UBCP/ACTRA

SCHEDULE "A"
APPLICATION
MEMBER ADDICTION MEMORIAL FUND

MEMBER INFORMATION

Name: _____

UBCP/ACTRA #: _____

Address: _____

_____

_____

Phone #: _____

Email: _____

REQUEST

I am requesting support in the amount of $_____ and I confirm that:

I am currently attending or will be attending, _____, a licensed
(Name of Facility)

and/or accredited substance use treatment facility. _____
(Initial)

I have included confirmation of my attendance from the treatment facility. _____
(Initial)

I have included confirmation from the treatment facility of the cost of treatment, payments made and the remaining balance owing. _____
(Initial)

FOR OFFICE USE ONLY

APPROVED BY: _____

AMOUNT: _____

DATE: _____