Office: Anacla Government Office, 170 Nookemus Rd, Anacla, BC, *V0R* 1B0
Phone: 1.888.644.4555 / 250.728.3414
Fax: 250.728.1222
Mail: Port Alberni Government Office, 4644 Adelaide St., Port Alberni, BC, V9Y 6N4
Phone: 250.723.0100
Fax: 250.723.4646

Prescription Support Program

1 Definitions

"Huu-ay-aht citizens" – as defined under the "Huu-ay-aht Citizenship and Treaty Enrolment Act 2011"

2 This policy applies to:

2.1 All Huu-ay-aht citizens over the age of 18 years of age,

2.2 A legal representative of a minor Huu-ay-aht child (under the age of 18 years)

Purpose

3 The purpose of the Prescription Support Program is to provide Huu-ay-aht citizens with financial support for medications that are not covered under the First Nations Health Authority (FNHA) or any third-party insurance program to cover the costs of the medication that is prescribed for our citizens. This funding support is for a medication that has been prescribed for one time use or being offered as a trial medication.

Policy

4 Funding can be accessed by citizens for their medications prescribed to them over $50.00 that are not covered under any of their medical plans. This funding does not cover the costs of a medication that needs to be refilled on a continuous basis. If you are employed, you are eligible for a partial payment . There is an appeal process that can be accessed through FNHA to seek approval for the medication.

Considerations:

- HFN will be the last resort payer.
- Point of contact with the applicant is the Community Health and Social Development Manager or designate
- Receipts are required and cannot be more than 30 days old.

4 Applications:

4.1 This Policy is not applicable to non-Huu-ay-aht citizens.

4.2 Applications must be in writing.

4.3 This funding is time limited funding as a result of the "Specific Claims" negotiations. It is subject to availability of funds. This program is considered a temporary program and may not continue after March 2017.

5 Appeals: Exceptions can be made in extreme circumstances (where a person's health will be severely compromised without the aid, e.g.: medical equipment and supplies) and where there is a disagreement with policy, the final decision resides with the Executive Director and the Director Community Services.

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Prescription Support Program

Name:

Address:

Telephone#:

Applicant date of birth:

Is this covered by other health insurance?

Amount requested: $

Receipts must be attached

Declaration:

I declare that the information given on this form is correct and complete to the best of my knowledge.

I understand that if I knowingly give information that is false, I may be liable to prosecution and will be required to repay any assistance received. Also, if I knowingly give information that is false, it may result in forfeiture of any future requests for financial assistance from the Huu-ay-aht First Nations.

I consent to my information being shared between agencies and external organizations for the purpose of processing my claim.

Signature of Applicant: ________________________________ _____Date___________________

Reviewed by: ____ Date___________________

Amount approved: ____

Approved by: ____ Date____________________