



**PRIVACY ACT STATEMENT**

Information collected on, and disclosed pursuant to, this document is collected pursuant to the BC *Social Development Policy and Procedures Manual* for the purpose of determining eligibility for assistance and will be maintained pursuant to the *Privacy Act* and described in the personal information bank INA-PPU-240. The accuracy of the information in this document may be checked by comparing it against information held by any federal or provincial department or agency or any private agency.

Please complete in full. Please print clearly.

Administering Authority: \_\_\_\_\_

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

**SECTION A: CLIENT INFORMATION – TO BE COMPLETED BY BAND SOCIAL DEVELOPMENT WORKER**

Client's Last Name	Client's First Name	Date of Birth (year/month/day)
Personal Health Number	What type of income assistance is being collected by the Client? (i.e., PWD, PPMB, etc.)	

**SECTION B: SERVICE INFORMATION – TO BE COMPLETED BY PRACTITIONER (MEDICAL/DENTAL/OPTICAL/OTHER)**

Patient's Last Name	Patient's First Name	Date of Birth (year/month/day)
Personal Health Number	Relationship to Client (i.e., same, son, daughter, husband, wife, etc.)	

Describe the non-insured procedures, services or supplies you are recommending, with the estimated cost.  
**Attach all required documentation (i.e., invoices, lab slips, prescriptions and/or BC-HB-03 form) to this form.**

Date	Qty.	FeeCode	Description	Amount

If these items/services have previously been provided, please give details, dates and amounts:

**SECTION C: RECOMMENDATION – TO BE COMPLETED BY BAND SOCIAL DEVELOPMENT WORKER**

- Relevant policy section is Chapter: \_\_\_\_\_ Section: \_\_\_\_\_ Dated: \_\_\_\_\_
- Items/services are within policy? Yes  No  If no, explain: \_\_\_\_\_
- Items/service rates are within policy? Yes  No  If no, explain: \_\_\_\_\_
- Time limits are within policy? Yes  No  If no, explain: \_\_\_\_\_

Comments: \_\_\_\_\_

**TOTAL RECOMMENDED AMOUNT: \$** \_\_\_\_\_

\_\_\_\_\_  
Signature of Band Social Development Worker

\_\_\_\_\_  
Date Signed

**SECTION D: AUTHORIZATION – TO BE COMPLETED BY BAND SOCIAL DEVELOPMENT WORKER OR FUNDING SERVICES OFFICER**

Check one of the following:  Recommendation Approved  Recommendation Denied

**Attach supplier documentation (i.e., invoices) to form or complete the following information for payment.**

TOTAL AUTHORIZED AMOUNT: \$ \_\_\_\_\_ NAME OF SUPPLIER: \_\_\_\_\_

ADDRESS OF SUPPLIER: \_\_\_\_\_

FOR AMOUNT UP TO \$500.00:

FOR AMOUNT OVER \$500.00:

\_\_\_\_\_  
Signature of Band Social Development Worker

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Funding Services Officer

\_\_\_\_\_  
Date Signed

**Note: This authorization may not be converted to cash or transferred to another person. It must be used for items/services for the Patient only. Authorization is invalid 30 days after the issue date of this form.**