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 from the Métis Nation–Saskatchewan?*

☐ YES ☐ NO

Citizenship Number*: _____

Address: _____

Postal Code: _____

Phone: _____

Emergency Contact Information

Name: _____ Relation: _____

Phone: _____

Métis Nation–Saskatchewan (MN–S)
310 20th St E
Saskatoon, SK S7K 0A7
(306) 343.8285
metisnationsk.com

Section 2

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

- ☐ Cancer-related
- ☐ Dialysis

For your medical 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
- ○ Patient Support Worker

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.

Section 4

We use the following information to calculate fuel costs. 20¢ per KM

Where are you travelling from? _____

Where are you travelling to? _____

Please describe how often you will use the program.

- Weekly Basis
- Bi-Monthly Basis
- Monthly Basis
- Bi-Yearly Basis
- Yearly 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+

Please provide us with any additional information we may need to serve you better.

CONSENT AND ACKNOWLEDGMENT

I understand that by submitting this intake form to the Métis Nation–Saskatchewan ("MN–S") for enrollment into the Medical Travel Assistance Pilot Program ("the Pilot Program"), I am consenting to the collection and use of my personal information for the purposes of administering my application and participation in the Pilot Program. I understand that this information is necessary for the purposes of administering my application and participation in the Pilot Program. I understand that my consent to collection and use of my personal information is a condition to my acceptance into the Pilot Program.

I hereby waive any and all claims against the MN–S, its employees, directors, officers and agents relating to the personal information that I am authorizing the MN–S to collect and use in administering my application and enrollment to the Pilot Program.

I _____(Print Name) of_____ (location) the Province of Saskatchewan DO HEREBY authorize MN–S to collection of my personal information provided in support of my application to enable the MN–S to assess my transportation needs and to enable MN–S to confirm my entitlement to participate in the Pilot Program and to administer my participation in the same. I make this solemn affirmation conscientiously believing it to be true and knowing that it is of the same force and effect as if made under oath.

○ **I agree to the Hotel Liability Policy (Must read & agree)**

I agree to abide by all hotel rules and regulations provided by the hotel set forth at the time of check in. I acknowledge that I may be liable for any incidental costs and damages I have caused or by any persons staying or visiting with me. Should any invoice following my stay be received by MN–S,

I acknowledge that I may be responsible for the charges incurred including incidentals (telephone, food, beverage, TV rentals, etc.) and other charges or damages, with the potential of limitations or suspension from future MN–S Medical Travel Assistance Program support.

I acknowledge that if I do not check in on the requested date without sufficient notice, I may also be responsible for the incurred no-show fee. MN–S must be notified with at least 48-hours' notice of cancellation to avoid a no-show fee.

By providing my consent, I acknowledge I will adhere to the responsibilities and requirements brought forward by MN–S Ministry of Health for hotel accommodations booked on my behalf.