

**Champagne and Aishihik First Nations
Education Policies and Procedures
Appendix B –School Supplies Supplementary Funding Application Form**

Primary Care Provider (this is who the check will be issued to):

Name: _____ Email address: _____

Address of child(ren) main residence _____

Telephone: _____ (Cell) _____ (Work)

Other Parent or Caregiver Information:

Name: _____ Email address: _____

Address: _____

Telephone: _____ (Cell) _____ (Work)

Name of Child or Children	Birthdate: Day/Month/Year	CAFN Enrolled Citizen * (Beneficiary)	Non- enrolled Citizen ** (Non- beneficiary)	Grade in Sept.	School Name and Location in Canada

Do all parents/caregivers agree to this request? Yes No

By signing, I acknowledge that I am the Primary Care Provider.

Primary Care Provider Signature: _____ **Date:** _____

PLEASE NOTE* Checks are mailed from the finance department so please ensure the correct mailing address is on this form. If you do not receive your check within 2-4 weeks please contact your Education Support Worker.

*CAFN Enrolled Citizen – is eligible to be enrolled in accordance to the CAFN Final Agreement – Chapter 3; and Section 5.1 (a) and 5.1(b) of the CAFN *Aghaalan* Enrollment Act. Enrolled citizens are considered beneficiaries.

**Non-Enrolled Citizen – a CAFN citizen who is not entitled to be enrolled under the CAFN Final Agreement – Chapter 3; but they have Indian Status with CAFN. Non-enrolled citizens are considered non-beneficiaries.

For Office Use Only

Date Received: _____

Approved: YES NO

Check Run #: _____

Reason: _____

Amount
Approved: _____

