URGENT HEALTH ASSISTANCE PROGRAM POLICY, PROCEDURE and APPLICATION

POLICY

Purpose

The Urgent Health Assistance Program (UHAP) provides immediate, short-term financial support for essential, non-insured health-related expenses for registered Xatśūll First Nation members. Eligible costs include prescription medications, medical supplies and equipment, dental/vision/hearing care, and emergency medical procedures when no other assistance is available.

UHAP is for urgent health-related needs only and has a maximum of $600 per fiscal year. Applicants must demonstrate the urgency or necessity of their request. Due to limited funding, not all requests may be approved, and support will depend on eligibility and available budget.

Note: Applicants 60 and over whose health-related emergency expenses exceed UHAP's $600 annual maximum may submit a supplemental request to the Elders' Emergency Assistance Fund for any remaining balance.

Eligibility

To apply for assistance, the applicant must:

- Be a registered Xatśūll First Nation Member
- Demonstrate financial need and have exhausted all other funding sources (e.g., FNHA, private insurance)
- Provide documentation from a licensed health professional (prescription, invoice, treatment plan)
- Have explored and been denied support from all other possible funding sources (e.g., XFN Family Wellness Team or Jordan's Principle for children, TCHSS, FNHA)

Funds

- Maximum of **$600 per fiscal year** (April 1 – March 31)
- Elders may apply to the Elder Fund to top up unmet costs
- Funds may be paid directly to the member **or** to service providers depending on the nature of the request and upon receipt of required documentation.
- Funds are **non-transferable** and for the benefit of the applicant only

- **Medical Interventions and therapy funding exceeding $600/yr is assessed on a case-by-case basis and requires a support letter from a health professional.**

Criteria

Eligible Expenses May Include (but are not limited to):

- Emergency Medical Expenses, Prescription Medications, Medical Supplies and Equipment, Dental and Vision Care, Medical procedures and therapies.

Requests must clearly show that the expense is **related to a situation that affects the applicant's health, safety, or ability to live independently**.

All requests must include **supporting documents** as determined by the Director of Community Services or designate. These may include, but are not limited to:

- Invoices or receipts for claimed expenses
- Proof of denial or exhaustion of other funding sources
- Health-professional documentation (e.g., prescription, treatment plan, support letter outlining need)
- Quotes from service providers

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PROCEDURE

- Applicants must complete the UHAP Application Form, available at Community Services Reception or online via the Xatśūll website. All required information must be provided and the application must be signed by the applicant before it can be reviewed.

- Once a completed application and all required documentation are received, the Community Services Department will review and respond to the request **within 5 business days**. If the application is marked as urgent or time-sensitive, it will be prioritized and reviewed as quickly as possible, ideally within **2 business days**.

  If the request is time sensitive, the applicant should clearly indicate this on the application. Otherwise, payment will be processed during the Finance Department's next scheduled cheque run.

Appeals Process:

If an application is denied, the applicant may request a review of the decision. Appeals must be submitted to the Director of Community Services in writing within **10 business days** of receiving notice of the denial and should include any additional information or documents that support the request.

Appeals will be reviewed by the **Director of Community Services and/or the Chief Administrative Officer**, and a final decision will be provided within **10 business days** of the appeal submission. All appeal decisions are final.

APPLICATION

Registered Xatśūll First Nation members seeking support through the Urgent Health Assistance Program (UHAP) must complete this UHAP Application Form. All requests will be assessed according to the UHAP Policy.

First Name:	Last Name:
Address:	
Date of Application:	Phone Number:
Date of Birth:	Band Number:

Purpose of Request. *Select one of the following*:

- ☐ **Prescription Medications:** Expenses related to prescribed medications necessary for health.
- ☐ **Medical Supplies and Equipment:** Costs associated with essential medical supplies and equipment.
- ☐ **Dental and Vision Care:** Expenses related to necessary dental treatments, eye examinations, eyeglasses, contact lenses, and other vision-related needs that are not fully covered.
- ☐ **Medical interventions and therapies:** Costs for procedures or treatments administered by a licensed healthcare provider, critical for a person's recovery or health.

- ☐ **Other Health Expenses:**_____

Please describe the steps you've taken and list all programs, agencies or departments you have contacted for assistance (e.g., FNHA, private insurance, Family Wellness, TCHSS):

Total Amount of Assistance Received from other sources: $_____

Specific Expenses Requested (Please list items with associated costs):

1. _____ - $_____
2. _____ - $_____
3. _____ - $_____

Total amount you are requesting (maximum $600/Year): $_____

Have you received assistance from the UHAP fund during the current fiscal year?
(April 1st to March 31st)

No: ___

Yes: ___ If yes, what was the amount you received: $_____

I, the undersigned, declare that the information provided in this application is accurate and true to the best of my knowledge. I understand that failure to provide complete and accurate documentation may delay the review process. I give consent for the Xatśūll First Nation Community Services Department to verify the details provided in this application, including documentation from health professionals and funding sources.

_____ _____

Applicant's Signature **Date**

Completed applications can be submitted via:
- Email: chr@xatsull.com
- In-person: Health Manager, Community Services Office

OFFICE USE ONLY

Date Received: _____

Reviewed by (print name & title):_____

Decision:

- ☐ **APPROVED**
- ☐ **DENIED**

_____ _____

Signature **Date**