shíshálh Nation

shíshálh Nation Community Services

APPLICATION FOR ENROLMENT

PLEASE PRINT IN CAPITAL LETTERS ONLY

This form may be completed with the assistance of the Community Member Services Staff.

To complete the shíshálh Nation Community Services Enrolment, Nation Members must obtain a Status Card, this can be obtained through the Nations Membership Services.

Nation Members requiring medical financial supports must be enrolled with the shíshálh Nation Community Services Department.

1 APPLICANT INFORMATION

APPLICANT LEGAL LAST NAME | APPLICANT LEGAL FIRST NAME | APPLICANT LEGAL SECOND NAME

A person must be a valid status card and reside on Nation Lands to qualify for shíshálh Nation Community care benefits, your current **residential** address is required.

BIRTHDATE (MM / DD/ YYYY) | DAYTIME TELEPHONE NUMBER

☐ NATION LAND ☐ LEASE LAND ☐ OFF NATION LAND

RESIDENTIAL ADDRESS | CITY | PROV | POSTAL CODE

MAILING ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRESS) | CITY | PROV | POSTAL CODE

2 STATUS AND PERSONAL HEALTH NUMBER

STATUS NUMBER | PERSONAL HEALTH NUMBER

PHOTOCOPIES OF CURRENT STATUS CARDS MUST BE ATTACHED. USE LEGAL NAMES WHEN COMPLETING THIS FORM.

3 SPOUSE AND CHILD INFORMATION

SPOUSE LEGAL LAST NAME | SPOUSE LEGAL FIRST NAME | SPOUSE LEGAL SECOND NAME | GENDER ☐M ☐F

STATUS NUMBER | PERSONAL HEALTH NUMBER

BIRTHDATE (MM/DD/ YYYY) | DAYTIME TELEPHONE NUMBER | CELL PHONE NUMBER

CHILD LEGAL LAST NAME | CHILD LEGAL FIRST NAME | CHILD LEGAL SECOND NAME | GENDER ☐M ☐F

STATUS NUMBER | PERSONAL HEALTH NUMBER

BIRTHDATE (MM/DD/YYYY)

3 SPOUSE AND CHILD INFORMATION continued

CHILD LEGAL LAST NAME | CHILD LEGAL FIRST NAME | CHILD LEGAL SECOND NAME | GENDER ☐M ☐F

STATUS NUMBER | PERSONAL HEALTH NUMBER

BIRTHDATE (MM/DD/YYYY)

☐ **IF YOU HAVE MORE CHILDREN, PLEASE CHECK BOX, ATTACH ADDITIONAL SHEET AND PROVIDE ALL INFORMATION**

4 NEXT OF KIN

LEGAL LAST NAME | LEGAL FIRST NAME

DAYTIME TELEPHONE NUMBER | CELL PHONE NUMBER

5 AUTHORIZATION MUST BE SIGNED BY APPLICANT

I have received information about the Community Member Services Department and agree to abide by the terms and conditions of the shíshálh Nation Policies. I understand that if a discrepancy exists between the information provided and the legislation, the legislation will govern. I understand that the information I have given is collected under the authority of the Freedom of Information and Protection Act (FIPPA) and the information will be used to assess eligibility for, and to administer: shíshálh Nation Community Services, NIHB, FNHA, VCH and other publicly funded health care programs.

I authorize Community Member Services Department to collect my health information from practitioners who provide publicly funded health care service(s) to me under MSP, NIHB, FNHA, VCH and other publicly funded health care programs, and I provide consent for those practitioners to disclose such information to the Community Member Services Department for the purposes of assessing eligibility for, and in regard to the administration of, NIHB, FNHA, VCH and other shíshálh Nation Membership Health f unded health care programs.

I understand that information may be disclosed by the Community Services Department pursuant to section 33 of FIPPA.

I declare that all information provided is true and I understand that the Community Member Services, Health Department may verify this information with shíshálh Nation Membership Services, Educational Services and Social Assistance Services as appropriate.

If you have any questions about the collection and use of your personal information, please contact: Community Member Services Health Department, PO Box 740, 5555 Sunshine Coast Hwy, Sechelt, BC V0N 3A0 or call 604-885-9404 or

1 866 885 2275 (toll-free)

SIGNATURE OF APPLICANT | DATE SIGNED (MM/DD/YYYY)

5 IMPORTANT INFORMATION

- **IDENTIFICATION:** You must send with your application: photocopies of your status card, that support the name and Indian Status of those applying.
- **RESIDENCY:** If you will no longer be a resident of Sechelt Indian Lands, you must notify the Community Member Services Health Department that this is the case, you will no longer be eligible for benefits.
- **ACCESS TO INFORMATION:** When collecting, using, and disclosing information, Community Member Services Health Department and its workers must comply with: BC Personal Information Protection Act (PIPA), Medicare Protection Act, Public Health Act, Health Professions Act, and Pharmaceutical Services Act; and any other applicable professional codes of ethics and standards of practice