Information for Band Members

Little Shuswap Lake Indian Band Compassionate Care Fund Application

Date:	
Name:	
Address:	
Relationship:	
Telephone:	
Email:	
Type of Grant Requested:	___ Funeral ___ Imminent Death ___ Medical Crisis ___ Palliative Care ___ Family Emergency
Funds Requested:	Meals – maximum amt _____ Breakfast @ 10.00 _____ Lunch @ 10.00 _____ Dinner @ 15.00 Travel from _____ to _____ _____ Km @ .20 (No receipts required) Other:
Description of need for Funds:	
TOTAL	

Amount Requested:	Date required:
Title of Health Professional Confirmation: (Required for Imminent Death, Palliative Care)	Health Professional Contact Info: Phone number or email
Applicant Signature	

For Office Use Only:

Request meets guidelines: Y N

Funding approved: _____

Authorized Signature
Social Worker, Health Director or Band Manager