

APPLICATION FOR FINANCIAL SUPPORT FROM BCAF

NOTE: Applicants are expected to have had a diagnosis of breast cancer to which this request relates. Breast Cancer Action Kingston offers financial support to those individuals residing in or receiving their treatment within the South East LHIN:

NAME: _____

MAILING ADDRESS: _____

TELEPHONE: _____

Verified Diagnosis of Breast Cancer: Yes No Date of Diagnosis: _____

Do you and/or your spouse/partner have a benefit plan to assist with costs? Yes No

Company name: _____

Have you applied to other agencies to assist with costs? Yes No

If yes, please list agencies: _____

Amount(s) requested/received: _____

What is your current employment status?

On leave with benefits On leave without benefits Unemployed N/A

Gross Monthly Household Income: _____ Gross Monthly Expenses for Self/Family: _____

Number of dependents _____

Sources of Income: _____

Financial Cap: Up to \$1,000 per year including any items below. Total maximum allowance per person of \$2,000.

Prosthesis - \$150 every 2 years

Partial Prosthesis - \$50 every 2 years

Wigs - \$250 every 2 years

Bras (maximum 2) - 50% every 2 years

Please circle the requirements and attach any relevant documentation and/or proof of purchase receipts.

Applicant's requirement for funds: (**e.g.** medications, prostheses, wigs, food, accommodation).

Missing information may cause a delay in processing the application.

Referred by: _____ Telephone: _____

AMOUNT REQUESTED: _____ **DATE:** _____

(Applicant's Signature)

(Signature of Witness)

OFFICE USE ONLY

AMOUNT APPROVED: _____

DATE: _____

SIGNATURE: _____

PAYABLE TO: _____