



FINANCIAL AID FOR COLD CAPPING – APPLICATION FORM

Low-income breast cancer patients may be eligible for a one-time grant to help offset some of the costs of cold capping. Grants are awarded based on specific eligibility criteria and the availability of funds.

Kindly note that those applying for this grant are not eligible to apply to CURE's Financial Assistance Program.

Eligibility Criteria

- ☐ The applicant must be **recently** diagnosed with breast cancer.
- ☐ Must be **starting active chemotherapy**.
- ☐ The applicant must be a Canadian citizen, approved landed immigrant or permanent resident.
- ☐ The application must be signed by either the patient's social worker, nurse or oncologist.

Required Documents

- ☐ Completed application
- ☐ A copy of Notice of Assessment for the last fiscal year (all 4 pages)
- ☐ Letter of intent written by the applicant **It should:**
 1. Explain your desire to cold cap in detail.
 2. Address the financial impact your diagnosis has had on you (and your family, if applicable)
- ☐ If applicable:
 - o A copy of spouse's Notice of Assessment (if applicable) for the last fiscal year (all 4 pages)
 - o Copies of birth certificates for all dependants under the age of 18
 - 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.

Financial Assistance Program 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 Please submit Proof of Birth if applicable		
What are your current sources of income? ☐ Employment income ☐ Salary insurance/employment insurance/disability insurance ☐ Retirement income ☐ Welfare ☐ Other (please specify)		
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? ☐ YES ☐ NO		

Medical Information		
This section must be completed by your health care professional (e.g. doctor, nurse, social		
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		Do you recommend the use of cold caps for this patient? ☐ YES ☐ NO
Expected Start Date of Chemotherapy (DD/MM/YY)		Expected End Date of Chemotherapy (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
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 .		
Name of Health Care Professional		Title
Hospital Centre	Phone	Email
Health Care Professional's Signature		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 110, Montreal, QC
H3P 3C8
Toll-Free Telephone 1-888-592-CURE | infocure@curefoundation.com