The 1986-1990 Hepatitis C Claims Centre
P.O. Box 2370, Station D
Ottawa Ontario, Canada
K1P 5W5
Tel: 1-877-434-0944

GEN 12

Loss of Services in the Home – MASTER FORM

Strictly Private and Confidential

CLAIMANT PLEASE AFFIX HERE ONE OF THE PREPRINTED LABELS PROVIDED

*** If you do not have the labels, call 1-877-434-0944 for instructions**

CORRECTIONS ONLY:
Write any name, address corrections below, if any corrections are necessary:

The information collected in this Form will help determine the duties the HCV Infected Person normally performed in the home and, where required, the HCV Infected Person's level of disability.

1) The disabled HCV Infected Person is living and is unable to perform services in the home because of his or her infection with HCV: the disabled HCV Infected Person or the Approved HCV Personal Representative of a living disabled HCV Infected Person who is a minor or mentally incompetent adult must complete this Form GEN 12 to claim compensation for loss of services in the home.

You must have the **Treating Physician** complete the "Disability Section" of the **Tran/Hemo 2 Treating Physician Form or Tran/Hemo 2D**. Please ensure the Treating Physician reviews this Form GEN 12 before completing the Treating Physician Form. Complete and return Form GEN 12 and the Treating Physician Form to the Administrator.

OR

2) The disabled HCV Infected Person who died on or after January 1, 1999 was unable to perform services in the home prior to his or her death because of his or her infection with HCV: the Approved HCV Personal Representative, on behalf of the Estate, must complete this Form GEN 12 to claim pre-death loss of services in the home.

You must have the **Treating Physician** complete the "Disability Section" of the **Tran/Hemo 2 Treating Physician Form or Tran/Hemo 2D**. Please ensure the Treating Physician reviews this Form GEN 12 before completing the Treating Physician Form. Complete and return Form GEN 12 and the Treating Physician Form to the Administrator.

AND/OR

3) The HCV Infected Person died either before or after January 1, 1999 and the HCV Infected Person's Dependants living with the HCV Infected Person at the date of death suffered a loss of the HCV Infected Person's services in the home after his or her death: the Dependant who has undertaken to submit the claim and complete this Form GEN 12 to claim **post-death loss of services** must complete the attached **Dependants Chart** and ensure that every Dependant living with the deceased at the time of death signs the Dependants Chart. A **Treating Physician** Form is not necessary to make a claim for post-death loss of services only. Complete and return Form GEN 12 to the Administrator.

SECTION A – PERSONAL INFORMATION

HCV INFECTED PERSON

1.	First Name	Middle Name/Initial	Last Name	
	Home Address	City	Province/Territory	Postal Code

APPROVED HCV PERSONAL REPRESENTATIVE

2.	First Name	Middle Name/Initial	Last Name	
	Home Address	City	Province/Territory	Postal Code

DEPENDANT

	First Name	Middle Name/Initial	Last Name	
	Home Address	City	Province/Territory	Postal Code

CLAIM DESCRIPTION

3.

Indicate Claimant type:

☐ Living disabled HCV Infected Person

☐ Approved HCV Personal Representative for the living disabled HCV Infected Person who is a minor or mentally incompetent adult

☐ Approved HCV Personal Representative for the disabled HCV Infected Person who is deceased – pre-death loss of services

☐ Dependant(s) of the deceased HCV Infected Person – post-death loss of services

Indicate claim type:

☐ Loss of Services ONLY

To claim compensation for Loss of Income or Loss of Support, you must complete the Loss of Income/Support - MASTER FORM GEN 10

Only one type of loss can be claimed for any period of time.

SECTION B - HCV INFECTED PERSON'S INFECTION INFORMATION

4.	Date of infection with HCV	DD / MM/ YYYY / /	**If unknown, leave blank. The date of infection will be assumed to be the earliest transfusion from a confirmed positive donor in the Class Period or, if this is unknown or inapplicable, the date of first receipt of Blood during the Class Period that is not from a donor known to be uninfected.**
5.	Date of Diagnosis with HCV	DD / MM/ YYYY / /	
6.	When did the HCV Infected Person first become disabled due to his or her infection with HCV, which led to an inability to perform the services he or she normally performed in the home?	Start Date DD / MM/ YYYY / /	
7.	If the HCV Infected Person is deceased, please indicate date of death.	Start Date DD / MM/ YYYY / /	

SECTION C – DESCRIPTION OF HOME

Description of home where the HCV Infected Person is or was a resident (check box that applies):

8.	☐ House	☐ Apartment	☐ Condominium	☐ Townhouse	☐ Other _____.
9.	Number of Residents		Number of Floors	Number of Rooms	Size of Lot

