

**APPLICATION FOR FINANCIAL SUPPORT FROM BCAF**

**NOTE:** Applicants are expected to have had a diagnosis of breast cancer to which this request for funding relates. **Breast Cancer Action Kingston offers financial support to those individuals residing in and/or receiving treatment within the South East LHIN:**

**NAME:** \_\_\_\_\_

**MAILING ADDRESS:** \_\_\_\_\_

**TELEPHONE:** \_\_\_\_\_

Verified Diagnosis of Breast Cancer: Yes  No  Date of Diagnosis: \_\_\_\_\_

Do you and/or your spouse/partner have a benefit plan to assist with costs? Yes  No

Company name: \_\_\_\_\_

Have you applied to other agencies to assist with costs? Yes  No

If yes, please list agencies: \_\_\_\_\_

Amount(s) requested/received: \_\_\_\_\_

**What is your current employment status?**

On leave with benefits  On leave without benefits  Unemployed  N/A

Gross Monthly Household Income: \_\_\_\_\_ Gross Monthly Expenses for Self/Family: \_\_\_\_\_

Number of dependents \_\_\_\_\_

Sources of Income: \_\_\_\_\_

**Financial Cap:** Maximum Allowance per Year \$1,000.00 per person

Prosthesis - \$150 every 2 years

Partial Prosthesis - \$50 every 2 years

Bras - 50% every 2 years

Wigs - \$250 every 2 years

Please circle the requirements and attach any relevant documentation. Missing information may cause a delay in processing the application.

Applicant's requirement for funds: **(e.g.** medications, prostheses, wigs, food, accommodation).

Referred by: \_\_\_\_\_ Telephone: \_\_\_\_\_

**AMOUNT REQUESTED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Applicant's Signature)

(Signature of Witness)

**OFFICE USE ONLY**

**AMOUNT APPROVED:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**PAYABLE TO:** \_\_\_\_\_