

# Application for Pregnancy/Breast-feeding Nutritional Allowance

Local ODSP/OW Office Stamp
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 OHIP Fee Code  
K056

**Section 1. To be completed by applicant**
**Applicant Information**

Last Name	First Name	Initial
Date of birth Y    M    D 	Member ID	Relationship to recipient <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> dependent child or dependent adult

**Section 2. 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

**Instructions** - Complete the information below, including your signature, to confirm that the applicant is pregnant or breast-feeding an infant 12 months of age or younger.

Last Name	First Name
Street Number	Unit/Suite/Apt.
Street Name	
City/Town/Municipality	Province
Telephone Number	Postal Code
<b>I am a legally qualified:</b> <input type="checkbox"/> Physician <input type="checkbox"/> Registered Nurse in the Extended Class <input type="checkbox"/> Registered Dietitian <input type="checkbox"/> Registered Midwife or a Traditional Aboriginal Midwife recognized and accredited by her or his Aboriginal community	<b>Stamp</b>

 and I confirm that \_\_\_\_\_ is pregnant or breast-feeding an infant 12 months of age or younger.  
*[Name of Applicant]*

 \_\_\_\_\_  
*[Signature of Approved Health Professional]*

 \_\_\_\_\_  
*[Date]*
**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 3. Pregnancy/Breast-feeding Nutritional Allowance**

The Pregnancy/Breast-feeding Nutritional Allowance is payable beginning in the month an approved health professional signs and dates this application form until the month the pregnancy ends. If the applicant is breast-feeding, the Allowance is payable up to and including the month the infant is 12 months of age.

 The applicant is:     lactose tolerant    or     lactose intolerant    \_\_\_\_\_  
*[Estimated date of delivery]*    or    *[Infant's date of birth if breast-feeding]*
**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)*

 This information is collected under the legal authority of the *Ontario Disability Support Program Act, 1997*, sections 5, 10, 45 & 46 or the *Ontario Works Act, 1997*, sections 7, 8, 15, 57 & 58 for the purpose of administering Government of Ontario social assistance programs including determining recipient eligibility and monitoring take up and referral trends.

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

