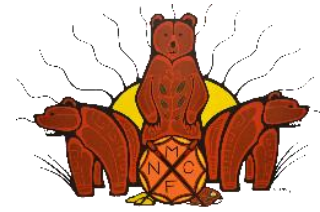




MISSANABIE CREE COMMUNITY HEALTH AND WELLNESS SERVICES



INTAKE FORM

DATE:		FILE #	
NAME:			
ADDRESS:			
CITY:			
PROVINCE		POSTAL CODE	
EMAIL		PHONE #	

Services provide a direct or secondary benefit to: Member Spouse Child

Member Status Card # 2 2 3 _____ Member Date of Birth _____ / _____ / _____
M M D D Y Y Y Y

Request: _____

Estimated cost for requested services: \$ _____

of previous requests _____ Is this a request that can be provided through other services? Y N

Has the recipient been declined by other services for this request? Y N

Quotes Attached _____ Quotes Requested _____

DOCTOR'S NOTE MAY BE REQUIRED PRIOR TO APPROVAL OF SERVICES IF REQUEST IS DUE TO MEDICAL ISSUE

Release of Information

I _____ hereby authorize _____
 to speak to _____ on my behalf in regards to
 _____ on the application submitted to Missanabie Cree First Nation.

Date: _____ / _____ / _____ Signature _____)

M M D D Y Y Y Y