

# REQUEST FOR FINANCIAL ASSISTANCE



**Société  
canadienne  
du cancer**      **Canadian  
Cancer  
Society**

Q U E B E C   D I V I S I O N

DATE \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**PLEASE RETURN THIS FORM TO:**  
**CANADIAN CANCER SOCIETY**  
 5151, de l'Assomption Blvd.  
 Montreal (Quebec) H1T 4A9  
 Telephone: 514 255-5151, ext. 6004

PATIENT	
NAME (AT BIRTH)	ADDRESS <span style="float: right;">APARTMENT</span>
GIVEN NAME	BIRTH DATE
CITY	POSTAL CODE
<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> COMMON LAW	TELEPHONE (    )
NAME OF SPOUSE OR RESPONDENT	AGE OF DEPENDANTS
NUMBER OF DEPENDANTS	

HEALTH STATUS	
DIAGNOSIS	TYPE OF TREATMENT
HOSPITAL	CHEMOTHERAPY <input type="checkbox"/>
	RADIOTHERAPY <input type="checkbox"/>
NAME OF ATTENDING PHYSICIAN (BLOCK LETTERS PLEASE)	SURGERY <input type="checkbox"/>
	OTHER (SPECIFY) <input type="checkbox"/>
SIGNATURE OF ATTENDING PHYSICIAN	
X	

FINANCIAL STATUS	
SOCIAL ASSISTANCE    YES <input type="checkbox"/> NO <input type="checkbox"/>	

ASSISTANCE FOR: TRAVEL ALLOWANCE	REHABILITATION
<input type="checkbox"/> TRAVEL ALLOWANCE	<input type="checkbox"/> CAPILLARY PROSTHESIS *
DISTANCE IN KILOMETERS FOR ONE ROUND-TRIP <input style="width: 50px;" type="text"/>	<input type="checkbox"/> BAGS FOR TEMPORARY COLOSTOMY *
	<input type="checkbox"/> DISPOSABLE UNDERWEAR (MAXIMUM: \$500 / YEAR)*
TRANSPORTATION MEANS: (Check one case or more)	
PERSONAL VEHICLE <input type="checkbox"/>	<input type="checkbox"/> ADAPTED BRA * (MAXIMUM: 2 / YEAR)
VOLUNTEER ACTIVITY CENTRE * <input type="checkbox"/>	<input type="checkbox"/> SUPPORT HOSE * (MAXIMUM: 4 / YEAR)
PRIVATE TRANSPORTATION COMPANY * <input type="checkbox"/>	<input type="checkbox"/> ELASTIC GLOVE OR SLEEVE * (MAXIMUM: 4 / YEAR)
TAXI * <input type="checkbox"/>	
TRAIN * <input type="checkbox"/>	<input type="checkbox"/> LYMPHEDEMA TREATMENTS * (MAXIMUM: \$500 / YEAR)
BUS * <input type="checkbox"/>	
PARKING * <input type="checkbox"/>	* ATTACH THE ORIGINAL INVOICE AND PRESCRIPTION
* ATTACH RECEIPTS	<b>OVER...</b>

## ADMISSIBILITY CRITERIA'S

The Canadian Cancer Society, a volunteer non-profit organization, KINDLY PROVIDES financial aid to LOW INCOME individuals who are touched by cancer. Beneficiaries of SOCIAL ASSISTANCE program (now called financial aid of last recourse or financial aid - Youth Solidarity) are not eligible to travel allowance, because a similar aid program is available to them.

### What are the admissibility criteria's?

One person (alone) whose gross annual income is less than: 22,171\$.  
A family unit\* of 2 people whose gross annual income is less than: 27,601\$.  
A family unit\* of 3 people whose gross annual income is less than: 33,933\$.  
A family unit\* of 4 people whose gross annual income is less than: 41,198\$.  
A family unit\* of 5 people whose gross annual income is less than: 46,727\$.  
A family unit\* of 6 people whose gross annual income is less than: 52,699\$.

**\* FAMILY UNIT: Is considered part of the family unit any individual who permanently resides at the same street address as the cancer patient.**

## IMPORTANT

1-THE PATIENT IS ASKED TO ATTACH A HOSPITAL ATTESTATION SPECIFYING THE DATE AND TYPE OF TREATMENT FOR EACH VISIT.

2-SO THAT YOUR REQUEST CAN BE HANDLED AS QUICKLY AS POSSIBLE, PLEASE ATTACH A PHOTOCOPY OF THE LAST INCOME TAX REPORT OF YOUR FAMILY UNIT AS WELL AS A PROOF OF THE CURRENT INCOME IF APPROPRIATE, TO THIS DOCUMENT.

3-CLAIMS MAY BE MADE FOR RETROACTIVE EXPENSES (UP TO 6 MONTHS) AS WELL AS FOR UPCOMING TREATMENTS.

4-THIS FORM MUST BE SIGNED BY THE TREATING PHYSICIAN AS WELL AS THAT OF THE APPLICANT.

## SIGNATURE OF APPLICANT

X

## FOR OFFICE USE

COMMENTS

APPROVAL