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? [redacted] 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: _____