London Health Sciences Centre
London Regional Cancer Program

Date of Application: _____

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: ☐ Male ☐ Female
Address:		City:
Province:	Postal Code:	Daytime Telephone:
Referred By: ☐ Healthcare Provider ☐ Self ☐ 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 YES	VENDOR CONTACTED NO	VENDOR NAME/ CONTACT INFORMATION
☐ Childcare during treatment	$	☐	☐	
☐ 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		☐	☐	
☐ Equipment rentals		☐	☐	
☐ Lymphedema supplies (e.g., compression sleeves) Assessed by Lymphedema Clinic ☐ YES ☐ NO		☐	☐	
☐ Mastectomy bras (maximum of two)		☐	☐	
☐ Mastectomy swimsuits (for therapeutic purposes)		☐	☐	
☐ Nutrition beverages (e.g., Ensure, Boost, etc.)		☐	☐	
☐ Prostheses (portion not covered by ADP)		☐	☐	
☐ Respite care		☐	☐	
☐ Transportation (when volunteer drivers are not available through the Canadian Cancer Society or other organizations). Pre-approval required.		☐	☐	
☐ Parking. Pre-approval required.		☐	☐	
☐ Wig (up to a maximum of $600)		☐	☐	
☐ Other head coverings when a wig is not selected (up to a maximum of $200.00)		☐	☐	
☐ Thameswood Lodge Meal Plan		☐	☐	
☐ Other:		☐	☐	

… over

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
☐ Employed	☐	☐	☐	☐
☐ Ontario Works	☐	☐	☐	☐
☐ Employment Insurance - Sick Benefits	☐	☐	☐	☐
☐ Ontario Disability Support Program	☐	☐	☐	☐
☐ Canada Pension Plan Disability	☐	☐	☐	☐
☐ Short Term Disability Benefits from Employer	☐	☐	☐	☐
☐ Long Term Disability from Employer	☐	☐	☐	☐
☐ Other _____ (e.g., critical illness insurance, retirement benefits)	☐	☐	☐	☐

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:

Incomplete information will result in delays processing your application.