CURE FOUNDATION FOR BREAST CANCER

CURE FOUNDATION FINANCIAL ASSISTANCE PROGRAM
FOR BREAST CANCER PATIENTS

Low-income breast cancer patients may qualify for a one-time grant to help ease the financial burden of their diagnosis. Grants are awarded based on specific eligibility criteria and the availability of funds.

More information

ELIGIBILITY CRITERIA

- The Applicant must be diagnosed with breast cancer.
  NOTE: Priority is given to those in active treatment (surgery, chemotherapy, immunotherapy, radiation) or 6 months post-treatment
- The applicant must be a Canadian citizen, permanent resident, or refugee
- **MANDATORY:** The application must be signed by either the patient's social worker, oncologist, nurse, or primary care physician.

REQUIRED DOCUMENTS

Checklist:

- O A copy of Notice of Assessment for the last fiscal year (**page with detailed calculations**)
- O A copy of spouse's Notice of Assessment (**if applicable**) for the last fiscal year(**page with detailed calculations**)
- O A copy of proof of birth for all dependents under 18 (if applicable).
- O **Only if on sick leave**: Proof of employment income in the year prior to breast cancer diagnosis; last pay stub, recent proof of salary, disability insurance or employment insurance.
- O Letter of intent written by the applicant explaining his or her situation in detail and the need for financial assistance. Please specify the financial impact your diagnosis has had on you (and your family if applicable) and identify precisely how these funds would be used to ease your financial burden. Kindly indicate the amount being requested CURE's Financial Assistance Form must be completed and signed by a health care professional, either the patient's social worker, nurse, oncologist, or primary care physician.
- O Applicant must disclose **ALL** sources of income, including a copy of Notice of Assessment for the last fiscal year **(all pages must be submitted)**

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ADDITIONAL INFORMATION

- Please send your completed application and all supporting documents by email to infocure@curefoundation.com OR
  By mail, 1320 Graham Boulevard, Suite 110 Montreal, QC H3P 3C8
  FAQ

POLICIES: Please read the application carefully. Failure to provide all documents required and/or signed will result in delay or being denied financial support.

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 Single Divorced/Separated Widowed

Number of dependents under the age of 18 _____
(Please submit a copy(ies) of proof of birth)

What are your current sources of income?

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

Have you received financial aid from CURE Foundation in the past?	***IF YES***, please indicate when: (DD/MM/YYYY)
O **YES** O **NO**	

The CURE Foundation relies on testimonials to continue its work. Would you be willing to share your story with us to help make a difference for other patients? ***This is not a requirement***

- O **YES**
- O **NO**

The CURE Foundation and its committee retains the right to deny all or a portion of any application. Policies are reviewed periodically and can be amended at any time.

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 the date of recurrence)** (MM/YY)
O Stage 0 O Stage 1 O Stage 2 O Stage 3 O Metastatic O Unknown	Most recent treatment: O Mastectomy O Chemotherapy/Immunotherapy O Radiation therapy O Ongoing O Other_____
Start date of treatment (DD/MM/YY)	End date of treatment (***if applicable)*** (DD/MM/YY)
Last day of work due to diagnosis: (***if applicable***) (DD/MM/YY)	Expected return to work date: (***mandatory, if applicable***) (DD/MM/YY)

MEDICAL INFORMATION Failure to complete this section will lead to delays in processing.		
Name of Health Care Professional		Title
Hospital Centre	Phone with extension XXX-XXX-XXXX Ext. XXXX	Email address
By signing, I authorize the CURE Foundation to contact me directly by phone or email to confirm the applicant's medical information. Confirmation of the applicant's medical status can also be sent directly to infocure@curefoundation.com.		
Health Care Professional's Signature (MANDATORY)		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.

Applicant's Signature (MANDATORY)	Date (DD/MM/YY)