Canadian Thalidomide Survivors Support Program
Extraordinary Medical Assistance Fund ('EMAF") Application

Instructions

The attached application is to be used to submit a request for funding from the Extraordinary Medical Assistance Fund (EMAF) to the CTSSP Administrator.

Please consult the following guiding documents for more information:

- **Comprehensive EMAF Guide**
- **EMAF Quick Reference Guide**
- **Frequently Asked Questions**

Your EMAF application will be considered in the fiscal year that the EMAF decision letter and payment are issued - prior to March 31st annually.

Any EMAF decisions and payments issued after March 31st are included in the new fiscal year cap. Survivors are encouraged to submit their EMAF application(s) before March 1st annually to ensure time for processing and payment before March 31st.

For the 2025-2026 fiscal year, the annual cap per Survivor will be reduced to $34,080 to keep the fund sustainable. This amount includes the Annual Lump Sum Payment of $4,080, meaning that Survivors will have up to $30,000 available toward eligible reimbursements, less any applicable carryover payments from 2024-2025.

Step 1 - Personal Information:

Please review and complete Section 1: Thalidomide Survivor Contact Information.

If you are a legally authorized Personal Representative submitting the application on behalf of the Thalidomide Survivor or if you provided assistance with the form, you must also complete Section 2: Person who helped complete this form. If proof of a right to act on behalf of the Thalidomide Survivor was not previously provided or if the identity of the Personal Representative has changed, please submit proof immediately.

Step 2 – Expense Details & Supporting Documentation:

Please complete Sections 3 and 4 to explain the expenses you are claiming for and how the adaptation or service you are requesting will help you.

Please write the Thalidomide Survivor's First and Last Name at the top of each additional page submitted if applicable.

Step 3 – Submit the form:

Please review all information in the application form and make a copy for your records before you send it. Send the original form and any supporting documentation to:

Canada Thalidomide Survivors Support Program
PO Box 507 STN B
Ottawa, ON, K1P 5P6
info@tsspcanada.ca; Fax: 1-866-262-0816

Privacy Statement:

The information requested in this Canadian Thalidomide Survivors Support Program Extraordinary Medical Assistance Fund ("EMAF") Application is being collected, used and retained by the Canadian Thalidomide Survivors Support Program Administrator ("Administrator") and its Agents for the purpose of operating and administering the Canadian Thalidomide Survivors Support Program Administration pursuant to the *Personal Information Protection and Electronic Documents Act*, S.C. 2000, c. 5 ("PIPEDA"). The information will be provided to the Government of Canada in order to facilitate the administration of the Canadian Thalidomide Survivors Support Program. Personal information is protected under federal legislation, including PIPEDA and the *Privacy Act*, and personal information may be used or disclosed in accordance with applicable legislation. You have the right to request access to your personal information. To do so, call 1-877-507-7706 or 1-877-627-7027 (TTY).

Section 1: Thalidomide Survivor Contact Information	
Language Preference:	☐ English ☐ French
Communication Preference:	☐ Mail ☐ Email *
First Name:	
Middle Name(s):	
Last Name:	
Date of Birth (mm/dd/yyyy):	
Sex at Birth:	☐ Male ☐ Female
Mailing Address:	
City/Town:	
Province/Territory/State/Country:	
Postal Code/Zip Code:	
Primary Telephone Number:	( ) –
Alternate Telephone Number:	( ) –
Email Address *:	

*If your communication preference is email, please add info@tsspcanada.ca to your email address book.

Section 2: Person who helped complete this application

☐ Same as Section 1 (If box is checked, no need to complete Section 2 boxes below)

First Name:	
Last Name:	
Email Address or Phone Number:	
Relationship to Survivor:	

Section 3: Description of Expenses

My total annual income excluding Ongoing Support Payments is: $ _____

For the purpose of applying the financial means test:

- ☐ I have enclosed a copy of my most recent Notice of Assessment from the CRA unless already on file with my Annual Forms Package for this year.
- ☐ I am not enclosing a copy of my most recent Notice of Assessment from the CRA and acknowledge that I will be assessed at the highest income level for the purpose of the finance means test

Please provide the details of your EMAF funding request in the table below.

You **must** provide two comparable estimates for expenses exceeding $10,000. Please contact the Administrator for help if needed.

Receipt/ Estimate Date	Description	Cost Including Tax	Receipt or Estimate Attached
Example only: 10/20/2020	***Replace kitchen cabinets***	***$11,298.51***	***Yes***

* You may use additional paper if more space is needed. Please write your name on each additional page.

Section 4: Additional Information

In the space below, please briefly explain how the adaptation or service you are requesting will help you and how it relates to your thalidomide birth differences. In addition to this brief explanation, a report from a health practitioner (e.g., doctor, massage therapist, occupational therapist etc.) to support the need for the requested adaptation or service including how it relates to your thalidomide birth differences is also helpful.

Section 5: Declaration and Signature

Section 5 must be completed by the Thalidomide Survivor or the Personal Representative with the legal authority to act on behalf of the Survivor. Please read the following declaration carefully before signing.

Declaration:

1. I have completed the Canadian Thalidomide Survivors Support Program Extraordinary Medical Assistance Fund ("EMAF") Application and I understand that the Administrator will be reviewing my application for completeness and may need to contact me to request additional information. I understand that the information provided in this application and the supporting documentation will be used to assess my request for funding under the EMAF.

2. **I also understand that by signing this Declaration I confirm that I have not received funding from any other federal, provincial or territorial program or other organization in regard to the expenses being requested in this application and if I have, I have notified the Administrator.**

3. I understand that my claim may be selected at random to undergo a review of the work completed for quality assurance purposes.

4. I agree to the sharing of my personal information, including but not limited to my contact information, with the Administrator, the Government of Canada and necessary authorized third parties, only for the purpose of processing my request for assessment.

By signing below, I indicate my agreement to the contents of this Declaration.

Thalidomide Survivor/Personal Representative:

Print Name: _____

Signature: _____

Date: _____
(mm/dd/yyyy)

Please make sure the following have been included with your completed application when returning it to the Administrator:

- ☐ Photocopies of receipts, estimates/quotations, medical notes/reports, and other documentation as applicable.
- ☐ Photocopy of your most recent Notice of Assessment from the CRA unless it is already on file or you have chosen not to submit it.
- ☐ Signed and dated Declaration for the Confirmed Survivor/Personal Representative in Section 5.

Return completed application by mail, email or fax to:

Canadian Thalidomide Survivors Support Program
PO Box 507 STN B
Ottawa, ON, K1P 5P6
info@tsspcanada.ca; Fax: 1-866-262-0816