MISSISSAUGAS OF THE CREDIT FIRST NATION

COMMUNITY WELLNESS EXPENSE CLAIM FORM - ADULT 2025-2026

Mailing Address: LM/Community Wellness 2789 Mississauga Rd., Hagersville, ON N0A 1H0
Email: cw@mncfn.ca

** **All applications must include front and back copies/pictures of 2 pieces of VALID ID, one being photo ID. Please ensure that all information on each ID is clearly visible. QUOTES, ESTIMATES AND/OR RECEIPTS ARE REQUIRED. MUST BE DATED APRIL 1, 2025 OR LATER. If registered after April 1st, 2025, quotes, estimates and/or receipts must be dated on or after the date of registration.**

** **POA documents must be included with each application (if applicable). POA must also include front and back copies/pictures of 1 piece of VALID photo ID.**

** **To avoid delays in processing, ensure that all sections are complete and legible, application is signed, and all required/supporting documents accompany your application. Ensure payment option is clearly indicated.**

FULL NAME *(as it appears on Status Card)*:	**REGISTRY NUMBER** *(10 Digit)*:
COMPLETE MAILING ADDRESS:	**BIRTHDATE** (YYYY-MM-DD): _____ / _____ / _____ YYYY MM DD
EMAIL ADDRESS:	**TELEPHONE NUMBER** *(including area code)*:

CHOOSE A PAYMENT METHOD

__ Cheque Mail Out **(Ensure address is complete, including city and postal/zip code)**	___ Direct Deposit **(Canada Only)*** ___ On File ___ New Account **(Include void cheque or direct deposit form)**

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 my personal information with outside agencies. ___ (MCFN MEMBERS PLEASE INITIAL HERE)

X ***Signature*** ***Date:***	**Total Receipts:** **Amount: $ 1,500.00**

---------- **DO NOT WRITE BELOW THIS LINE. FOR OFFICE USE ONLY** ----------

Documents provided for identity: Department's Initials_____

__ CIS/SCIS __ DL __ HC __ BC __ Prov. Photo ID Card __ Passport __ Other ID (_____)

__ Proof of POA/Decision-Making Authority

Amount Claimed:		Remaining Balance:	
1500	00	0	00

Account Number:	64 300
Dept. Number:	100 030
Cheque Number:	
Cheque Date:	

Date Received _____ Department Signature: _____