HAISLA NATION

Attention: Haisla Nation Funding Coordinator
C/O Haisla Health Centre, 130 Owekeno Avenue, Haisla, BC, V8C 9B5
Ph: 250-632-3600 / Toll Free: 1-888-842-4752 Ext. 303

Application for Haisla Nation (HN) Supplemental Health Assistance

Full Legal Name: (Last, Middle, First)		Telephone #:	
Address – Line 1:		Date of Birth: (YY-MM-DD)	
Address – Line 2:		Haisla Status #:	
Name of parent/guardian if applicant is a child:		Personal Health #:	

Applicant information

Type of assistance required:	☐ Dental ☐ Vision ☐ Medical supplies / Equipment ☐ Pharmacy/Medications	Are you already set up with the Haisla Nation to receive funds via EFT? (Direct deposit)	☐ Yes ☐ No
Does the applicant have any outstanding debt to the Haisla Nation organization?	☐ Yes ☐ No	If yes, is there a payment plan in place?	☐ Yes ☐ No
Does the applicant have workplace medical insurance?	☐ Yes ☐ No	Has applicant exhausted workplace insurance?	☐ Yes ☐ No
Has applicant exhausted FNHA coverage?	☐ Yes ☐ No	If yes, what amount has been covered? *(Provide documentation)*	$
Is the applicant receiving social assistance from the Ministry of Social Development?	☐ Yes ☐ No		
Has the applicant been turned down by the Ministry of Social Development?	☐ Yes ☐ No		

Estimate funding	
Medical Supplies & Equipment	$
Dental	$
Vision	$
Pharmacy/Medication	$
Other – please explain:	$
(Minus amount covered by FNHA and/or private insurance)	($)
Total	$ 0.00

Declaration

- If I should withdraw, be asked to withdraw and/or am terminated from an HN funded Supplemental Health Assistance Program, I agree to pay in full all monies disbursed on my behalf to HN.
- In the event that I have failed to abide by the HN Supplemental Health Assistance Guidelines, due to my violation of the same, I agree to pay in full all monies disbursed on my behalf to HN.
- I understand that if I do not attend a medical service, I am responsible for paying for the funding assistance I have applied for; and I will be invoiced directly.
- I understand that if I do not complete a medical service or if the service is completed earlier than anticipated the time for which funding was provided, that I am responsible for paying for the portion of the unused funding assistance I have applied for; and I will be invoiced directly.
- I certify that all the information provided by me on this form is truthful and accurate.
- I understand that all applications are reviewed on a case-by-case basis and that upon review my application may be declined or only partially approved.

Applicant's signature:	Date:

FOR OFFICE USE ONLY

Reviewed by:	Date:
Approved by:	Date:
Last Updated by:	Date/Time:
Comment:	