

KIMMUNITY ANGELS SOCIETY

Financial application

Legal Name of Applicant

Address

Phone

Email

Marital Status

single

Married

Common-Law

To which do you most identify?

Male

Female

Trangendermale

Transgender female

Gender Variant/ non confirming

Not Listed

Prefer not to say

Please tell us how we can help (include appointment dates and times)

Are you eligible for benefits through the Veterans Affairs Canada to cover travel and accommodations for medical appointments?

Yes

No

If yes, please call Veterans Affairs Canada at 1-866-522-2122

Have you or do you expect to receive funds from another organization to assist with your current request?

Yes

No

Do you have a registered Status Card issued by the Government of Canada?

Yes

No

If yes, please call the First Nations Health Authority (Non-Insured Health Benefits in BC) at 1-800-317-7878

Do you (or your partner) have any extended health benefits or disability insurance that covers travel and accommodations for medical appointments?

Yes

No

If yes, please call the MSDPR at 1-866-866-0800.

Do you (or your partner) have any extended health benefits or disability insurance that covers travel and accommodations for medical appointments?

Yes

No

If yes, please contact your plan to assist with coverage.

Do you receive monthly income from an investment (e.g. RRSP, whole life insurance, savings account, trust account, rental property, interest, dividend or property, other), please enter the amount you receive each month. Please specify

DECLARATION OF APPLICANT

1. By signing this application I agree and acknowledge that any financial assistance provided by Kimmunity Angels Society will be utilized only for the expenses outlined in this application.
2. I agree to provide verification of applicant's household income for the purpose of determining eligibility for financial support from Kimmunity Angels Society.
3. I agree to provide medical verification from the applicant's attending physician for the purpose of determining eligibility for financial support from Kimmunity Angels Society.
4. I authorize Kimmunity Angels to collect, use, and disclose my personal information for the following purposes:
determine whether I am eligible for financial assistance with Kimmunity Angels for medical purposes
to determine what other resources may be available to me
to assist in meeting my request as outlined on page one of this application

Kimmunity Angels Society is a trusted steward of community funds. As such the application process ensures community funds are dispersed responsibly and efficiently. Information is gathered solely to determine eligibility and to assist the applicant/family in pursuing additional financial resources. All information will be kept confidential and will only be used to determine eligibility

By signing this, I agree all terms in the declarations of applicant

signature



DECLARATION OF KIMMUNITY ANGELS

Kimmunity Angels Society honors the Personal Information Protection Act. All information collected is used only for the purpose of determining eligibility, assisting to meet the request as per page one of this application and to assist the applicant/family in pursuing additional financial resources.