

**Cook's Ferry Indian Band  
ELDER'S HEALTH SUPPORT PROGRAM  
Funding Policy**

Cook's Ferry Indian Band is in a position to assist Cook's Ferry Band Elders, to enhance their health and wellbeing through financially supporting their Health & Wellness through a program funded by the Nlaka'pamux Legacy Trust (2013) Available Band Funds.

Funding is available to a maximum of \$2000 per individual Registered Band Member 60 years or older, per fiscal year (Fiscal year being April 1 to March 31) until the Budget is depleted. The goal is to assist as many as possible. Elders may submit applications for funding as per the following criteria.

**Applicant Eligibility:**

The following criteria must be met to be eligible for funding:

1. Be a registered Cook's Ferry Indian Band member 60 years or older; and
2. Submit an application with supporting documentation; and
3. Provide an invoice for direct payment to a supplier; or
4. Provide a receipt for reimbursement;
5. No repayments are permitted.

**Ineligible Costs:**

1. Costs covered by other sources;
2. Food and Fuel

Eligible costs must support the health and well-being and benefit the Elder applicant only. Eligible costs are eligible between April 1 to March 31, Applications may be submitted for eligible dates (April 1 to March 31) Prior to April 30 of the current Fiscal Year.

**Funding Application Process**

Funding will be allocated up to a maximum of \$2000 per eligible applicant. Applicants, or their authorized designate, are to fill out the Elder's Health Support Program Application in full and submit the supporting documentation to the address on the application form. Applicants are eligible for an aggregate maximum of \$2000 during this period, with supporting documentation provided. Applications will be reviewed for completeness and considered for funding if complete.

**COOK'S FERRY INDIAN BAND  
ELDER'S HEALTH SUPPORT PROGRAM  
FUNDING POLICY**

Applicants may apply for the full \$2000 on one application or make several applications until they have reached the maximum. Note that applications are accepted until the middle of April.

Applications will be reviewed and processed as received. Applicants can expect the turn around to be up to 2 weeks from the receipt of their application. All payments will be issued in Canadian funds only.

**Obligations of Cook's Ferry Indian Band**

All applications, approvals and denials will be kept on file and kept confidential. Applications and Reports will be provided to the Nlaka'pamux Legacy Trust. Adhere to the Elder's Health Support Program Funding Policy. Consider each request fairly and transparently as per the Policy. Keep a record of amounts available to eligible membership.

**Grievance Procedure**

If applicants are unsatisfied with the decision made on their application, they must submit in writing the reasons why they feel they should be reconsidered for funding to the Band Manager within 30 days of notification of the decision. The Program Coordinator will forward the request to the Band Manager who will make a decision and inform the applicant of the results within 10 business days. If the applicant is still unsatisfied, they may send in a grievance for to Chief and Council for review. Chief and Council will make the final Binding Decision within 15 business days.

**COOK'S FERRY INDIAN BAND  
ELDER'S HEALTH SUPPORT PROGRAM  
APPLICATION FORM**

PO Box 130  
Spences Bridge, B.C. V0K 2L0  
Tel: 250-458-2224 Fax: 250-458-2312  
Email: [finance@cookserry.ca](mailto:finance@cookserry.ca)

1. Persona Data

Full Name: \_\_\_\_\_  
10-digit status registry number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Mailing address: \_\_\_\_\_  
\_\_\_\_\_  
Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

2. Have you applied for Elder's Health Support funding in the past? Yes  No

If yes, what was the date you last received funding? \_\_\_\_\_

3. Please provide brief details of your request:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Please indicate the supporting documentation you have attached:

- Receipt  Prescription  
 Invoice  Doctor's Note  
 Other (Health Care Provider Referral) Please describe:  
\_\_\_\_\_

5. Type of payment requested:

- Reimbursement  Direct Payment to Service Provider

I, \_\_\_\_\_, am requesting \$\_\_\_\_\_ from the Elder's Health Support Program. I have read, understand, and agree to the policy.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Authorized Designate: \_\_\_\_\_ Date: \_\_\_\_\_

**COOK'S FERRY INDIAN BAND  
ELDER'S HEALTH SUPPORT PROGRAM  
AUTHORIZED DESIGNATE**

PO Box 130  
Spences Bridge, B.C. V0K 2L0  
Tel: 250-458-2224 Fax: 250-458-2312  
Email: [finance@cooksferry.ca](mailto:finance@cooksferry.ca)

Elder Applicants applying to the Elder's health Support Program who would like to have someone authorized on their behalf to work with Program Coordinator to address the application can use this form to authorize an individual to represent them. Applications submitted by individuals other than the applicant themselves will not be processed unless this form is completed in full and submitted with the application, or they can prove legal guardianship over the applicant.

Date: \_\_\_\_\_

I, \_\_\_\_\_, authorize the following to submit this application for the Elder's Health Support Program to Cook's Ferry Indian Band as my authorized designate for the purposes of seeing this application through.

**Authorized Designate Information:**

Full Name: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Printed Name of Witness: \_\_\_\_\_

**COOK'S FERRY INDIAN BAND  
ELDER'S HEALTH AND WELLBEING SUPPORT PROGRAM  
GRIEVANCE FORM**

PO Box 130  
Spences Bridge, B.C. V0K 2L0  
Tel: 250-458-2224 Fax: 250-458-2312  
Email: [finance@cooksferry.ca](mailto:finance@cooksferry.ca)

1. Personal Data

Full Name: \_\_\_\_\_

10 Digit status registry number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

What are your grounds for appealing the Band Manager's decision?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Authorized Designate: \_\_\_\_\_ Date: \_\_\_\_\_

**Office Use Only**

C&C receipt of appeal: \_\_\_\_\_

Date of Hearing: \_\_\_\_\_

Decision of C&C: \_\_\_\_\_