Ontario

Ministry of Children, Community and Social Services

Ontario Disability Support Program
Ontario Works

Application for Pregnancy/Breast-feeding Nutritional Allowance

Local ODSP/OW Office Stamp

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
		☐ self ☐ spouse ☐ 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 their Indigenous 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	Postal Code

Telephone Number	**Stamp**

I am a legally qualified:

☐ A Physician
☐ A Registered Nurse in the Extended Class
☐ A Registered Dietitian
☐ A Registered Midwife or a Traditional Aboriginal Midwife recognized and accredited their Indigenous community

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 your Indigenous 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 _____ or _____
Estimated date of delivery 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.

  Disponible en français