huu ay aht

ANCIENT SPIRIT, MODERN MIND

Prescription Support Policy Application

Name:

Address:

Applicant date of birth:

Name of Spouse:

Spouses date of birth:

Are you or our spouse covered by any medical health benefits?

Are you or your spouse employed?

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 maybe 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 on 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_____