

## Bone Marrow Transplant (BMT)/CAR-T Therapy Supplement Application Form

### Overview

We know that traveling for CAR-T therapy or bone marrow transplants can be challenging, especially if you are also dealing with physical or financial challenges, or if the treatment centre is far from home.

Our BMT/CAR-T Therapy supplement is a financial grant available to help offset the costs of relocating when undergoing a bone marrow transplant or CAR-T therapy.

This grant is provided to you by direct deposit (or cheque mailed to the address provided on this form if direct deposit is not preferred/possible).

If you have questions about the process or the information you need to submit, please call us directly at **1 888-939-3333** or send an e-mail to [BCTravelFund@cancer.ca](mailto:BCTravelFund@cancer.ca)

We're here to help.

### What you need to send us for this application

- Fill out and sign this application form
- A completed and signed EFT Enrollment Form (Section 8 of this form) **as well as a void cheque or direct deposit form from your bank** if you wish to have funds deposited directly into your bank account. If Section 9 of this form is not complete, it will delay funding.
- If auto deposit is not possible or preferred, a cheque will be mailed to you instead

To submit application by email, please send to: [BCTravelFund@cancer.ca](mailto: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 1 – Your eligibility

- A cancer diagnosis
- You are currently or will soon be receiving CAR-T therapy or a bone marrow transplant (autologous or allogenic)
- You need to travel more than 45 minutes (one way) for treatment
- Your current combined household income does not exceed \$150,000 annually

### **\*Re-application after 30 Days:**

- If you are approved for and receive this supplement but must stay away from home for more than 30 days because of your treatment (e.g. your treatment has been extended), you can re-apply for additional support.
- You are eligible to reapply every 30 days if your treatment requires you to remain away from home because treatment has been extended.

## Section 2 – Your contact/personal 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	Month & Year of Birth:

### Section 3 – Bone Marrow Transplant (BMT) and CAR-T Therapy

Are you/will you be receiving a Bone Marrow Transplant/CAR-T Therapy?

- Yes       No

If yes, please indicate the date of the Bone Marrow Transplant/CAR-T Therapy:

Name of clinic where you are/will be receiving a Bone Marrow Transplant/CAR-T Therapy:

BC Cancer Identifying Number (7 digits):

\*Type of treatment you are receiving/will receive:

- Auto Transplant (Autologous Stem Cell Transplant)  
 Allo Transplant (Allogeneic Stem Cell Transplant)  
 CAR-T Therapy

### Section 4 – Your household income

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

- Less than \$29,999 annually  
 Between \$30,000 and \$79,999 annually  
 Between \$80,000 and \$99,999 annually  
 Between \$100,000 and \$150,000 annually

Applicant Initials \_\_\_\_\_

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

What is the distance (one way) from your home to the treatment centre?

\_\_\_\_\_ km

Are your travel costs for treatment being fully covered by another organization or third party?  
(Examples include flights, accommodations, or travel expenses)

Yes       No

**Section 6 – Healthcare provider sign-off (to be completed by a member of the BMT/CAR-T Therapy treatment team)**

I confirm I've obtained consent from my patient to submit this referral on their behalf to the Canadian Cancer Society (CCS). I acknowledge that I have informed the patient that CCS may contact them directly regarding this referral. I have explained the purpose of the disclosure of the information to the patient and have advised them that CCS may use the information to communicate directly with the referring health care provider. I informed the patient that CCS will keep all information confidential and will only use it for the purposes outlined below.

The patient must be made aware that CCS collects personal information to manage their participation in the program, inform them about other services and contact them to provide updates about CCS's impact and ways to support CCS or give. CCS may also use their information for program evaluation and quality assurance. CCS may share their personal information with third parties including service providers, consultants and advisors outside their province or territory or outside of Canada only to carry out the purposes identified above, or as required by law.

CCS may contact them by mail, email, phone or text. They can exercise their right to access your information or have it corrected, unsubscribe from communications or withdraw their consent by calling **1 888-939-3333** or emailing [privacy@cancer.ca](mailto:privacy@cancer.ca). For more information about CCS's privacy practices, visit [www.cancer.ca/privacy](http://www.cancer.ca/privacy)

*I confirm*

Healthcare professional name and professional title:

Healthcare professional's phone number and e-mail address:

**Healthcare Professional's Signature**

**X**

*I HEREBY CERTIFY that the applicant's situation is as indicated.*

## Section 7 – Patient consent and signature

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. The 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, within or outside your province or 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](mailto:BCTravelFund@cancer.ca)

For more information about our privacy practices, visit [www.cancer.ca/privacy](http://www.cancer.ca/privacy)

*I consent*

### If applying by e-mail:

I understand that email is not a secure means of communication. I agree to send and receive communications including personal health and bank account information by email.

*Yes*       *No* (CCS may only communicate with you by telephone or mail)

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

*Yes*       *No*

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.

**Signature:**

**X**

**Date:** (MM/DD/YYYY)

## Section 8 - Electronic Fund Transfer Enrollment Form

### Payee Information

**Full Name:**

**Phone Number:**

**Mailing Address:**

**E-mail Address:** (optional)

### Financial Institution Information

**Bank Name:**

**Account Holder's Full Name:**

**Transit #:** (5 digits)

**Bank #:** (3 digits)

**Account #:** (up to 12 digits)

### Payee Sign-Off

I authorize the Canadian Cancer Society to initiate credit deposit via electronic fund transfer to the designated bank account identified on this form.

**Signature:** (Please type full name here if filling out electronically)

**Date:** (MM/DD/YYYY)

**X**

The Canadian Cancer Society will transmit your payment electronically and provide an electronic payment stub based on the information provided. It is important that any changes to your contact or banking information be communicated to the Society to ensure prompt and accurate payment.

**IN ADDITION TO COMPLETING THIS PAGE, PLEASE ALSO ATTACH A VOID CHEQUE or DIRECT DEPOSIT FORM (FROM YOUR BANK) TO THIS APPLICATION FORM**