ċeċəwət leləm
"Helping House"
Tsleil-Waututh Nation

MEDICAL FUND APPLICATION

Name: **Date:**

Child's Name: **Band Number: 549**

Applying for:

☐ **Medication** ☐ **Dental** ☐ **Eye Care** ☐ **Physio/Chiro**

☐ **Medical Supplies/Equipment** ☐ **Transportation** ☐ **Other:**

Please indicate if you met any of these criteria (if you do, you do not need to fill out the rest of the form)

☐ **Elder: (55+)** ☐ **SA/IA** ☐ **PWD**

We need to ask some financial questions for the review process. ***(Please complete all questions.)***

1. **What is your monthly income?**
2. **Employer:**
   Social Assistance:
   Contact Person
   ☐ **On Reserve** ☐ **Off Reserve**
3. **Marital Status:**
   Name of spouse/partner:
   Does your spouse/partner work? ☐ **Yes** ☐ **No**
   Employer:
   Spouse/Partner Monthly Income:
4. **Do you or your spouse have a medical plan?** ☐ **Yes** ☐ **No**
   If yes, plan name:
5. **Do you have children?**☐ **Yes** ☐ **No**
   a. **If yes, how many ?** **Ages:**
   b. **Do they live with you?**☐ **Yes** ☐**No**
   c. **Do you receive family allowance?**
      ☐ **Yes (Amount: $)** ☐**No**
6. **What are your monthly expenses?**

Mortgage/Rent:	
Hydro:	
Gas:	
Vehicle Expenses:	
Food:	
Cable:	
Phone:	
Other:	
Other:	
Total Monthly Expenses:	

Doctor or Dentist Contact Info:

Diagnosis: **Notes:**

Declaration:

I hereby certify that the above information is true and give consent to release my financial information.

Signed:

Office Use Only:

Verified By:

Verified By Phone:

Additional Notes:

Amount: **Payable To:**

- ☐ **Invoice Treatment Plan**
- ☐ **Prescription/Pharmacare Receipt**
- ☐ **Original Receipts**
- ☐ **Diagnosis and Prognosis**
- ☐ **Other Insurance Provider Information**
- ☐ **Other:**
- ☐ **Referral**
- ☐ **NIHB Criteria Checked**