CURE FOUNDATION FINANCIAL ASSISTANCE PROGRAM FOR BREAST CANCER PATIENTS

APPLICATION FORM

The CURE Foundation Financial Assistance Program was created to address the financial impact of a breast cancer diagnosis on the patient. The program offers grants of up to $2000 to applicants to provide some relief during a very challenging time in their life.

Eligibility Criteria

- The applicant must be diagnosed with breast cancer (priority given to those in active treatment*) or 6 months post-treatment
- The applicant must be a Canadian citizen, approved landed immigrant or permanent resident
- Each application can be submitted for a maximum of $2000 (funds permitting)
- Each applicant can submit one application per year, with a lifetime maximum of $4000 to be allocated in total.
- The application must be signed by either your social worker, nurse, oncologist

*Active treatment: For the purse of this application, this refers to surgery, chemotherapy and radiation

Required Documents

- A copy of Notice of Assessment for the last fiscal year (page with detailed calculations)
- A copy of the spouse's Notice of Assessment (if applicable) for the last fiscal year (page with detailed calculations)
- Only if you are on sick leave: Proof that you had employment income in the year prior to your breast cancer diagnosis (e.g. your last pay stub, recent proof of salary or disability insurance or employment insurance)
- A letter written by the applicant explaining his or her situation and need for financial assistance, amount requested and what the funds will be used for (maximum one page)

If needed, we may ask for other documents.

CURE
BREAST CANCER
CANCER DU SEIN

Financial Assistance Application Form

Personal Information		
First Name		Last Name
Date of Birth (DD/MM/YY)		Email
Phone (Home)		Phone (Cell)
Address		Apartment
City	Province	Postal code

Marital status

- ☐ Married
- ☐ Common law
- ☐ Widow
- ☐ Single
- ☐ Divorced/separated

Number of dependents under the age of 18

What are your current sources of income?

- ☐ Employment income
- ☐ Salary insurance/employment insurance/disability insurance
- ☐ Retirement income
- ☐ Welfare
- ☐ Other (please specify)

Medical Information This section must be completed by your health care professional (e.g. doctor, nurse, social worker)		
Date of Breast Cancer Diagnosis (MM/YY)		If this is a recurrence, please indicate date of recurrence (MM/YY)
☐ Stage 0 ☐ Stage 1 ☐ Stage 2 ☐ Stage 3 ☐ Metastatic ☐ Unknown		Last treatment received ☐ Mastectomy ☐ Chemotherapy/Immunotherapy ☐ Radiation therapy ☐ Ongoing ☐ Other
Start date of treatment (DD/MM/YY)		End date of treatment (if applicable) (DD/MM/YY)
Last day of work due to diagnosis (DD/MM/YY): (if applicable)		Expected return to work date (DD/MM/YY): Mandatory if applicable
Name of Health Care Professional		Title
Hospital Centre	Phone	Email
Health Care Professional's Signature (attesting the accuracy of the information indicated above)		Date (DD/MM/YY)

I certify that the above information is accurate and complete. The anonymized data will be used for statistics. For verification purposes, I authorize the CURE Foundation to discuss my file with the members of my medical team. I understand that the CURE Foundation reserves the right to refuse any request for any reason that it deems reasonable, that the amount paid must respect the limits of the budget allocated annually for this program and that the amounts granted and eligibility criteria are subject to change without notice.

Signature	Date

Please send your application (with all required documents) by mail or email:
CURE Foundation – Financial Assistance Program
1320 Graham Blvd., suite 130, Montreal, Quebec, H3P 3C8
Phone (toll free) 1-888-592-CURE/ infocure@curefoundation.com