



LRCP PATIENT ASSISTANCE PROGRAM – Application
(supported by the Massel-Cruickshank and Gene Goodreau Patient Assistance Funds)

The Patient Assistance Program is intended to help people who experience a financial hardship as a result of their cancer diagnosis and treatment. The Program helps people at all points in their journey including diagnosis, treatment, palliative care and survivorship.

FAMILY INFORMATION

Patient Name:		
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:		City:
Province:	Postal Code:	Daytime Telephone:
Referred By: <input type="checkbox"/> Healthcare Provider <input type="checkbox"/> Self <input type="checkbox"/> Other (Please Specify):		

HEALTH INFORMATION

Diagnosis:	Date of Diagnosis:
Current Treatment:	
Oncologist/Surgeon:	Hospital/Facility:
LRCP Social Worker (if applicable):	

REQUEST FOR FUNDING (Explanation of need and anticipated costs.)

	ANTICIPATED COST	VENDOR CONTACTED		VENDOR NAME/ CONTACT INFORMATION
		YES	NO	
<input type="checkbox"/> Childcare during treatment	\$	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Drugs (Trillium Drug Program assists Ontario residents with high prescription drug costs, in relation to their household income.) TELEPHONE: 1-800-575-5386 TRILLIUM WEBSITE: http://www.health.gov.on.ca		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Equipment rentals		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Lymphedema supplies (e.g., compression sleeves) Assessed by Lymphedema Clinic <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mastectomy bras (maximum of two)		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mastectomy swimsuits (for therapeutic purposes)		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Nutrition beverages (e.g., Ensure, Boost, etc.)		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Prostheses (portion not covered by ADP)		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Respite care		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Transportation (when volunteer drivers are not available through the Canadian Cancer Society or other organizations). Pre-approval required.		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Parking. Pre-approval required.		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Wig (up to a maximum of \$600)		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other head coverings when a wig is not selected (up to a maximum of \$200.00)		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Thameswood Lodge Meal Plan		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other:		<input type="checkbox"/>	<input type="checkbox"/>	

Do you have extended health benefits to cover some of these expenses related to your treatment? YES NO
(e.g., wigs, Personal Support Worker etc.)

Do you have a private drug plan? YES NO

Are you receiving services from the Community Care Access Centre? YES NO

Are you seeking: Reimbursement (attach original receipts) or Direct payment to vendor

How has the diagnosis and/or treatment of your cancer impacted your ability to pay for these expenses?

OTHER SOURCES OF FUNDING RECEIVING OR APPLIED (If YES, for what expenses)

Trillium Drug Program YES NO

Assistive Devices Program (ADP) YES NO

Kelly Shires Fund (Breast Cancer) YES NO

Other:

HOUSEHOLD INCOME

(A household is a single person or two or more people who are dependant on each other financially.)

Do you have dependents living in your home? (e.g., spouse, children) YES NO

If YES, please list the ages of the dependents: _____

Financial Benefits You are Receiving or Made Application To (please check all that apply):

	APPLICANT (PATIENT)		SPOUSE (PARTNER)	
	RECEIVING	APPLIED	RECEIVING	APPLIED
<input type="checkbox"/> Employed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ontario Works	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Employment Insurance - Sick Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ontario Disability Support Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Canada Pension Plan Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Short Term Disability Benefits from Employer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Long Term Disability from Employer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____ (e.g., critical illness insurance, retirement benefits)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The information provided in this application accurately reflects my current financial situation. I have experienced financial hardship as a result of being diagnosed with cancer and undergoing treatment.

APPLICANT'S NAME (PLEASE PRINT):

DATE:

APPLICANT'S SIGNATURE:

OFFICE USE ONLY

APPROVED BY:

DATE:

AMOUNT APPROVED:

COMMENTS: