☐ 6 m ☐ 12 m ☐ Indefinite	_____ *Health Professional's Initials*
☐ Stage 3 & 4 chronic wounds or burns >10% body surface area *Note: Applicants with both conditions indicated will qualify under Stage 3 & 4 only*	☐ 6 m ☐ 12 m ☐ Indefinite	_____ *Health Professional's Initials*
☐ Unintended Weight Loss Due to one or more of the following conditions (please check the degree of weight loss): Amyotrophic Lateral Sclerosis Anorexia Nervosa Cirrhosis (Stage 3 and 4) Congestive Heart Failure Crohn's Disease Cystic Fibrosis HIV/AIDS Lupus Malignancy Multiple Sclerosis Ostomies Pancreatic Insufficiency Short Bowel Syndrome Ulcerative Colitis ☐ >5% and ≤ 10% weight loss ☐ >10% weight loss	☐ 6 m ☐ 12 m ☐ Indefinite	_____ *Health Professional's Initials*

Section IV - Applicant Declaration & Consent for Release of Information

The person applying for the Special Diet Allowance, or someone lawfully authorized to sign on their behalf, must sign this declaration and consent for release of information.

If the Special Diet Allowance is for a child under 16, then this declaration and consent for release of information must be signed by the social assistance applicant/recipient or other individual who is lawfully authorized to sign on behalf of the child.

[Important: the application will not be approved if the declaration and consent to release of information is not signed]

I declare to the best of my knowledge that the information on this form is true, correct and complete and I consent to the release, by the health practitioner who has completed this form, to the Ministry of Community and Social Services ("ministry") and/or a delivery agent designated under the *Ontario Works Act, 1997* ("delivery agent"), of any information in my health records relating to the information provided on this application form. I understand that the ministry and/or delivery agent would be using this information in my health records to determine my initial eligibility or ongoing eligibility for the Special Diet Allowance.

I have read and signed this consent freely and voluntarily. I understand that I can refuse to sign the consent but that the Special Diet Allowance will not be provided if the consent is not signed. I understand that I can revoke or amend the consent at any time but that this may affect my eligibility for the Special Diet Allowance.

_____ _____

[Signature of Applicant or Other Lawfully Authorized Individual] *[Date]*

Note: The Criminal Code of Canada s.s. 380 (1) states that everyone who by deceit, falsehood or other fraudulent means defrauds the public of any property, money or valuable security, is guilty of an offence. The *Ontario Works Act, 1997*, Sec. 79/*Ontario Disability Support Program Act, 1997*, Sec. 59 states a person who knowingly receives a benefit or assistance that he/she is not entitled to receive under the Act and regulations is guilty of an offence.

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)

The information on this application form is collected under the legal authority of the *Ontario Disability Support Program Act, 1997*, sections 5, 10, 45 and 46 or the *Ontario Works Act, 1997*, sections 7, 8, 57 & 58 for the purpose of administering Government of Ontario social assistance programs including determining recipient eligibility for the Special Diet Allowance ("Allowance") and monitoring that the Allowance is properly issued in accordance with the eligibility requirements and purpose of the Allowance by compiling trends and/or data with respect to: Allowance usage, the medical conditions for which recipients qualify under the Allowance, and the completion of the Allowance form.

For more information contact _____ at (____) _____, in your local Ontario Works or ODSP office.