



Heskw'en'scutxe Health Services Society

Mental Health A&D Support

Confidential

Date of Request:

Requested By:
HHSS Staff:

Date of Scheduled Appointment	Time	Address / Destination	Depart from
			CF / SB

Client Name:	Appointment Type:	<input type="radio"/> Family Meeting w/ Ministry <input type="radio"/> Court Appearance <input type="radio"/> After Care / Other
--------------	-------------------	--

Reason for Appointment:	
-------------------------	--

Agency and Contact:	Phone:	
---------------------	--------	--

Special Instructions:	
-----------------------	--

Support Requested	<input type="radio"/> Mileage requested, (.23 per km X _____ km X 2) Total: \$ _____ <input type="radio"/> Meal requested, select one: <input type="radio"/> Client + Escort \$48; <input type="radio"/> Client or Escort only \$24; <input type="radio"/> Other:	
<input type="radio"/> Make payment to the Escort	Total: \$	Escort Name:

A signature is required by the facilitator to verify the appointment was attended.

I, _____ by signing below, verify that the client listed above attended the meeting at the date and time recorded.

Facilitator's Signature: _____ Date: _____

Notes: Please record the date, times and necessary details. **Attach documentation for appointment receipts/reports if applicable.**

Verification completed by: _____

Client's Signature: _____

I give consent to Heskw'en'scutxe Health Services' health worker to contact the identified agency to verify my appointment for approval. And understand that I am committed to attending this appointment, that support given is contingent on participation and that if I fail to make this appointment, will be required to return the amount awarded. Failing to meet this commitment can result in denial of future requests.

Manager's Approval: _____
Date: _____