Wahnapitae First Nation
Health Discretionary Fund Policy

Amended by Band Council Motion: BCM20/21-12-178
At Chief and Council Meeting of: December 12, 2020

Adopted by Band Council Motion: BCM 11/12 #82
At Chief and Council Meeting of: July 19th, 2012

PURPOSE:

To establish a Health Discretionary Fund to fund health products and services not covered by OHIP or NIHB or other private health coverage

To ensure the implementation of the Wahnapitae First Nation's revenues for health are allocated in a fair and equitable manner for the benefit of the Wahnapitae First Nation members and permanent on-reserve residents.

ELIGIBILITY:

WFN members and WFN permanent residents and offspring of eligible individuals up to one year of age whose household income is below the Canadian Standard of Living and on a fixed or low income cut-off threshold of relative poverty such as old age security, social assistance, mothers allowance, disability etc.

WFN members and WFN permanent residents within a situation that involves life threatening/emergency major crisis/terminal illness or death

ALLOCATION:

Ontario Lottery Gaming Commission and Impact Benefit Agreement revenues will be accessed to fund allocations of the Health Discretionary budget which will be determined annually by the Chief and Council.

There is a cap of approximately $4,000.00 maximum total per year

Individuals accessing funds will be on a first come first served basis annually

PROCESS FOR REQUESTING FUNDS:

All other appropriate health benefits and funding sources must be exhausted prior to accessing this program.

Chief LR

An application must be completed for prior approval to determine eligibility.

Eligible recipients or guardians of recipients must complete the health benefits form and attach original receipts and necessary documentation from the Physician or specialist outlining associated costs and submit to the attention of the Health Director for verification and approval.

Requests will then be forwarded to the Finance Director for payment disbursement.

HEALTH COVERAGE:

- **Travel Out of Town:**
  - Travel for immediate family* in case of life threatening/terminal illness or death.
  - Travel for additional parent/guardian for children's appointments covered by Health Canada.
  - Out of town costs beyond WFN policy:

  Rates are as follows:
    - Rooms will be covered to a maximum of $75.00/night (receipt required)
    - Meals @ $10.00/meal
    - Mileage @ $0.15 cents/km (gas receipt required)
    - Hospital parking (receipt required)
    - Public transportation

- **DENTAL:**
  - Essential dental expenses maximum of $200 per year (not cosmetic)
  - Orthodontics work will be covered for children under 18 years of age (Max $200 per year)

- **OPTOMETRISTS:**
  - Prescription eye wear/repairs/replacements (Max $200 every calendar year)
  - Certain eye surgery procedures; No cosmetic costs (Max $200 per year)

- **PHYSIOTHERAPY:**
  - Treatment plan required; No insurance claims. Need to check hospital waiting lists. (Max $200 per year)

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- **MEDICATIONS:**
  - All prescriptions not covered by non-insured health benefits or OHIP (Max $200 per year)

- **EQUIPMENT:**
  - Short term rental/lease or purchase of certain Medical assistive devices to be approved on a case by case basis (Max $200.00 per year)

- **RECORDS:**
  - Forms, Doctor's letters, medical records. (Max $200 per year)

- **MEDICAL PROCEDURES:**
  - Physicals, circumcisions, no cosmetic procedures (unless physician referred) will be approved on a case to case basis. (Max $200 per year)

* Immediate family is defined as Spouse, Mother, Father, Brother, Sister, Mother In-law, Father in-law, Daughter in-law, Son In-law, Brother in-law, Sister in-law, Step Mother/Father, Step brother/Sister, Grandparents, and children/Step-children, Grandchildren.

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REIMBURSMENT CLAIM FOR WFN HEALTH BENEFITS

This form must be signed and completed in full.
Provide copies of proof of total household income including previous year's taxation assessment, and proof of current income: Yes ___ No ___
If no please attach explanation:
If incomplete, it will be returned to you which will delay the processing of the claim.
Enclose original receipts – Copies are not acceptable.

With Regards to this Claim:

Have you accessed First Nation and Inuit Health? Yes ____ No ___
If yes, please attach documentation. If no, please explain why.
Do you have any other group health insurance coverage available to you? Yes ___ No ___
If yes, have you accessed it? Yes ___ No ___
If no, please explain why _____

Print Client Name: **Address:** **City:** **Postal Code:**	**Date of Birth:** **Phone #**	**Registry #**
Type of Expense: **i.e. vision, dental etc.**		**Amount Charged**
		TOTAL $

I hereby certify that the above information is true and accurate.

_____ _____

SIGNATURE or (Parent/Guardian Signature of Client under 18 years of age) **DATE**

Mail or deliver this form and original receipts to:

Attention: Health Director
Wahnapitae First Nation, 259 Taighwenini Trail Road, Capreol, ON P0M 1H0

For inquiries please call: (705) 858-0610

Chief LR