Ditidaht
FIRST NATIONS

NITINAHT WEEKLY

March 27th ,2019 – April 03rd 2019

Ditidaht First Nation

Public Works Department
PO Box 340, Port Alberni, BC V9Y 7M8 Ph: (250) 745-3333 Fx: (250) 745-3332

On Monday April 1 from 9am to 4pm a detour will be in effect, while emergency road repairs to a failing wooden boxed culvert takes place.

The detour route will add 6-8 minutes to the trip as you go up and around and come in on what was known as the old dump road.

* Including up to December 31, 1991 *

LEGAL NOTICE

Sixties Scoop Survivor?

You may be eligible for compensation. Please read this notice carefully.

A settlement has been approved between the Federal Government of Canada and certain survivors of the Sixties Scoop that provides compensation for loss of cultural identity for certain survivors.

WHO IS INCLUDED?

The settlement includes people who:

- are registered Indians (as defined in the *Indian Act*) and Inuit *as well as people eligible* to be registered Indians; and
- were removed from their homes in Canada between January 1, 1951 and December 31, 1991 and placed in the care of non-Indigenous foster or adoptive parents.

Those who meet the criteria above will be included in the settlement as "Class Members". All Class Members, except those who validly opt out, are eligible for compensation.

In addition, all Class Members, except those who validly opt out, will be held to the terms of the settlement and covered by the releases in the settlement.

WHAT DOES THE SETTLEMENT PROVIDE?

(a) compensation will be available for all Class Members who were adopted or made permanent wards and who were alive on February 20, 2009; and

(b) a foundation will be created to enable change and reconciliation. The mandate and governance of the foundation will be defined through a consultation process with survivors across the country. The work of the foundation may include providing access to healing/wellness, commemoration and education activities for all communities and individuals impacted by the Sixties Scoop – including those outside of the defined "Class."

HOW DO I GET THIS MONEY?

To make a claim for money, you must fill in a Claim Form and send it to the claims office by **August 30, 2019**. Copies of the Claim Form are available at sixtiesscoopsettlement.info.

You do not need to pay a lawyer to complete the form. The administrator will help you fill out the form and there are lawyers you can speak with free of charge.

Also, if you do not have papers from the relevant provincial or territorial child service agency documenting your placement in care or documenting your status, you should still complete the Claim Form. The administrator will make the necessary record checks for you as needed.

HOW MUCH MONEY WILL I GET?

Your payment will depend on how many Eligible Class Members submit claims in the settlement. The range of compensation will likely be $25,000 - $50,000.

The details are explained in the settlement agreement. A copy of the settlement agreement is available at sixtiesscoopsettlement.info.

WHAT IF I WANT TO EXCLUDE MYSELF FROM THE SETTLEMENT?

If you want to exclude yourself from the settlement, you must opt out of the class action by October 31, 2018.

If you opt out, you will not be entitled to any compensation from the settlement and your claim against Canada in respect of the Sixties Scoop will not be released. A copy of the Opt Out Form is available at sixtiesscoopsettlement.info.

If you have commenced a legal proceeding against Canada relating to the Sixties Scoop and you do not discontinue it on or before October 31, 2018, you will be deemed to have opted out of the settlement.

Important Note: The settlement does not interfere with any Class Member's ability to pursue legal proceedings against provinces or territories or their agencies for physical, sexual, or psychological abuse suffered as a result of the Sixties Scoop.

WANT MORE INFORMATION?

Visit sixtiesscoopsettlement.info, call 1-(844)-287-4270, or email sixtiesscoop@collectiva.ca.

DO YOU KNOW ANY OTHER SURVIVORS OF THE SIXTIES SCOOP?

Please share this information with them.

First Nations Health Authority
Health through wellness

540 - 757 West Hastings Street
Vancouver, BC
Canada V6C 1A1

T 1.800.317.7878
F 1.888.299.9222
www.fnha.ca

Dear Client:

The First Nations Health Authority (FNHA), Health Benefits has designed this check list in order to process your medical transportation travel and/or reimbursement request in a timely manner. Correct completion of the required forms and associated documentation is crucial to ensure that your travel request and/or reimbursement is processed quickly and efficiently.

Request for Medical Transportation Form

This form must be filled out and submitted to our office at least **five (5) days prior to your appointment** to ensure sufficient time for our office to make your travel arrangements.

The following documentation must also be submitted along with the Medical Transportation request form:

a. Documentation from a doctor's office confirming your upcoming appointment complete with the date and time

b. Copy of the physician's referral including the office address, date, time, and reason for the appointment (if applicable) – FNHA, Health Benefits funds travel to the nearest appropriate health professional and/or health facility. Depending on the nature of your appointment, medical justification may need to be provided to support your travel request.

Physician Escort Request Form

If you require an escort, this form must be completed **by the physician** indicating the medical/legal reason for an escort. The physician should also include a brief description of why and/or how an escort would be assisting you.

