GRANT APPLICATION

HEALTH

Please ensure to complete the application in full (Incomplete applications will not be considered)

Applicant Information

First Name:_____ Last Name: _____

Street Address:_____ Apartment Number: _____

City: _____ Province: _____ Postal Code: _____

Phone Number: _____ Email: _____

Date of Birth: _____ Status Card Number: _____

Request Information (Please provide a brief description of requested Item(s) below)

Prescriptions			Orthopedics			Medical Equipment	
Glasses			Orthodontics			Medical Letters	
Dental			Chiropractic			Other (please Explain)	
Therapy			Physiotherapy				
Massage Therapy			Acupuncture				

Applicant Eligibility

	YES	NO	N/A
Is the Beneficiary a member of the Atikameksheng Anishnawbek?			
Copy of Beneficiary Indian Status Card provided?			

30-1 Reserve Road. Naughton, ON. P0M 2M0 - located on Atikameksheng Anishnawbek First Nations

T - 705-692-2235 F - 705-692-7225 TF - 1-877-221-9588 E - atiktrust@vianet.ca

GRANT APPLICATION

HEALTH

Please ensure to complete the application in full (Incomplete applications will not be considered)

Expected Costs and Funding Information				
Description of Expected Cost	**Amount**		**Other Sources of Funding**	**Amount**
Prescriptions	$		Personal Contributions (if any)	$
Glasses	$		Private Health Insurance (if any)	$
Dental	$		Health Canada - NIHB	$
Therapy	$		Requested from Atikameksheng Trust	$
Massage Therapy	$			
Orthopedics	$			
Orthodontics	$			
Chiropractic	$			
Physiotherapy	$			
Acupuncture	$			
Medical Equipment	$			
Medical Letters	$			
Other (Please explain)	$			
TOTAL EXPECTED EXPENSES	$		TOTAL REQUIRED	$

Grant Component Requirements	YES	NO	N/A
Copy of receipts or invoices provided?			
Fee paid directly to the service provider/supplier? If yes... attach confirmation of fee and billing information - to issue payment			
Confirmation from a health professional or service provider - for request of funds Expected benefit and the actual cost for procedure, equipment or supplies.			
Confirmation that the expenses are approved or denied by FNIHB, OHIP or Private Health Insurance.			
Shawenekezik Health staff recommendation is on file?			

Certification and Authorization to confirm personal information:

I certify that the above information and attachments are true, correct and complete. I am aware that by submitting this application online deems the application signed. I am aware that the information in this application and the attached proposal will be used to assess grant eligibility. I give permission to the Atikameksheng Trust to access the information from the following organizations to confirm information provided in my application:

___ Atikameksheng Anishnawbek Health Dept ___ Other (Please Specify) _____

Applicant Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

30-1 Reserve Road. Naughton, ON. P0M 2M0 - located on Atikameksheng Anishnawbek First Nations

T - 705-692-2235 F - 705-692-7225 TF - 1-877-221-9588 E - atiktrust@vianet.ca