

# MISSISSAUGAS OF THE CREDIT FIRST NATION

## COMMUNITY WELLNESS EXPENSE CLAIM FORM-ADULT 2022-2023 – 2<sup>nd</sup> DISTRIBUTION

Mailing Address: LMR/Community Wellness 2789 Mississauga Rd., R.R. #6 Hagersville, ON N0A 1H0

Email: [cw@mncfn.ca](mailto:cw@mncfn.ca)

FULL NAME (as it appears on your Status Card):	REGISTRY NUMBER (10 DIGIT):
FULL MAILING ADDRESS (including Postal/Zip Code):	BIRTHDATE (YYYY-MM-DD):
EMAIL ADDRESS (required if getting Direct Deposit):	TELEPHONE NUMBER (including area code):
PLEASE INDICATE THE FOLLOWING OPTIONS:  <input type="checkbox"/> Cheque Mail Out  <input type="checkbox"/> Direct Deposit (Canada only)* *Include a void cheque or direct deposit form*  <input type="checkbox"/> On File <input type="checkbox"/> New Account	<b>All applications must include front and back photocopies of 2 pieces of ID, 1 being photo ID. Please ensure that all information on each ID is clearly visible.</b>

I hereby authorize the use of my address/email for various MCFN initiatives (such as. Voter's List, MCFN Community Trust, Eagle Press Newsletter, Governance Community Engagement, Internal Department's use). Under no circumstances will MCFN share your personal information with outside agencies.

\_\_\_\_\_ (BAND MEMBERS PLEASE INITIAL HERE)

<b>X</b>  _____ <i>Signature</i>	<b>Total Receipts:</b>  Amount: \$ <b>1,500.00</b>
_____ <i>Date</i>	

-----Do not write below this line. For Office Use Only-----

Documents provided for identity: \_\_\_\_\_ Department's Initials \_\_\_\_\_  
 Status Card    Confirmation of Status    D.L.    H.C.    B.C.    Other ID ( \_\_\_\_\_ )

Amount Claimed:	Remaining Balance:

Account Number:	64300
Dept. Number:	100030
Cheque Number:	
Cheque Date:	

Department Signature: \_\_\_\_\_

Date Received \_\_\_\_\_