

**MANITOBA REGION-INCOME SUPPORT PROGRAM
SPECIAL NEEDS APPLICATION**

ONLY THOSE WHO ARE "HEAD OF HOUSEHOLD" WILL BE ELIGIBLE FOR APPLIANCES.

PLEASE CONFIRM HEAD OF HOUSEHOLD BEFORE APPLICATION IS COMPLETED.

APPLICANT NAME: _____

DATE OF APPLICATION: _____

FIRST NATION: **SANDY BAY** _____

TREATY NUMBER: _____

ADDRESS: _____

IS APPLICANT IN RECEIPT OF SOCIAL ASSISTANCE FROM THE FIRST NATION IN THE CURRENT MONTH? YES NO

IF YES, PLEASE SPECIFY TYPE OF ASSISTANCE:

- 1) REGULAR SOCIAL ALLOWANCES
- 2) CARE OUT OF PARENTAL HOME _____
- 3) SUPPLEMENT TO INCOME _____

REASON FOR SPECIAL NEEDS REQUIREMENT:

- 1) REPLACEMENT, REPAIR OF FURNISHINGS OR APPLIANCES
- 2) TRAVEL ASSISTANCE _____
- 3) SET UP OF NEW HOUSE _____
- 4) OTHER(Please specify): _____

AMOUNT OF SPECIAL NEEDS PROVIDED:	_____	\$
ITEMS/SERVICES PROVIDED	_____	\$
	_____	\$
	_____	\$
	_____	\$
	_____	\$
	_____	\$
	_____	\$

ISSUING AUTHORITY _____
CHIEF/COUNCILOR PORTFOLIO HOLDER(if applicable) _____
SIGNATURE OF APPLICANT _____

DELIVERED BY: _____
DELIVERY DATE: _____