| HEALTH DISCRETIONARY FUND POLICY |
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| **Policy Type:** | **Health** | **Initially Approved:** | **07/19/2012** |
| **Policy Sponsor:** | **Health Department** | **Last Revised:** | **02/25/2025** |
| **Primary Contact:** | **Health Director** | **Review Scheduled:** | **02/2026** |
| **Approver:** | **Chief and Council<br>BCM WFN 24/25-02-282** | | |

## PURPOSE:

To establish a Health Discretionary Fund to fund health needs and services not covered by OHIP, ~~or~~ NIHB or other private health coverage.

To ensure the implementation of the Wahnapitae First Nation's revenues for health are allocated in a fair and equitable manner for the benefit of the Wahnapitae First Nation members. ~~and permanent on-reserve residents. .(based on chief and council decision of who will be serviced)~~

## ELIGIBILITY:

Registered members of Wahnapi~~a~~tae First Nation who are at a financial need to support service costs above OHIP, NIHB and other private health coverage.

~~WFN members and WFN permanent residents and offspring of eligible individuals up to one year of age whose household income is below the Canadian Standard of Living and on a fixed or low income cut-off threshold of relative poverty such as old age security, social assistance, mothers allowance, disability etc. based on chief and council decision of who will be serviced) RECOMMEND – NO FINANCIAL INFO NECESSARY~~

~~WFN members and WFN permanent residents within a situation that involves life threatening/emergency major crisis/terminal illness or death based on chief and council decision of who will be serviced~~

## ALLOCATION:

Ontario Lottery Gaming Commission and Impact Benefit Agreement revenues will be accessed to fund allocations of the Health Discretionary budget which will be determined annually by the Chief and Council.

~~There is a cap of approximately $8,500.00 maximum total per year.~~

Accessing funds will be on a first come first served basis annually.

## PROCESS FOR REQUESTING FUNDS:

All other appropriate health benefits and funding sources must be exhausted prior to accessing this program.

An application must be completed for prior approval to determine eligibility.

Eligible recipients or guardians of recipients must complete the health benefits form and attach original receipts and necessary documentation from the Physician or specialist outlining associated costs and submit to the attention of the Community Wellness Coordinator for verification and approval.

Approved Requests will then be forwarded to the Finance Director for payment disbursement.

Appeal for denied applications will be reviewed by the Health Director and Executive Director and this decision will be final.

## HEALTH COVERAGE:

Eligible Members maximum approval of $1,000.00 for the following:

The Health Discretionary Fund will be distributed to assist with the medical coverage that is above the allowable amounts with NIHB, OHIP and other private ~~insurance~~ health coverage up to a maximum of $1,000.00 annually. This includes but is not limited to the following:

1. Travel Out of Town:
    a. Rooms to be covered to a maximum of $200/night (receipt required).
    b. Milage, meals, and per diem rates ~~to be found in~~ as per the Finance Policy.
    c. Travel out of town requires a physician referral based on services not being available locally or specific specialist recommendation from the physician.

~~1.~~

2. Chiropractor, Osteopath, Podiatrist/Chiropodist, Message Therapist, Naturopath/Dietician, Speech Therapy, Equipment, Audiologist, Optometrist, Dental, Physiotherapist, Athletic Therapist, Psychologist, Social Worker, and Acupuncturist.

3. Any other medical needs not listed in this policy will be reviewed/assessed on a case-by-case basis by the Community Wellness Coordinator and Health Director.

4. Medical Procedures:
    a. Cosmetic Medical procedures will be reviewed only with a physician referral, reviewed ~~with~~ by the Community Wellness Coordinator and Health Director.

~~**Travel Out of Town:**~~

~~Travel for immediate family* in case of life threatening/terminal illness or death.~~

- Travel for additional parent/guardian for children's appointments covered by Health Canada.
- Out of town costs beyond WFN policy:
- Rates are as follows:
  - Rooms will be covered to a maximum of $75.00/night (receipt required)
  - Meals @ $10.00/meal
  - Mileage @ $0.15 cents/km (gas receipt required)
  - Hospital parking (receipt required)
  - Public transportation

Chief & Council to advise on rate increases for the following travel rates

**DENTAL:**

- Essential dental expenses maximum of $200 per year (not cosmetic)
- Orthodontics work will be covered for children under 18 years of age (Max $200 per year)

**OPTOMETRISTS:**

- Prescription eye wear/repairs/replacements (Max $200 every calendar year)
- Certain eye surgery procedures; No cosmetic costs (Max $200 per year)

**PHYSIOTHERAPY:**

- Treatment plan required; No insurance claims. Need to check hospital waiting lists. (Max $200 per year)

**MEDICATIONS:**

- All prescriptions not covered by non-insured health benefits or OHIP (Max $200 per year)

**EQUIPMENT:**

- Short term rental/lease or purchase of certain Medical assistive devices to be approved on a case by case basis (Max $200.00 per year)

**RECORDS:**

- Forms, Doctor's letters, medical records. (Max $200 per year)
- **MEDICAL PROCEDURES:**

- Cosmetic Medical procedures will be reviewed only with a physician referral, reviewed with the Community Wellness Coordinator and Health Director

- ~~Physicals, circumcisions, no cosmetic procedures (**unless physician referred**) will be approved on a case to case basis. (Max $200 per year)~~

~~a.~~ ~~* Immediate family is defined as Spouse, Mother, Father, Brother, Sister, Mother In-law, Father in-law, Daughter in-law, Son In-law, Brother in-law, Sister in-law, Step Mother/Father, Step brother/Sister, Grandparents, and children/Step-children, Grandchildren. (based on chief and council decision of who will be serviced)~~

**REVISION HISTORY:**

| Date (mm/dd/yyyy) | Motions |
|---|---|
| 07/19/2012 | BCM 11/12 #82 |
| 12/12/2020 | BCM 20/21-12-178 |
| 02/25/2025 | BCM WFN 24/25-02-282 |

**REIMBURSMENT CLAIM FOR WFN HEALTH BENEFITS**

This form must be signed and completed in full.
Enclose original receipts

**With Regards to this Claim:**
Have you accessed First Nation and Inuit Health? Yes ____ No ___
If yes, please attach documentation. If no, please explain why.
Do you have any other group health insurance coverage available to you? Yes ___ No ___
If yes, have you accessed it? Yes ___ No ___
If no, please explain why _____

| **Print Client Name:**<br><br>**Address:**<br><br>**City:**<br><br>**Postal Code:** | **Date of Birth:**<br><br>**Phone #** | **Registry #** |
|---|---|---|
| **Type of Expense:**<br>**i.e. vision, dental etc.** | | **Amount Charged** |
| | | |
| | | **TOTAL $** |

I hereby certify that the above information is true and accurate.

_____ _____

**SIGNATURE** or (Parent/Guardian Signature of Client under 18 years of age) **DATE**

Mail or deliver this form and original receipts to:

Attention: Community Wellness Coordinator
Wahnapitae First Nation, 259 Taighwenini Trail Road, Capreol, ON P0M 1H0
*For inquiries please call: 705-858-7700*