CANCER SUPPORT NORFOLK

APPLICATION FOR FINANCIAL ASSISTANCE

Date of Current Application: _____

Have you applied before? Yes ☐ No ☐

If Yes, when?: _____

First Name:_____Last Name:_____

Address: _____

City:_____ Postal Code:_____

Home Phone:_____Work Phone:_____

Cell Phone:_____Email:_____

Marital Status:_____ Date of Birth (DD/MM/YYYY):_____

# of Dependents:_____ Age of Dependent(s): _____

Please explain your financial circumstances:

_____

_____

_____

Are you receiving benefits from any of the following programs? (please check all that apply)

☐ CPP ☐ ODSP ☐ Ontario Works ☐ Veteran's Affairs ☐ Native Affairs

☐ WSIB ☐ Other (please specify): _____

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Please Explain How the CSRP Can Help You. (Please attach another sheet of paper if needed.)

_____

_____

_____

_____

_____

_____

_____

_____

Please Explain Your Diagnosis

Date of Diagnosis:_____ Type of Cancer_____

Name of Treatment Centre/Clinic:_____

Treatment Received to Date:_____

_____

_____

_____

_____

Additional Treatment Required:_____

_____

_____

_____

_____

Family or Treating Physician:_____

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Medical or Support Professional Section
(Please have your Family Doctor, Oncologist, Social Worker, Registered Naturopathic Doctor, Nurse Practitioner, Registered Nurse, etc fill out this section.)

Medical Diagnosis & Comments:_____

_____

_____

_____

_____

I have read and reviewed this complete application and can confirm to the best of my knowledge that this applicant is currently undergoing Cancer Treatment.

_____ Date:_____
Signature of Professional

_____

Printed Name & Professional Designation

Applicant Release of Confidential Information

I certify that the above information is accurate, to the best of my knowledge. I also understand that this information is confidential and will not be released to others unless so directed by myself or unless law requires it. The information enclosed in the application will only be used for the CSRP Trust Fund. I understand that my identity will be protected and kept confidential.

_____ Date:_____
Applicant Signature

IMPORTANT WARNING: This application and any files transmitted with it contain CONFIDENTIAL information, including PRIVATE AND CONFIDENTIAL HEALTH INFORMATION which is intended for the use of the CSRP. If the reader of this application/attachment is not the intended recipient, employee, or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, reproduction, reading, or copying of this information is STRICTLY PROHIBITED. If you received this application in error, please notify the sender immediately and the CSRP at info@csrp.ca or (519-426-0219).

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Please Help the CSRP Help Others in Norfolk

How did you hear about the CSRP?_____

_____

_____

_____

What other ways could the CSRP be of assistance to Cancer patients & families?

_____

_____

_____

Other comments or suggestions: _____

_____

_____

_____

_____

Please ensure all of the following are included

- ☐ Current Pathology Report (if available)
- ☐ Current Notice of Assessment
- ☐ Proof of Citizenship or Landed Immigrant Status
- ☐ Proof of other funding received
- ☐ Receipts / Estimates

Cancer Support & Resource Program 645 Norfolk ST N Simcoe, ON N3Y4L2 519-426-0219
Email: info@csrp.ca www.csrp.ca

Helping Our Community "FACE CANCER WITH COURAGE"