

Travel Treatment Fund - Application Form

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 the 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 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

We're here to help.

Section 1 – What you need to send us for this application

- Fill out and sign this application form
- If you are traveling **25 km or less** (one way), you are not required to complete Section 7 ("Healthcare provider sign-off")
- If you are traveling **more than 25 km** (one way), you are required to complete Section 7 ("Healthcare provider sign-off").
- You are not required to submit any financial records or receipts
- A completed and signed EFT Enrollment Form (last page 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 we do not receive the EFT Form, and a copy of a void cheque, 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

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 2 – Your eligibility

- A cancer diagnosis
- You are currently in active treatment or will soon be undergoing active treatment
- Your household income and travel distance meet criteria listed in Section 4 of this form
- You have not received Travel Treatment Funding in the previous 12 months

Section 3 – Your contact and 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:

Preferred Payment Method: Cheque Direct Deposit

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 \$100,000 annually and I am traveling more than 25 km (one way)

Applicant Initials _____

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

What is the total distance from your home to the treatment centre (one way)? If traveling to multiple treatment centres, please provide the distance for the location that is furthest (one way) from your home.

_____ 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 – Your health information

You have a cancer diagnosis

- Yes
- No

You are currently in active cancer treatment or will soon be undergoing active cancer treatment
(e.g. surgery, chemo, radiation, immunotherapy)

- Yes
- No

BC Cancer Identifying Number (7-digits):

Name and Location of Treatment Centre Providing
Treatment:

Section 7 – Healthcare provider sign-off

Only required if patient is travelling more than 25 km one way – to be completed by a regulated healthcare provider (e.g. Oncologist, Registered Social Worker, Physician, Registered Nurse, Indigenous Patient Navigator)

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 the client 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. For more information about CCS's privacy practices, visit www.cancer.ca/privacy

I confirm

Healthcare professional name:

Healthcare professional title:

Healthcare professional's phone number:

Healthcare professional's e-mail address:

Healthcare Professional's Signature

X

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

Section 8 – 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

For more information about our privacy practices, visit 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 receive communications from CCS regarding my application status (which may include clarifying or requesting additional personal health and financial information).

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

If receiving email from CCS regarding my application, I agree that the CCS 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.

Applicant Signature:

Date: (MM/DD/YYYY)

X

Electronic Fund Transfer Enrollment Form

OPTIONAL: Please complete and submit this page as part of your application if you require payment by direct deposit

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) X	Date: (MM/DD/YYYY)

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