



**TRAVEL TREATMENT FUND &  
EXCEPTIONAL ASSISTANCE APPLICATION FORM**  
(New Brunswick)

<b>PATIENT INFORMATION</b> (This section must be completed by the <b>APPLICANT</b> )		
<input type="checkbox"/> Female <input type="checkbox"/> Male	Application date (MM/DD/YY):	
Last name	Address	Apartment
First name	City	
Date of birth (MM/DD/YY)	Province	Postal code
Phone (        )	Email ( <b>mandatory</b> )	
<input type="checkbox"/> Married <input type="checkbox"/> Common-law partner <input type="checkbox"/> Widow(er) <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single		
Number of people in the family unit (including the applicant):	Name of spouse/partner <input type="checkbox"/> or caregiver <input type="checkbox"/> :	
Number of people under 18 years old:	Phone of spouse/partner <input type="checkbox"/> or caregiver <input type="checkbox"/> (        )	
<b>PATIENT HEALTH INFORMATION</b> (This section must be completed by the <b>HEALTH CARE PROFESSIONAL</b> )		
<b>** Please note that any missing information will cause delays **</b>		
Cancer diagnosis (mandatory):	Name(s) of hospital(s) / clinic(s) providing treatment:	
<input type="checkbox"/> 10 appointments or more for <b>the current year</b> <input type="checkbox"/> Less than 10 trips (more than 200 km) <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiotherapy <input type="checkbox"/> Surgery <input type="checkbox"/> Other treatment or diagnostic tests (specify):	Treatment starting date (MM/DD/YY) :  Please check here if you are applying for Exceptional Assistance Fund (and see page 4 for details) <input type="checkbox"/> Exceptional Assistance (Other rehabilitation needs / material or special needs). Please specify:	
Name of health care professional (in block letters):	Health care professional's title:	
Health care professional's <b>signature</b> (doctor, nurse or social worker only)	Phone:	
X I hereby certify that the applicant's situation is as indicated	E-mail:	



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**ELIGIBILITY CRITERIA**

To be eligible for this 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** related to your treatments OR live **more than 200 km away from your treatment centre**. Beneficiaries of the social assistance program are not eligible for this program. Only one travel allowance is granted per year.

**NOTE:** if your family unit revenue exceeds the following levels, you may be eligible to our Exceptional Assistance Fund. Please see page 4 for more details.

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

A family unit includes any person in the family who resides permanently at the same address as the person 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 the social assistance program.

**DOCUMENTS REQUIRED TO COMPLETE YOUR APPLICATION**

- This **application form** with **all boxes completed** and your **signature** below
- The most recent **NOTICE OF ASSESSMENT** from the Canada Revenue Agency for **all family members residing in household over 18 years old**.
- The Direct Deposit Enrolment Form with your **signature** and a **void cheque**  
The payment of this allowance will be made by **DIRECT DEPOSIT ONLY** for an indefinite period.
- IMPORTANT:** If your financial situation (or your partner's) has changed during the year, you must also send 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).

**APPLICANT'S SIGNATURE**

I consent that the information I provide for the Travel Treatment Fund Program will be used to register me as a client and to communicate with me about my application. 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: 514 255-2808

Email: [financialassistance@cancer.ca](mailto:financialassistance@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.

Name / Nom P.O. Box / C.P. 000 City / Ville, Canada H0H 0H0	<b>Example / Exemple</b>	Cheque No. N° de chèque	0000000
Pay to the order of Payez à l'ordre de	<i>"Void"</i>		\$ _____
	<i>&lt;&lt;Null&gt;&gt;</i>		_____ Dollars
	Signature		
⑈ 9999 ⑈ 1:999999 9999: 999 999 9⑈			

### 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



Canadian  
Cancer  
Society

EXCEPTIONAL ASSISTANCE  
(New Brunswick)

**EXCEPTIONAL ASSISTANCE**

The Exceptional Assistance Fund offers the two types of financial assistance to New Brunswick patients that exceeds the low income level by up to 10 000 \$. This form and all other requirements must also be met to be eligible to the Exceptional Fund.

**Travel to treatment allocation:** to help cover the costs associated with travel to the treatment centers.

**Special needs allocation:** to help cover the costs of any rehabilitation material, equipment or other special needs in relation to the cancer such as breast prosthesis, compression sleeve and glove, dental work, bras, podiatry services, etc.

This special need needs to be certified by the health care professional on page 1 of this form.

A **copy of a receipt** from the patient or an **estimate of the cost** of the special needs will also be required from the patient.

This form should also be completed with all required documents.