APPLICATION FOR FINANCIAL SUPPORT FROM BCAK

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 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:** _____