Master Applications for Securing Financial Assistance

Date:_________________________(dd/mmm/yyyy)

Patient Information:

Full Legal Name: ____

Preferred Name: ____

Address: ____

____

____

Home Phone: __________________________ Cell Phone: ___________________________

Email: ____

Other: ____

____

I am a: ___ Canadian Citizen ___ Permanent Resident

I identify as: ___ First Nations [*status card number*]: _____________________________________

___Metis

___Inuit

Date of Birth (dd/mmm/yyyy): _____________________________

Gender:

PHN (Personal Health Number):

Family/Relationship Status:

___ Single ___Married ___Common Law

___Divorced ___Separated ___Widowed ___Other

Full Legal Name of Partner: ____

Do you have dependents living in your home? ___Yes ___No

If "Yes", what are their ages? ____

(*Please retain/attach proof of birth*)

What is the total number of people living in the household? ______________

What is/are the relationship(s) to the applicant: ________________________________

____

____

Employment Information:

Occupation and/or Title: ____

___Employed ___Self-Employed

Are you currently working? ___Yes ___No

If “No”, what was your last day worked due to your diagnosis? ___________________(dd/mmm/yyyy)

What is your expected RTW (Return to Work) date? ________________________(dd/mmm/yyyy)

If you are self-employed, please provide a copy of for T2125 and/or T5013 or an audited profit and loss statement.

If you are employed, who is your current employer? ____

____

Employer phone and contact information: ____

____

If you are on leave from work, please provide a copy of your ROE (Record of Employment).

Please attach your resume.

If you don’t have a resume, please add your work history for the past 5 years.

If applicable, is your partner/spouse currently working? ___Yes ___No

If your partner/spouse is not able to work, is it due to your diagnosis? ___Yes ___No

If your partner/spouse is not able to work, will they be able to return to work in the next 6 months?

___Yes ___No

Medical Information:

Date of Diagnosis: _____________________(dd/mmm/yyyy)

If this is a recurrence, please indicate the date of recurrence: _____________________(dd/mmm/yyyy)

Type of Cancer: ____

Stage of Cancer: ___Stage 1 ___Stage 2 ___Stage 3 ___Stage 4 ___Unknown

Surgery Dates (dd/mmm/yyyy): ____

Chemotherapy Start Date (dd/mmm/yyyy): ____

Chemotherapy End Date (dd/mmm/yyyy): ____

Radiation Start Date (dd/mmm/yyyy): ____

Radiation End Date (dd/mmm/yyyy): ____

Additional Treatments Required: ____

____

Assessing Doctor/Provider's Name: ____

Assessing Doctor/Provider's Title: ____

Assessing Doctor/Provider's Contact: ____

____

Hospital(s) Name(s): ____

____

Hospital(s) Contacts i.e. phone and/or email: ____

____

Family GP/NP or treating doctor: ____

Family GP/NP or treating doctor's contact information i.e. phone and address: ____________________

____

Please describe your medical condition/history: ____

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Please retain any supporting medical documents.

Assistance/Equipment Request:

In a few words, describe your current assistance/equipment needs: ______________________________

____

____

In a few words, what is/are the justifications for the equipment needed? _________________________

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If financial, what is the requested amount? ____

Equipment requested: ____

What is the amount requested per piece of equipment? ____

1st quote for equipment NEW: ____

2nd quote for equipment NEW: ____

1st quote for equipment USED: ____

Total amount requested for equipment: ____

How long will you require the equipment? ____

Additional notes: ____

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Please retain any supporting documents/cover letter here.

Signature of the Attending Medical Professional:

Oncologist, Social Worker, Primary Care Nurse, or Occupational Therapist

I have read and reviewed this complete application and to the best of my knowledge can confirm that this applicant is currently undergoing cancer treatment and is in need of financial assistance.

Please Print Name: ____

Please Print Occupation: ____

Attending Medical Professionals phone number: ______________________________________

Attending Medical Professionals email: ____

____

Signature

____

Date signed (dd/mmm/yyyy)

Description of Disability:

What is your diagnosed disability? ____

____

____

What was the date of your injury/diagnosis? ____

____

____

BC REHAB – *other funding sources:*

Have you exhausted all other funders before applying to BC REHAB? ___Yes ___No

Name of Funder	Phone Number	Asked Amount	Committed Amount

Do you have medical coverage/benefits? ___Yes ___No

If "Yes", what is the name of the provider? ____

What amount does your provider cover? _____________________________

What is the outstanding amount? ______________________________

Are you willing/able to contribute your own money toward this need? ___Yes No___

If you are willing/able to contribute your own money toward this need, how much? ________________

If you are not willing/able to contribute, please explain why: ___________________________________

____

____

Please retain any supporting documents here.

Medical Equipment Provision Program (MEPP) & Ministry of Social Development and Social Innovation (MSD):

Are you an IN/OUT patient at a rehabilitation hospital? ___Yes ___No

If "Yes", have you applied to the MEPP Program? ___Yes ___No

If you are on MSD and have been denied for the equipment, have you appealed? Please elaborate or explain why: ____

____

____

____

If you applied to the MSD for funding and were successful, but did not receive the full amount you requested, did you appeal for the full amount? Please elaborate or explain why: ___________________

____

____

____

If you are over the age of 65 and in need of equipment, have you applied to MSD for Life Threatening Needs? Please elaborate or explain why: ______________________________________

____

____

____

Have you received funding from BC REHAB in the past? ___Yes ___No

If "Yes", what was the amount allocated? _________________________________

Please retain any supporting documents here.