NOVA SCOTIA
Department of Health and Wellness

Self Managed Care Funding Status Form

Continuing Care 1-800-225-7225 toll free across Nova Scotia 8:30 a.m. to 4:30 p.m., 7 days a week

Reset | Print

To Be Completed By SMC Continuing Care Coordinator

Client Name:	Health Card Number:
District SIN:	Client Fee Category:

☐ New SMC Funding Request
☐ Other Requests
☐ Extend Current Funding For Another Year
☐ Increase ☐ Decrease ☐ Hold ☐ Restart ☐ Terminate

Approved Monthly SMC Funding Amount $ _____

Client Fee (Based On Client Fee Category) $ _____

Cost of HCNS Nursing Services (If Applicable) $ _____

SMC Monthly Deposit $ _____

Signature of SMC Continuing Care Coordinator _____ Date (mm/dd/yyyy) _____

Signature of SMC Supervisor (Required for New SMC Funding Only) _____ Date (mm/dd/yyyy) _____

To Be Completed By Financial Services Officer

Self Managed Care Funding Start Date _____
Date (mm/dd/yyyy)

or ☐ Placed On Self Managed Care Funding Waitlist

Information To Clients RE: Financial Report Due Dates

Financial Report Due Dates For Each Fiscal Year
(For New Clients, Start On Next Closest Date. Due Dates Are Then Ongoing)
March 31st
June 30th
September 30th
December 31st

Please Send To:
FSO: _____
Address:

Signature of Financial Services Officer _____ Date (mm/dd/yyyy) _____