APPLICATION
FOR BREAST PUMP DISCRETIONARY BENEFIT

For Staff Use: Please complete and submit to Ontario Works or the Ontario Disability Support

Client Information

Client Last Name: First Name:

Tel #: Member ID:

Address:

Child's Name: Child's Date of Birth:

Case Coordinator: Ontario Works Office Fax #:

Breast Pump Information

☐ Initial Assessment **OR** ☐ Reassessment

A breast pump is required for the following reasons:

☐ Medically indicated

☐ Other

Type of Pump Recommended (please check one):

☐ High-Quality Electric Pump (rental)

Pump is required from: to:

☐ Small Electric Pump (purchase)

☐ Hand Pump (purchase) ***Only recommended for situations requiring abrupt weaning***

Participant has received the following resources (please check):

☐ Breast Pump Discretionary Benefit information sheet

☐ Breast Pump Rental Locations factsheet

☐ Storing Expressed Breastmilk factsheet

☐ Breastfeeding Matters booklet

☐ **MANDATORY -** Health Connection phone number provided to client for breastfeeding support, **1-800-361-5653**

Quote

Advise client that they are responsible for sending the quote to the case worker.

Only one quote during initial assessment is required. The client can upload to their My Benefits Account or send directly to their case workers if they have not activated their account. The client must provide the following information in their quote:

PUBLIC HEALTH
1-800-361-5653
TTY: 1-866-512-6228
york.ca/breastfeeding

23-5062

York Region

Type of pump recommended by HCP:

Name of Vendor:

Store Location:

Phone #: Fax #:

Rental Fee per month (including cost of collection kit if applicable):

OR Purchase Price:

For clients requiring assistance in completion and/or submission of the quote (cognitive or physical challenges), please complete the above on their behalf.

If quote information is available at time of assessment it may also be included on this form.

Health Care Professional/Assessor

The following designations are approved to assess and submit application to OW/ODSP:

Qualified Health Care Professional:

Medical Doctor, Nurse (NP, RN, RPN, PHN), International Board-Certified Lactation Consultant, Midwife, Registered Social Worker

Assessor's Name: **Designation:**

Signature: **Date:**

Consent

Consent only to be completed during initial assessment.

I, , hereby authorize and direct the above stated professional to release my completed Breast Pump Discretionary Benefit application(s) and make available to Ontario Works or the Ontario Disability Support Program (ODSP) for the purpose of OW/ODSP determining my eligibility for a breast pump through the Breast Pump Discretionary Benefit Program.

DATED: **Verbal Consent Obtained**

Signature of Person Obtaining Verbal Consent: _____

This information is being collected pursuant to the *Health Protection and Promotion Act*, R.S.O. 1990, c.H.7 and will be retained, used, disclosed and disposed of in accordance with the *Municipal Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c.M.56, the *Personal Health Information Protection Act*, 2004, S.O. 2004, c. 3 and all applicable federal and provincial legislation and regulations governing the collection, retention, use, disclosure and disposal of information. Any questions regarding this collection may be directed to the Director of Child and Family Health, 17250 Yonge Street, Newmarket, Ontario, L3Y 6Z1, 1-877-464-9675.