HAISLA NATION COUNCIL
Haisla Health Centre
Haisa PO Box 1101 Kitamaat Village, BC V0T 2B0
Telephone: 250-632-3600 Fax: 250-632-3686

Application for HNC Supplemental Medical Assistance

Applicant information

Legal name: _____ Telephone: _____

Address: _____ Date of Birth: _____

_____ Haisla Band Number _____

_____

Personal Health Number _____ Name of parent/guardian if applicant is a child _____

Application Information

Type of assistance required:

- ☐ Dental
- ☐ Vision
- ☐ Medical supplies & Equipment
- ☐ Medical Transportation
- ☐ Pharmacy/Medications

Does applicant have any outstanding debt to Haisla Nation Council? ☐ Yes ☐ No

If yes, is there a payment plan in place? ☐ Yes ☐ No

Does 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 applicant receiving social assistance from Ministry of Social Development? ☐ Yes ☐ No

Has applicant been turned down by Ministry of Social Development? ☐ Yes ☐ No

Estimate funding

Medical Supplies & Equipment $ _____

Dental $ _____

Vision $ _____

Pharmacy/Medication $ _____

Medical transportation $ _____
(i.e., hotels, meals, transport, etc.)

Other $ _____
Explanation: _____

Minus amount covered by FNHA and/or private insurance (($ _____))

TOTAL $ 0

Declaration

I, _____, agree to the following terms and conditions upon being granted supplemental medical assistance:

- I need to make full disclosure of my medical insurance, or the lack thereof, from my workplace.
- If I should withdraw, be asked to withdraw and/or am terminated from an HNC funded supplemental medical assistance program, I agree to pay in full all monies disbursed on my behalf to Haisla Nation Council.
- In the event that I have failed to abide by the HNC supplemental medical assistance guidelines, due to my violation of the same, I agree to pay in full all monies disbursed on my behalf to Haisla Nation Council.
- I understand that if I do not attend a medical service, that 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 complete earlier than anticipated 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 information provided by me on this form is truthful and accurate.

Applicant's signature: _____ Date: _____

FOR OFFICE USE ONLY

Reviewed by: _____ Date: _____

Approved by: _____ Date: _____

Last updated by: _____ Date/Time: _____

Comment: _____