SOCIAL DEVELOPMENT
Health Services Unit
P.O. Box 5500, Fredericton, N.B., E3B 5G4
Toll Free: 1-844-551-3015
Fax: (506) 453-3960

DÉVELOPPEMENT SOCIAL
Unité des services de santé
C.P. 5500, Fredericton N.-B., E3B 5G4
Sans Frais: 1-844-551-3015
Télécopieur: (506) 453-3960

GUIDELINES FOR MAINTENANCE OF EQUIPMENT
NOT PURCHASED BY HEALTH SERVICES

Social Development will consider the maintenance (repair and modification) of equipment that the Health Services Program did not purchase under the following conditions:

1. The applicant has an active Social Development Health Card that has the proper coverage for the equipment requiring repair or modification.
2. The applicant has no other equipment that meets the same need.
3. The equipment is an eligible benefit under the Health Services Program.
4. The applicant owns the equipment requiring repair.
5. The repairs, modifications or replacement of accessories are feasible and cost effective, given the age and condition of the equipment.
6. Health Services has confirmed the applicant's eligibility under the Health Services Program for the equipment requiring repair, modification or replacement of an accessory.
7. The applicant (or their legal representative) completes the Application for Equipment Maintenance.
8. The applicant's therapist or supplier provides all necessary information to confirm eligibility i.e. application form applicable to the benefit, prescriptions, etc.
9. All eligibility criteria must be met in order for equipment maintenance to be approved.
10. Please review the eligibility criteria in the Respiratory Services Guidelines before submitting this application.

** *Please note that this application process does not cover the purchase or replacement of CPAP or BPAP machines that the client has obtained through another party.*

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New Nouveau Brunswick CANADA

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APPLICATION FOR EQUIPMENT MAINTENANCE

PART A : CLIENT INFORMATION

LAST NAME	FIRST NAME	DATE OF BIRTH
ADDRESS	**CITY, TOWN, VILLAGE**	**POSTAL CODE**
TELEPHONE	**HEALTH CARD NUMBER**	**PRIVATE INSURANCE**
		Yes ☐ No ☐

PART B : EQUIPMENT INFORMATION & VENDOR INFORMATION

FIXED CPAP ☐ AUTO SET CPAP ☐ BPAP ☐

MAKE	MODEL	SERIAL NUMBER
AGE OF EQUIPEMENT	**VENDOR**	**VENDOR ID NUMBER**

Product & Equipment	Please provide the brand and serial number where applicable. In case of repairs, please attach the appropriate Service Technician report.		Service Dates	COST
Repairs	☐			$
Mask	☐			$
Supplies	☐			$
Other	☐			$
			TOTAL	$ 0.00

I am applying for coverage of repairs and modifications for the equipment listed in Part B of this form. I understand that if this request is approved, repairs, maintenance and replacement of essential accessories for the listed equipment will be funded by Social Development, provided my Health Card remains active with the proper coverage and I agree to the following terms and conditions of the Equipment Loan Agreement.

1. I confirm that I own this equipment.
2. I will care for this equipment as per the instructions received from my therapist, supplier or service technician.
3. I will have all repairs and maintenance completed by a certified service technician.
4. I will operate this equipment safely.
5. This agreement will terminate when this equipment is replaced or no longer required.

Client or Legal Guardian Signature: _____ Date: _____

If the equipment is over 5 years of age, have you verified that the equipment is still functioning properly?	☐ YES	☐ NO
Is the equipment in question still meeting the client's needs?	☐ YES	☐ NO
All necessary documentation specified in the Health Services Guidelines is included with this application.	☐ YES	☐ NO

Vendor Signature : _____ Date : _____

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APPROVED APPROVEE	☐	REFUSED REFUSE	☐	PENDING INFO EN ATTENTE D'INFO	☐

PLEASE SUBMIT DOCUMENT WITH YOUR BILLING

APPROVAL NUMBER / NUMERO D'APPROBATION

Administrator
Administrateur _____ Date : _____

EXPIRES / EXPIRE :

REGISTERED / ENREGISTRER DATE : _____