SECTION C – SERVICES IN THE HOME

10. Indicate the total hours per week the HCV Infected Person normally performed the following services in the home.

Category	Task	Hours Per Week BEFORE HCV Disability	Hours Per Week (Currently or Immediately Prior to Death)
Shopping	Groceries		
	Other		
Meals	Meal Preparation		
	Cooking		
	Washing Dishes		
Laundry	Washing/Drying		
	Ironing		
	Sewing		
Cleaning	Bed Making		
	Bathrooms		
	Washing Floors		
	Oven/Refrigerator		
	Vacuuming		
	Garbage Removal		
Home Maintenance Activities	Grass Cutting		
	Gardening/Pool		
	Snow Shoveling		
	Vehicle Maintenance		
Financial Activities	Balancing a Bank Book		
	Paying Bills		
Child Care			
Other			
	TOTAL	_____ **HOURS**	_____ **HOURS**

SECTION D - PAST LOSS OF SERVICES IN THE HOME INFORMATION

11. **If the number of hours the HCV Infected Person normally performed services in the home for any year following his/her disability due to the HCV infection was different from the information currently or immediately prior to death, provided in the Chart at line 10 above, indicate the appropriate information for each year of disability:**

INSERT CALENDAR YEAR OF DISABILITY	INDICATE NUMBER OF HOURS OF SERVICES NORMALLY PERFORMED PER WEEK

SECTION E – DECLARATION BY THE CLAIMANT (NOT TO BE COMPLETED WHEN CLAIMING FOR POST-DEATH LOSS ONLY)

I certify that the information provided is true and correct. I am not making any false or exaggerated claims to obtain benefits.

_____ **Date Signed**

_____ **Signature of the disabled HCV Infected Person or Approved HCV Personal Representative**

SECTION F – DEPENDANTS CHART/ POST-DEATH LOSSES ONLY

The attached Dependants Chart is to **be completed by the Dependant** who has undertaken to submit the claim and this Form. After this Chart is fully completed and signed as indicated below and supporting documentation is collected, the Dependant must return this Form GEN 12 and supporting documentation to the Administrator.

The Dependants Chart must **list every** living **Dependant <u>who was living with the HCV Infected Person at the time of his or her death</u>**.

- List the required information in the Dependants Chart, forming part of Form GEN 12.
- **Each Dependant named in the Chart must sign the Chart** where indicated. If the Dependant is a minor or mentally incompetent adult, the Personal Representative of such person must sign the Chart.
- **Each Dependant must read the Certification** statement above the Chart carefully before signing.

If any <u>Dependant is a mentally incompetent adult</u>, please indicate the name of the person appointed to act as his or her legal Guardian in the address column and provide a copy of the court order appointing such Guardian.

If any <u>Dependant is a minor</u> in the province where he or she resides, please indicate the name of the **adult who has care, custody and control of the minor** in the address column. Should the Dependant claim for post-death loss of services be approved, this adult will hear further from the Administrator about receiving payment.

Counterparts: For convenience, the **Dependant who has undertaken to submit the claim may make one or more machine copies** of the **completed Dependants Chart** on which he/she has named every Dependant, living with the HCV Infected Person at the time of his or her death and <u>send such a copy to Dependants</u> who must complete any additional personal information and, date and sign the Dependants Chart in front of a witness. <u>Dependants must return their original signed copy to the Dependant who has undertaken to submit the claim</u>. Such copies are called counterparts. The Dependant who has undertaken to submit the claim must file all forms, including signed original counterparts, with the Administrator in a single submission.

GEN 12

APPROVED HCV PERSONAL REPRESENTATIVE PLEASE AFFIX HERE ONE OF THE PRE-PRINTED LABELS PROVIDED

If you do not have the labels, call **1-877-434-0944** for instructions

CORRECTIONS ONLY:
Write any name and address corrections below, if any corrections are necessary:

DEPENDANTS CHART

CERTIFICATION-Each Dependant to whom the HCV Infected Person was providing support or was under a legal obligation to provide support must read and sign this Dependants Chart.

By signing this Dependants Chart, I certify that: a) I do not know of any living Dependant, who is a Spouse, Child, Parent, Sibling, Grandchild, Grandparent or former Spouse to whom the HCV Infected Person was providing support or was under a legal obligation to provide support on the date of death other than the Dependants listed in this Chart; b) all of the information provided in this Chart is true and complete to the best of my knowledge, information and belief; and c) I am not making any false or exaggerated claims to obtain benefits.

Name of Dependant	Dependant is a mentally incompetent adult	Dependant is a minor	Home Address and telephone number (If the Dependant is a mentally incompetent adult or a minor include name of legal Guardian or adult with care custody and control)	Date of Birth D/M/Y	Social Insurance Number	Relationship to HCV Infected Person	Signature of Dependant or the Personal Representative of a minor/mentally incompetent adult Dependant	Living with the HCV Infected Person at the time of death?
	☐ Yes	☐ Yes		/ /				☐ Yes
	☐ Yes	☐ Yes		/ /				☐ Yes
	☐ Yes	☐ Yes		/ /				☐ Yes
	☐ Yes	☐ Yes		/ /				☐ Yes

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	☐ Yes	☐ Yes		/ /				☐ Yes
	☐ Yes	☐ Yes		/ /				☐ Yes
	☐ Yes	☐ Yes		/ /				☐ Yes
	☐ Yes	☐ Yes		/ /				☐ Yes