Confirmation of Attendance Form

After your appointment is complete, this form must be **stamped by the physician** and/or **signed by the physician** where you attended your appointment confirming your attendance. Please ensure that the date and time of your appointment have also been included on the form. If the section regarding pending appointments is completed by the same doctor, this will eliminate the need to obtain another confirmation of appointment.

First Nations Health Authority
Health through wellness

Reimbursements

In order to process your reimbursement the following required documentation must be sent to our office:

1. Request for Medical Transportation Form (please clearly indicate what you are requesting for reimbursement)
2. Confirmation of Attendance including date and time (signed/stamped by medical professional)
3. Copy of Physician's Referral (if applicable)
4. Physician Escort Request Form (if applicable)
5. Original receipts complete with all travel information (if applicable)

Notes about receipts:

- We do not accept faxed copies or photocopies of receipts
- We do not accept receipts that have been altered without confirmation from the provider
- We do not require gas and/or meal receipts as those totals are calculated in office based on regional mileage and meal allowance rates

FNHA policy states that all invoices submitted for payment for the reimbursement of expenses for medical transportation benefits must be submitted within one (1) year of the service being provided. Requests for reimbursements submitted more than one (1) year after the service is rendered will be rejected.

It is recommended that you make photocopies of all documentation submitted to our office for your reference.

We hope that you find this information helpful. If you have any questions please feel free to contact our office at 1-800-317-7878, press#1 and then #1 again for Patient Travel.

Yours Truly,

Health Benefits
Patient Travel
First Nations Health Authority

First Nations Health Authority
Health through wellness

CONFIRMATION OF APPOINTMENT FORM

PERSONAL AND CONFIDENTIAL

To be completed by Health Professional or Health Facility and fax to 1-250-745-3741

The First Nations Health Authority, Health Benefits, provides Medical Transportation Benefits to assist First Nations clients, who are residents of BC, to access medically, required health services that cannot be obtained on the reserve or in the community of residence.

One criteria of the Medical Transportation Program is that the client **must** provide written confirmation of appointment from the health provider in order to have future medical travel arranged. We appreciate and thank you for your cooperation.

Please confirm that the following patient has an appointment at your office:

Patient Name:	Date of Birth:
Date of Appointment:	Time of Appointment:

Physician's Professional Address Stamp:

STAMP HERE

Physician Name: (please print clearly):

Physician Signature:

_____

This form must be **stamped with the physician's address** or **signed by the physician** confirming your appointment. Please ensure that the date and time of the appointment has also been included on the form. If the section regarding pending appointments is completed by the same doctor, this will eliminate the need to obtain another confirmation of appointment.

PENDING APPOINTMENT (if known)

Date of appointment: _____ Time: _____

Internal Office Use Only

Case #: _____ TA #: _____

Ditidaht Community Services

P.O. Box 340 Port Alberni, B.C. V9Y-7M8 PH: 745-3331 FAX: 745-3741

HEALTH BENEFITS MEDICAL TRANSPORTATION REQUEST FORM

Part 1 – Client Information

Surname:		First and Middle Names:
Status Number: BC Health Care Card Number:		Date of Birth: / / YY/ MM/ DD):
Address:		Telephone Number#:
City:	Province/Territory:	Postal Code:

Part 2 – Escort Information

Escort Required	YES ____	NO ____	Status Number (if applicable)
Escort Name:			Date of Birth: : / / (YYYY/MM/DD)

Part 3 – Health Practitioner / Health Facility Information

Name:	Telephone Number:
Address:	City/ Province/Territory:
Specialty:	Appointment Date(s) and Time(s):

Part 4 – Travel Information / Mode of Transportation

Date of Departure:				Return Date:
Transported From:				Transported To:
Transportation Type:	☐ Plane	☐ Bus	☐ Boat	☐ Wheels for Wellness
	☐ Taxi	☐ Private Vehicle: _____ x $0.23/KILOMETRE = $_____		

Part 5 – Accommodation

Accommodation Type:	☐ Commercial ☐ Private	
Accommodation Check – In Date:		Accommodation Check – Out Date:
Indicate if two (2) Beds Required: YES or NO		Wheelchair accessible Room Required: YES or NO
Total Amount of Meals Requested:		

Part 6 – Authorization and Signature

I authorize the release of any records that are relevant to the processing and payment of all claims held by the service provider to First Nations Health Authority, it's agents or contractors, or any appropriate Health Professional licensing or Regulatory Body for the purpose of administrative audit. I declare the information to be true and accurate and do not contain a claim for any benefit or service previously paid for by First Nation Health Authority; Health Canada; or by any other plan(s)/program(s) that is noted in the statement or explanation of benefits.

Client, Parent, Guardian or Person having a legally recognized authority **Date:** / / (YYYY/MM/DD)

Print Name: **Signature:**

Please complete this form and attach a copy of the referral letter (if applicable), including the specialist's information, confirmation of appointment, Physician Escort Form (if applicable).

Note: Original Receipts for Hospital Parking, Tolls, Ferry, Air, Bus, Taxi, and Hotel MUST be mailed to our office indicating to whom it should be payable to with the referral and confirmation of appointment.