



Métis Nation-Saskatchewan (MN-S)

Cancer & Dialysis Travel Assistance Program

Intake Form



Hours of operation are 8:30 AM - 4:30 PM Monday to Friday

Email to: healthprograms@mns.work

Fax to: 306-249-4934

Mail to: #310 - 20th Street East, Saskatoon SK S7K 0A7

Please note, abuse of the program and/or staff harassment may result in refusal from the program.

Section 1

First Name: _____ Middle Initial: _____ Last Name: _____

Birth Date: _____

Are you a citizen or an immediate family member of a citizen from the Métis Nation-Saskatchewan?*

YES NO

Citizenship Number (or immediate family member's)*: _____

Family member's name: _____

Relation to family member: _____

Address: _____

Postal Code: _____

Phone: _____

Emergency Contact Information

Name: _____ Relation: _____

Phone: _____

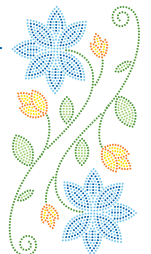
What is your COVID-19 vaccination status?*

First Dose

Fully vaccinated

Exemption

Please upload, email or mail your proof of vaccination status or medical exemption letter to the addresses at the top of this form. This can be a photo/ copy of your vaccination card, or a screen shot of your QR code.



Section 2

What will you be using the Medical Travel Assistance Program for?*

Cancer-related

Dialysis

For your treatment travel, which will you be needing assistance for? (Check all that apply).

Accommodations

Do you want MN–S to book your hotel? YES NO

If yes, what dates do you need a hotel for? _____

Where is your appointment located?: _____

Gas/Parking

Healthy Food Allowance

Section 3

Do you have any additional medical conditions that the program administrator should be made aware of?

YES (please explain)

NO

Physician Name: _____

Physician Phone Number: _____

Please attach documentation of your appointment with this form.

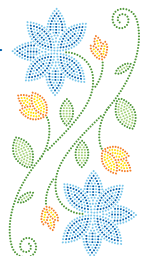
(ATTACH DOCUMENT ON BACK OF FORM OR WITH FORM)

NOTE: To receive reimbursement, you will also need to submit Confirmation of Attendance from your doctor after your appointment.



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Section 4

The following information is used by program administrators to calculate fuel costs accordingly. Include information for the vehicle you will be using or that someone else uses to drive you to your appointments.

What is the make of the vehicle? * _____

What is the model of the vehicle? * _____

What is the year of the vehicle? * _____

Please describe how often you will use the program.

Weekly Basis

Bi-Yearly Basis

Bi-Monthly Basis

Yearly Basis

Monthly Basis

Unknown

Please select your yearly household income before tax. Reimbursement will be prioritized for those citizens with high needs and low income.*

Low (under \$40,000)

Medium (\$40,000 - \$80,000)

High (\$80,000 +)

Provide an explanation if applicable:

How many dependents live with you in your home

*(e.g. children under the age of 18, sick, disabled or elderly requiring care)?**

1

2

3

4

5+



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