ALC Co-Payment Contact Sheet
(Social Work / Co-Payment Specialist)

For Co-Payment Specialist and Patient / Power of Attorney / Trustee

Patient Name: _____

Patient Account #: _____ Ward: _____

Package issued by Social Worker:

Social Worker Name: Extension:

Discuss the following when a co-payment package is given to Patient/POA/Trustee:

- ❑ co-payment start date
- ❑ maximum co-payment cost ($1,848.73/month) and whether you may qualify for a lower fee
- ❑ meeting to be setup with Co-Payment Specialist
- ❑ co-payment forms MUST be returned within 2 weeks

ALC Co-payment discussed with:

Capable patient (please circle): Yes No

If No, with whom (specify name & relationship): _____

Patient receiving social assistance (ODSP/OW): Yes No Member ID: _____

Patient returning home from Medically Complex: Yes No

ALC billing start date: _____ (TBD date)

ALC designation: _____ (TBD-LTC or TBD-CCC.NTLD-C)

Date of discussion: _____

Name and address where co-payment billing should be sent:

Name:_____

Street Address: _____

City: _____ Postal Code:_____

Home Phone #:_____ Cell or Business #:_____

Forward this completed form to the attention ALC Co-payment Specialist, ext. 49850 or FAX the form to 905-549-6725

A copy of this sheet MUST be given to the Patient / POA / Trustee