

Travel Treatment Fund Form B - Apply By Email or Mail

Consent Requirement: This application form is to be completed by patients, caregivers, or hospital/cancer clinic staff only. Patient information can only be submitted if the patient or their authorized representative has given consent to share their information with the Canadian Cancer Society (CCS).

Overview

We know that getting to cancer treatment can be difficult, especially if you are also dealing with physical or financial challenges, or if the treatment centre is far from home. Our Travel Treatment Fund is a financial grant available to help offset costs of travelling to cancer treatments.

If you are approved for the Travel Treatment Fund, you are eligible for a one-time payment per year while undergoing active treatment. This payment is made directly to you by a cheque mailed to the address provided on this form.

If you have questions about the process or the information you need to submit, please call us at **1-888-939-3333**.

We're here to help.

Section 1 – Your eligibility

- A cancer diagnosis
- You are **currently in active treatment**, or you have **completed your cancer treatment** on or after April 1, 2023
- There is no minimum number of treatment appointments required to qualify
- Your household income and travel distance meet criteria listed in Section 4 of this form
- People who receive the BC Employment and Assistance program may still apply for the Travel Treatment Fund
- You have not received Travel Treatment Funding in the previous 12 months

Section 2 – What you need to send us for this application

- Fill out and sign this application form
- If you are travelling **25 km or less** (one way), please complete Section 6.
You are not required to complete Section 8 (healthcare provider sign-off) for this travel distance
- If you are travelling **more than 25 km** (one way), please complete Section 6 and 8.
You are required to have healthcare provider sign-off for this distance
- Healthcare provider sign-off should be done at your next regularly scheduled appointment.
Please do not schedule a new appointment to have this application signed
- You are not required to submit any financial records or receipts

To submit application by email, please send to: BCTravelFund@cancer.ca

To submit application by mail, please send to: Canadian Cancer Society
Attn: Travel Treatment Fund (TTF)
575 W 10th Ave, Vancouver, BC V5Z 4C3

Section 3 – Your contact information

| | |
|---|--|
| First name | Last Name |
| Main phone number | Permission to leave voicemail on main number? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alternate phone number | Permission to leave voicemail on alternate number? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Residential Address | City |
| Province | Postal Code |
| Mailing Address (if different) <i>Please include PO Box/Apartment/Suite/Unit etc.</i> | |
| Email Address | |

Section 4 – Your household income

Please check the box that matches your **current** household financial situation:

- Less than \$29,999 annually (no minimum travel distance required)
- Between \$30,000 and \$79,999 annually (no minimum travel distance required)
- Between \$80,000 and \$99,999 annually and I am travelling more than 25 km (one way)
- Between \$100,000 and \$150,000 annually and I am traveling more than 100 km (one way)

Are your travel costs being covered in full by any other organization?

- Yes No

Patient/Caregiver Initials _____

Section 5 – Estimated distance travelled (one way) to your treatment

What is the total distance from your home to the treatment centre? If you have travelled/expect to travel to multiple locations, please provide the distance to the location furthest from your home.

_____ km

Has **Hope Air** arranged travel support (flights) for you after October 2, 2023?

- Yes No

Section 6 – Your health information

BC Cancer Identifying Number

Hospital/Cancer Centre Providing Treatment

Did you/will you receive treatment on or after April 1, 2023?

- Yes No

Section 7 – Bone marrow transplant (BMT)

Did you/will you receive a Bone Marrow Transplant?

- Yes No

If yes, please indicate the date of the Bone Marrow Transplant:

Name of clinic where you received/will receive Bone Marrow Transplant:

Type of Bone Marrow Transplant you received/will receive:

- Auto (Autologous Stem Cell Transplant) Allo (Allogeneic Stem Cell Transplant)

Section 8 – Healthcare provider sign-off

(Only required if you are travelling more than 25 km)

| | |
|--------------------------------------|---|
| Healthcare Professional Name & Title | Healthcare Professional's Phone Number |
| Healthcare Professional Email | <p>Healthcare Professional's Signature</p> <p>X</p> <p>I hereby certify that the applicant's situation is as indicated.</p> |

Section 9 – Our privacy policy

We collect your personal information through this and other forms to register you as a client and to communicate with you about your application for the Travel Treatment Fund. Information collected may also be used for other applicable CCS transportation, accommodation, information programs and services. We may share your personal information with third parties, including Hope Air, within or outside the province of British Columbia or outside Canada to carry out the purposes identified above, or as required by law.

You have the right to withdraw your consent to the use or communication of your information at any time. We may contact you by mail, email, phone, or text. You can exercise your right to access your information or have it rectified or unsubscribe from communications by calling **1-888-939-3333** or emailing BCTravelFund@cancer.ca

For more information about our privacy practices, visit www.cancer.ca/privacy

Section 10 – Patient consent and signature*(To be completed by patient or patient's caregiver)*

I HEREBY CERTIFY that the information provided above is complete, true, and correct.

I understand that the information provided in this application will be validated by Canadian Cancer Society staff and additional financial documentation may be requested if necessary.

If applying by email: I understand that email is not the most secure means of communication.

I agree to send and receive communications including personal health information by email.

I agree that the Canadian Cancer Society will not be liable for any breaches of privacy, whether caused by me or a third party.

Signature**Date****X**