Hamilton Health Sciences

ALC Co-Payment Contact Sheet

Social Worker to fax this completed form, to:
(905) 549-6725
cc the patient, power of attorney and/or trustee

Inquiries:
Hamilton Health Sciences - St. Peters
T: 905-521-2100 ext. 12411

PLEASE PRINT CLEARLY

Last Name _____ First Name _____

Address _____

City _____ Province _____ Country _____ Postal Code _____

HIN _____ Version Code _____ Date of Birth:(dd/mm/yy) _____ Patient Account #/MRN _____

Discuss the following when a copayment package is given to the patient, Power of Attorney, and/or Trustee:

- ☐ Co-payment start date
- ☐ Maximum co-payment cost per month ($1,891.31) and whether the patient may qualify for a lower fee
- ☐ Meeting to be set up with Co-payment Specialist
- ☐ Co-payment forms MUST be returned within 2 weeks

ALC Co-payment discussed with:

Capable patient? ☐ Yes ☐ No

→ If No, with whom (specify name and relationship) _____

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

Patient returning home from Medically Complex? ☐ Yes ☐ No

ALC Designation: ☐ TBD-LTC ☐ TBD-CCC.NTLD-C

ALC billing start date (TBD date): (year/month/day) _____

Date of discussion: (year/month/day) _____

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

Name:		Email address:	
Street Address:			
City:		Postal Code:	
Home phone #:		Cell or Business #:	

I have provided the co-payment package to the patient, power of attorney, trustee and/or substitute decision maker.

Social Worker Name: _____ Extension: _____