

1- PERSONAL INFORMATION				
First Name		Last Name		
Date of Birth (DD/MM/YY)		Email (Read section 5 carefully)		
Phone (Home)		Phone (Cell)		
Address		Apartment		
City		Province Quebec		Postal code
<input type="checkbox"/> Married	<input type="checkbox"/> Common-law	<input type="checkbox"/> Widow(er)	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced/Separated
Number of dependants under the age of 18 :				
What are your current sources of income?				
<input type="checkbox"/> Employment income		<input type="checkbox"/> Retirement income		
<input type="checkbox"/> Salary insurance/ employment insurance / disability insurance		<input type="checkbox"/> Welfare		
<input type="checkbox"/> Other, please specify : _____				
IMPORTANT : Please attach the necessary documents and sign section 5				

2- MEDICAL INFORMATION				
This section must be completed by your health care professional (Ideally your nurse or social worker)				
Date of Breast Cancer diagnosis (MM/YY)		If this is a recurrence, please indicate date of recurrence (MM/YY)		
<input type="checkbox"/> Stage 0 <input type="checkbox"/> Stage 1	<input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3	<input type="checkbox"/> Stage 4	<input type="checkbox"/> Unknown	
Last treatment received <input type="checkbox"/> Mastectomy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Immunotherapy <input type="checkbox"/> Radiation therapy <input type="checkbox"/> Other : _____		Start date of treatment (DD/MM/YY)	End date of treatment (DD/MM/YY)	
Last day of work due to diagnosis (DD/MM/YY): (Mandatory if applicable)		Expected return to work date (DD/MM/YY): (Mandatory if applicable)		
Name of Health Care Professional		Title		
Hospital Center	Phone		Email	
Health Care Professional's signature (attesting the accuracy of the information indicated above)			Date (DD/MM/YY)	

3- ELIGIBILITY CRITERIA

In order to consider your application for financial aid, you must meet the following criteria:

- your gross family annual income, estimated for the current year, must be lower than the following, depending on your situation:

<input type="checkbox"/> Single person/parent	30 000\$	<input type="checkbox"/> Couple	40 000\$
<input type="checkbox"/> + 1 dependent child*	36 000\$	<input type="checkbox"/> + 1 dependent child*	46 000\$
<input type="checkbox"/> + 2 dependent child*	42 000\$	<input type="checkbox"/> + 2 dependent child*	52 000\$
<input type="checkbox"/> + 3 dependent child*	48 000\$	<input type="checkbox"/> + 3 dependent child*	58 000\$

**The dependent child must be under 18 years of age*

- you must be currently undergoing treatment OR up to one-year post-treatment (mastectomy, chemotherapy, immunotherapy, radiotherapy or other *)

**Exclusion: hormone therapy, reconstructive surgeries*

4- REQUIRED DOCUMENTS

If you meet the eligibility criteria, please attach the following documents to the completed form:

- A specimen cheque in your name, or a void cheque in your name
- A copy of your provincial notice of assessment for the last fiscal year (the page with the detailed calculations)
- A copy of your spouse's (if applicable) provincial notice of assessment for the last fiscal year (the page with the detailed calculations)
- Only if you are on sick leave: Proof that you had employment income in the year prior to your breast cancer diagnosis (e.g. your last pay stub, recent proof of salary or disability insurance, or employment insurance)

**If needed, we may ask you for other documents*

5- YOUR CONSENT AND SIGNATURE

I certify that the above information is accurate and complete. The anonymized data will be used for statistics.

For verification purposes, I authorize the Quebec Breast Cancer Foundation to discuss my file with members of my medical team.

I understand that the budget available for the financial assistance program is revised each year, as are the eligibility criteria which are then adjusted accordingly.

I understand that the Quebec Breast Cancer Foundation reserves the right to refuse any request for any reason it deems reasonable, that the amounts granted must respect the limits of the budget allocated annually for this program and these amounts granted and the eligibility criteria may, in addition to annually, change without notice.

In accordance with the Law 25, I consent to the Quebec Breast Cancer Foundation storing my personal information in their secure database here in Quebec. According to its confidentiality policy, the Foundation may use this information (first name, last name, address, e-mail and telephone number) to send you information and solicitations related to breast cancer.

I agree to receive and send electronic communications, understanding that communications by this means (for example, sending my application or documents) are not completely secure.

I agree that Quebec Breast Cancer Foundation will not be liable for any privacy breaches.

I authorize the Quebec Breast Cancer Foundation to make direct deposit based on the information provided on the specimen cheque in my name (or the void cheque in my name).

Signature

Date (MM/DD/YY)

Those eligible for the financial assistance program may receive up to:

- \$ 1000 / application, for people diagnosed with metastatic breast cancer (stage 4)
- \$ 1000 / application, for those who are on sick leave because of breast cancer (stage 0-3), and under the age of 65
- \$ 200 / application for other eligible persons

A minimum of 12 months must separate each application.

As indicated in Section 4, you must enclose with your application a specimen cheque in your name, or a void cheque in your name.
Payment is made by direct deposit.

If you need assistance completing your application, or if you have any questions regarding the financial assistance program, please contact:

Isabelle
Coordinator, Financial Assistance Program
isarrazin@rubanrose.org
Phone (toll-free) : 1 877 990-7171 #245

Please send your application (with all the required documents) by mail or email:

Quebec Breast Cancer Foundation – Financial assistance program
1115, avenue Laurier Ouest, Montreal (Quebec) H2V 2L3
aidefinanciere@rubanrose.org