TRAVEL TREATMENT FUND APPLICATION FORM
(British Columbia & Yukon)

PATIENT INFORMATION (This section must be completed by the APPLICANT)		
☐ Female ☐ Male	Application date (MM/DD/YY):	
Last name	Address	Apartment
First name	City	
Date of birth (MM/DD/YY)	Province	Postal code
Phone ( )	Email (**mandatory**)	
☐ Married ☐ Common-law partner ☐ Widow(er) ☐ Divorced ☐ Separated ☐ Single		
Number of people in the family unit (including the applicant):	Number of people under 18 years old:	
Name of spouse ☐ or caregiver ☐:	Phone of spouse or caregiver: ( )	

PATIENT HEALTH INFORMATION (This section must be completed by the HEALTH CARE PROFESSIONAL)	
Cancer diagnosis (mandatory):	☐ Financial support drug program (symptom management drugs)
☐ 10 appointments or more for **the current year** ☐ less than 10 appointments (more than 200 km) ☐ Chemotherapy ☐ Radiotherapy ☐ Surgery ☐ Other treatment or diagnostic tests (specify):	BC personal health number (care card): Fair PharmaCare Registration Number* (e.g. A12345678):
Name(s) of hospital/clinic providing treatment):	Start date of treatment (MM/DD/YY)
Name of health care professional (in block letters):	Health care professional's title:
Health care professional's **signature** (doctor, nurse or social worker only) X I hereby certify that the applicant's situation is as indicated above	Phone: E-mail:

*To register for Fair PharmaCare, or if you are registered but do not know your number, you can contact Health Insurance BC: From the Lower Mainland, call 604 683-7151 and from the rest of BC, call toll-free 1 800 663-7100. Register online at: https://pharmacare.moh.hnet.bc.ca

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ELIGIBILITY CRITERIA

To be eligible to this financial assistance program, you must be undergoing active cancer treatment and **meet the following low-income criteria**. You also need to have at least 10 appointments during the year for your treatments or live more than 200 km away from your treatment centre. Beneficiaries of **Income Assistance, First Nations or Veteran Affairs** programs are not eligible for this program since other financial assistance programs are available. Only one travel allowance is granted per year.

Please check the box that corresponds to your current FAMILY UNIT FINANCIAL SITUATION.

Family unit includes any person in the family who resides permanently in the same household as the person living with cancer.

- My family unit consists of one (1) person whose gross annual income is less than $25,920. ☐
- My family unit consists of two (2) people whose gross annual income is less than $32,270. ☐
- My family unit consists of three (3) people whose gross annual income is less than $39,672. ☐
- My family unit consists of four (4) people whose gross annual income is less than $48,166. ☐
- My family unit consists of five (5) people whose gross annual income is less than $54,630. ☐
- My family unit consists of six (6) people whose gross annual income is less than $61,612. ☐
- My family unit consists of seven (7) or more people whose gross annual income is less than $68,598. ☐

I am a beneficiary of Income Assistance, First Nations or Veteran Affairs programs. ☐

DOCUMENTS REQUIRED TO COMPLETE YOUR APPLICATION

- ☐ This **application form** with all information completed and your signature below
- ☐ The most recent **Notice of Assessment** from the Canada Revenue Agency for all members of the family unit over 18 years old (line 150). (Canada Revenue Agency phone number: 1 800 959-8281)
- ☐ IMPORTANT: If your financial situation (or that of your spouse) has changed during the year, you must also send a proof of your current family unit income (record of Employment Insurance, bank statements for the past 3 months or any official document that will help us see your current income level).
- ☐ The **Direct Deposit Enrolment Form** with your **signature** and a **void cheque**

  Note that the payment of this allowance will be made by **DIRECT DEPOSIT ONLY** for an indefinite period.

APPLICANT'S SIGNATURE

I consent that the information I provide for the Travel Treatment Fund and Financial Support Drug Program application will be used to register me as a client, communicate with me about my application and the program. The CCS collects your medical and financial information only to confirm your eligibility for the program, for statistical purpose and keeps it in secured location.

Applicant's signature:

x

Please note that, for an indefinite period, we will not be able to process requests received by mail.

PLEASE RETURN THIS FORM BY FAX OR E-MAIL TO:

Travel Treatment Fund / Canadian Cancer Society
Phone: 1 888 939-3333 / Fax: 1 888 675-6507
Email: traveltreatmentfund@cancer.ca

Canadian Cancer Society	DIRECT DEPOSIT ENROLMENT FORM

In the context of the spread of the coronavirus (COVID-19) and in order to limit contact with people at higher risk (such as the clientele we serve), the Canadian Cancer Society will no longer issue checks for payment of financial assistance for transportation.

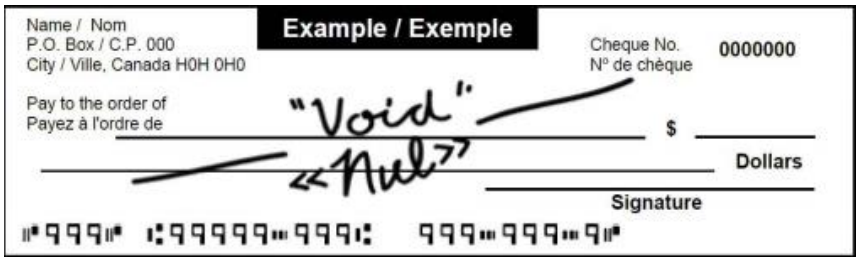
Without a valid signed Direct Deposit Consent Form and a void cheque, you will be unable to receive a payment.

Identification information

First name		Last name
Address		
City	Province	Postal code

Banking information

Please attach a “void” cheque to this form (see example below). The cheque must be associated with the Canadian bank account where your payment will be deposited. Only a void cheque (or a statement from your bank) will be accepted for a direct deposit.



Consent

By signing below, I authorize the Canadian Cancer Society (CCS) to deposit any payment directly into the above-mentioned account and agree to promptly notify the CCS of any change in the banking information herein provided.

Applicant’s signature	Date