MEDICAL HEALTH FUND APPLICATION

Date of Application: ______________________________

Name of Applicant: ______________________________ Date of Birth: ______________________

Legal Parent/ Guardian/ Substitute Decision Maker: ____

Mailing Address: ____

Phone Number: ___________________________ Band Number: __ __ __ __ __ __ __ __ __ __

Check type of request and attached required documentation as per policy:

- Medical Supplies and Equipment
- Prescription Drug Benefits
- Immunizations
- Inter-Professional Treatment and Therapies
- Foot Care Services
- Vision Care
- Support for Medical Emergency Travel
- Traditional Healing
- Other (please identify): ____

Describe the nature of the request (attach a separate letter if more space is required):

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Identify which benefit plan(s) or other funding sources you are eligible for:

- Non-Insured Health Benefits (NIHB)/ Indian Affairs
- Work benefit plan (please name) ____
- Other benefits or funding (identify source and amount) __________________________________

Amount Requested: ________________ (attach estimate, invoice or receipt)

By providing my signature below, I, the applicant verify that:

1. These expenses are not covered by other health benefit plans or funding sources (i.e. fundraising) or that other health benefit plans or funding sources have been exhausted; and
2. I have read the Nipissing First Nation Medical Health Fund Policy.

Signature: ____

Review, date and sign the **Medical Health Fund Acknowledgement and Waiver** attached to this form.

Reviewed by: ___________________________________ Date Reviewed: ____________________

- Approved
- Not Approved. Reason____

MEDICAL HEALTH FUND

ACKNOWLEDGEMENT AND WAIVER

The undersigned hereby acknowledges having requested funds from Nipissing First Nation's Medical Health Fund for financial assistance with treatment costs, to the extent such treatment may include "Alternative Forms" of treatment including Herbalistic Treatment and Traditional Healers, and/ or the purchase of new or used equipment, the undersigned acknowledges that Nipissing First Nation makes no recommendation and assumes no responsibility or liability for the undersigned choice of treatment.

The undersigned has personally chosen the form of treatment without any recommendations from Nipissing First Nation and Nipissing First Nation assumes no responsibility or liability of any kind regarding any choices made or not made by the undersigned with respect to such treatment.

The undersigned hereby acknowledges that Nipissing First Nation shall not in any event be liable for, or assume any risks associated with any direction, indirect, incidental or consequential damages, personal injury, suffering or complications in anyway connected with the use or misuse of services and or equipment of Alternative Forms of Treatment and the information or lack of information and distribution of therapies.

For these reasons, and in consideration of Nipissing First Nation having provided financial assistance, the undersigned hereby waives and releases any and all entitlement to make any claim against Nipissing First Nation or its employees or agents for damages resulting from such treatment.

I have read and understand the above statement and acknowledge that my choice of Treatment is at my own risk and this acknowledgement is binding on my Executors, Administrators, Heirs and Assigns.

Signature: ____

Print Name: ____

Date: ____