Travel Treatment Fund - Application Form
(Alberta, Saskatchewan)

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 traveling for cancer treatments.

If you are approved for the Travel Treatment Fund, you will receive a one-time payment per year while undergoing active treatment. This payment is made directly to you by electronic fund transfer (auto deposit) or by cheque mailed to the address you provide on this form.

If you have questions about the process or the information you need to submit, please call us directly **1-888-939-3333** or send an e-mail to Transportation@cancer.ca

We are here to help.

Section 1 – Your eligibility

- You have a cancer diagnosis and are currently or will soon be undergoing active treatment
- You live less than 70 kms away (one way) from your treatment centre and will have **a minimum of 10 in-person treatment related appointments**
- You meet the household income criteria listed in Section 4 of this form
- You have not received Travel Treatment Funding in the previous 12 months
- You have not received transportation support through the Canadian Cancer Society's Wheels of Hope driving program in the previous 12 months
- You do not have your medical travel expenses covered by a 3rd party

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

- A completed and signed application form. If you do not complete all required sections, your application will be delayed.
- Completed healthcare professional sign-off (Section 5 of this form).
- A completed and signed EFT Enrollment Form (page 6 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 7 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.
- Please do not submit income verification documentation (e.g. copies of bank statements or previous year's tax returns). This information is not required and will be destroyed if received.

Section 3 – Your contact information and address

First name:	Last Name:	
Main phone number:	Permission to leave voicemail on main number? ◯ Yes ◯ No	
Alternate phone number:	Permission to leave voicemail on alternate number? ◯ Yes ◯ No	
Email Address:		
Residential Address:		
City:	Province:	Postal Code:
Mailing Address (if different) *Please include PO Box/Apartment/Suite/Unit etc.*		

Preferred Payment Method: ◯ Cheque ◯ Direct Deposit

Section 4 – Your household income

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

Note: Any dependents' income (under the age of 25, living at home with you) should not be counted towards the total household income.

- ◯ Single person whose gross annual income is less than $30,000
- ◯ Family unit of 2 people whose combined gross annual income is less than $37,000
- ◯ Family unit of 3 people whose combined gross annual income is less than $44,500
- ◯ Family unit of 4 people whose combined gross annual income is less than $53,500
- ◯ Family unit of 5 people whose combined gross annual income is less than $60,000
- ◯ Family unit of 6 people whose combined gross annual income is less than $67,500
- ◯ Family unit of 7 or more people whose combined gross annual income is less than $74,500

Patient/Caregiver initials _____

Please do not submit income verification documentation (e.g. copies of bank statements or previous year's tax returns). This information is not required and will be destroyed if received.

Section 5 – Patient Health Information

To be completed by any member of the healthcare team (Doctor, Nurse, Social Worker)

Minimum of 10 in-person treatment related appointments?

◯ Yes ◯ No

Treatment start date: (MM/DD/YYYY)	Treatment completion date if known: (MM/DD/YYYY)

Name of hospital/cancer centre providing treatment:

Privacy Disclosure

By checking the box, 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.

Section 5 – Patient Health Information (continued)

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.

◯ *I confirm*

Healthcare professional name:

Healthcare professional title:

Healthcare professional's phone number:

Healthcare professional's e-mail address:

Privacy Disclosure

We collect your personal information through forms, by phone or in person to manage your participation in the program, inform you about other services and contact you to provide updates about our impact and ways to support us or give. We may also use your information for program evaluation and quality assurance. We may share your personal information with third parties including service providers, consultants and advisors outside your province or territory or outside of Canada only to carry out the purposes identified above, or as required by law.

We may contact you by mail, email, phone or text. You can exercise your right to access your information or have it corrected, unsubscribe from communications or withdraw your consent by calling **1-888-939-3333** or emailing privacy@cancer.ca For more information about our privacy practices, visit www.cancer.ca/privacy

Healthcare professional's signature:

X

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

Section 6 – Patient consent and signature

To be completed by patient or patient's caregiver.

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*

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, 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 Transportation@cancer.ca

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

◯ *I consent*

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)

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

To submit application **by mail**, please send to: *Canadian Cancer Society c/o Juravinski Hospital*
Attention: Travel Treatment Fund
711 Concession Street, Hamilton, Ontario L8V 1C3

Electronic Fund Transfer Enrollment Form

Optional *- Please complete and attach this page to your application if you wish to have funds deposited directly into your bank account.*

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