Canadian Cancer Society

Version 1.0

Travel Treatment Fund (TTF) and Exceptional Assistance Fund Application Form – New Brunswick

Overview

We understand 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. At the Canadian Cancer Society (CCS), we offer transportation support for those who are currently attending cancer treatment.

Our Travel Treatment Fund (TTF) may be able to offset some of your travel costs. You can apply for it if you live in one of the areas listed below, and you can reapply each year if you are still receiving treatment. We will do a financial assessment to see if you qualify.

Complete all the sections of this application form except section 5. Have your doctor or someone else from your healthcare team complete section 5.

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

Section 1 – Your eligibility

- You must be undergoing active cancer treatment.
- If you travel less than 200 km one way to your treatment centre, you must have a minimum of 10 appointments related to your treatment in the year.
- If you live in **BC**/**ON**/**NB**/**PEI**/**NS** and are travelling more than 200 km one way, there is no minimum number of appointments needed to qualify.
- Beneficiaries of social assistance programs are not eligible for the TTF.

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

1. A completed and signed copy of **this application form**. If you don't complete all sections, your application may be delayed.
2. A copy of the previous year's **Notice of Assessment(s)** from the Canada Revenue Agency for yourself and anyone in your family who is 18 years of age or older and lives in your household.
3. A completed and signed **EFT Enrollment Form** with your bank account information. We need this form to be able to deposit money into your account. If you didn't receive the form from us or have questions about how to fill it in, call us.
4. A **void cheque or a direct deposit form** from your bank for the above bank account.

Section 3 – Your household income (financial assessment)

Check the box that matches your current family financial situation. A family unit includes any person in the family who lives permanently at the same address as you.

- ☐ My family unit consists of 1 person whose gross annual income is less than $25,920.
- ☐ My family unit consists of 2 people whose combined gross annual income is less than $32,270.
- ☐ My family unit consists of 3 people whose combined gross annual income is less than $39,672.
- ☐ My family unit consists of 4 people whose combined gross annual income is less than $48,166.
- ☐ My family unit consists of 5 people whose combined gross annual income is less than $54,630.
- ☐ My family unit consists of 6 people whose combined gross annual income is less than $61,612.
- ☐ My family unit consists of 7 or more people whose combined gross annual income is less than $68,598.

☐ I am the beneficiary of a government social assistance program.

Section 4 – Your contact information

Application date (MM/DD/YYYY)	Address	Apartment
Last name	City	
First name	Province	
Date of birth (MM/DD/YYYY)	Postal code	
Home phone number	Permission to leave voicemail on home phone number? ☐ Yes ☐ No	
Cell phone number	Permission to leave voicemail on cell phone number? ☐ Yes ☐ No	
Email address		

Section 5 – Patient health information
(This section must be completed by a healthcare professional)

Type(s) of cancer diagnosed	Name of healthcare professional
Minimum of 10 treatment-related appointments expected for the current year? ☐ Yes ☐ No	Healthcare professional's title
Please check here if the Patient is applying for Exceptional Assistance Fund - see below for details. ☐ Yes (patient has other rehabilitation needs/material or special needs) ☐ No Please specify:	
Treatment start date (MM/DD/YYYY)	Healthcare professional's phone number
Treatment end date – if known (MM/DD/YYYY)	Healthcare professional's email address
Name of hospital(s)/clinic(s) providing treatment	**Healthcare professional's signature** **X** I hereby certify that the applicant's situation is as indicated.

Exceptional Assistance Fund:

The Exceptional Assistance Fund is offered in place of (and in certain cases, in addition to) the Travel Treatment Fund and is available to patients in New Brunswick that may exceed the low-income level by up to $10,000. The breakdown of funding that a patient may receive is as follows:

(1) **Travel to treatment allocation**: to help cover the costs associated with travel to the treatment centers.

(2) **Special needs allocation**: to help cover the costs of any rehabilitation material, equipment, or other special needs in relation to the cancer such as breast prosthesis, compression sleeve and glove, dental work, bras, podiatry services.

- Special needs must be confirmed by the Healthcare Professional completing Section 5 (above) in this form.
- A completed and signed copy of this application form as well as all other requirements must be met to be eligible for the Exceptional Assistance Fund.
- A copy of a receipt(s) from the patient or an estimate of the cost of the special needs will also be required to be submitted by the patient as part of this application.

Section 6 – Your consent and signature

I understand that the information I provide for the Travel Treatment Fund Program will be used to register me as a client and to communicate with me about my application in accordance with the Canadian Cancer Society's (CCS) privacy policy.

Find more information on CCS's privacy policy at https://cancer.ca/privacy-policy

I authorize CCS to deposit any payments directly into the provided bank account and agree to promptly notify CCS of any change in my bank account information.

Submitting application by email

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 (If you choose No, CCS will communicate with you by telephone or mail only.)

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

☐ Yes ☐ No

Collecting your information

CCS collects your personal contact and health information in order to provide you with services. We may also use your information, in accordance with our privacy policy, to keep in touch around other CCS activities that may interest you, such as our support programs, fundraising opportunities or feedback to improve our services.

Do you give your consent to collect this information for these additional purposes?

☐ Yes ☐ No

Your signature **X**	**Date (MM/DD/YYYY)**

Section 7 – Where to send this application

If you live in:	**Return this form and supporting documents by post, fax, or email to:**
New Brunswick	Canadian Cancer Society, Attn: Travel Treatment Fund (TTF) 1550 Upper James St, Suite 300, Hamilton, ON L9B 2L6 Phone: 1-888-939-3333 Fax: 1-866-263-6757 Email: transportation@cancer.ca