REQUEST FOR FINANCIAL ASSISTANCE

Société canadienne du cancer
Canadian Cancer Society
QUEBEC DIVISION

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 APARTMENT
GIVEN NAME BIRTH DATE	CITY
☐ MARRIED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ COMMON LAW	POSTAL CODE
NAME OF SPOUSE OR RESPONDENT	TELEPHONE ( )
NUMBER OF DEPENDANTS	AGE OF DEPENDANTS

HEALTH STATUS

DIAGNOSIS	TYPE OF TREATMENT
HOSPITAL	CHEMOTHERAPY ☐
	RADIOTHERAPY ☐
NAME OF ATTENDING PHYSICIAN (BLOCK LETTERS PLEASE)	SURGERY ☐
	OTHER (SPECIFY) ☐
SIGNATURE OF ATTENDING PHYSICIAN X	

FINANCIAL STATUS

SOCIAL ASSISTANCE YES ☐ NO ☐	

ASSISTANCE FOR: TRAVEL ALLOWANCE / REHABILITATION

TRAVEL ALLOWANCE	REHABILITATION
☐ TRAVEL ALLOWANCE	
DISTANCE IN KILOMETERS FOR ONE ROUND-TRIP ☐	☐ MATERIAL FOR TEMPORARY COLOSTOMY *
	☐ DISPOSABLE UNDERWEAR (MAXIMUM: $500 / YEAR)*
TRANSPORTATION MEANS: (Check one case or more)	
PERSONAL VEHICLE ☐	☐ ADAPTED BRA * (MAXIMUM: 2 / YEAR)
VOLUNTEER ACTIVITY CENTRE * ☐	☐ SUPPORT HOSE * (MAXIMUM: 4 / YEAR)
PRIVATE TRANSPORTATION COMPANY * ☐	☐ ELASTIC GLOVE OR SLEEVE * (MAXIMUM: 4 / YEAR)
TAXI * ☐	
TRAIN * ☐	☐ LYMPHEDEMA TREATMENTS * (MAXIMUM: $500 / YEAR)
BUS * ☐	
PARKING * ☐	* ATTACH THE ORIGINAL INVOICE AND PRESCRIPTION
* ATTACH RECEIPTS	**OVER...**

ADMISSIBILITY CRITERIA'S

The Canadian Cancer Society, a volonteer 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: 23,298$.
A family unit* of 2 people whose gross annual income is less than: 29,004$.
A family unit* of 3 people whose gross annual income is less than: 35,657$.
A family unit* of 4 people whose gross annual income is less than: 43,292$.
A family unit* of 5 people whose gross annual income is less than: 49,102$.
A family unit* of 6 people whose gross annual income is less than: 55,378$.
A family unit* of 7 people or more whose gross annual income is less than: 61,656$.

*** 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 QUEBEC 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. NOTE THAT NO OTHER SIGNATURE WILL BE ACCEPTED BUT THE ONES MENTIONED ABOVE.

SIGNATURE OF APPLICANT

X

FOR OFFICE USE

COMMENTS

APPROVAL