Haying in the 30`s Cancer Support Society
100% Fundraiser for Victims of Cancer.

Box 35, Mallaig, Alberta T0A2K0

If your application is accepted, you can expect to receive assistance within 3 months.

Note: ALL INFORMATION PROVIDED WILL BE KEPT CONFIDENTIAL.
In order to maintain the privacy of applicants, inquiries on the status of an application will only be provided to the individual seeking assistance.

CRITERIA: This voluntary Non Profit Society was formed to provide financial assistance to those faced with **cancer**. As we hear of people diagnosed with cancer and undergoing treatments, we do our best to help out with costs such as transportation, fuel, lodging, etc.

In order to comply with government regulations, we are now required to have confirmation/verification that the applicant is undergoing cancer treatments. Therefore documentation is required from the physician in order for payment to be issued.

The personal information on these forms is collected for the sole purpose to process this request. This information is kept strictly confidential and will not be used for any other purpose. The payment will be considered non-taxable income for the recipient.

THESE ITEMS ARE REQUIRED FROM THE APPLICANT/RECIPIENT FOR ASSISTANCE:

- ☐ **Page A - Explanation and signature**
- ☐ **Page B - Completed application form that is provided**
- ☐ **Page C - Medical form that is provided**
- ☐ **Page D - Completed Declaration form that is provided**

We do not accept photocopies, only original signatures.

Forward all required information to us **BY MAIL** at the above address, and we will do our best to assist you. Application will be delayed if proper information is not provided. Applications are reviewed each month. **PLEASE NOTE: THIS IS A ONE TIME PAYMENT ONLY**

Please use the back of this sheet to explain how you heard about this society: >>>>>>>>>>>>>>

I have completed all the above requirements. ***SIGNATURE*** ___________________________________

PAGE A	FOR OFFICE USE ONLY				

APPLICATION for ASSISTANCE

Date of Application: Day Month Year	**PLEASE NOTE: THIS IS A ONE TIME PAYMENT ONLY**

Surname	Given Name	Middle Name

MAILING ADDRESS	CITY	PROVINCE	POSTAL CODE
DATE OF BIRTH Day Month Year	**PHONE #**	**MALE OR FEMALE**	**MAIDEN NAME (if applicable)**

If this applicant is less than 18 years of age, provide parent/guardian information.

First and Last Name Relationship Address Signature	First and Last Name Relationship Address Signature

Cancer Diagnosis	Treatment Start Date
Oncologist First Name: Last Name:	Phone # ( )
Family Physician First Name: Last Name	Phone # ( )

Take Care & God Bless

Haying in the 30's Cancer Support Committee

(For processing purposes, all documentation required as per Victim Assistance Information must be attached to this Application Form)

(Revised 07/2017)

PAGE B	**FOR OFFICE USE ONLY**				

MEDICAL INFORMATION – (To be completed by physician)

(Treating Physician must sign and confirm treatment and diagnosis information.)

Patient Name ____

Date of Birth ____

What type of **cancer** is the patient being treated for? _______________________________

Cancer of the (blood, or lymph nodes, liver, or other) ____
Please specify

Date of Diagnosis ____

Date Treatment commenced ____

Physician First Name _____________________ **Last Name** _______________________________________

- ☐ **Family Physician**
- ☐ **Oncologist**
- ☐ **Nursing Practitioner**

Office stamp/address

____

Phone # (   ) **email**

This voluntary Non Profit Society was formed to provide financial assistance to those faced with **cancer**. As we hear of people diagnosed with **cancer** and undergoing treatments, we do our best to help out with costs such as transportation, fuel, lodging, etc.

I understand that the Haying in the 30's Cancer Support Society provides financial assistance to patients being treated for CANCER. I certify that the above medical information regarding this patient's diagnosis and treatment is accurate to the best of my knowledge.

Physician Signature ____

Date ____

PAGE C	FOR OFFICE USE ONLY				

DECLARATION

APPLICANT'S FULL NAME (print please) ___________________________________

DATE OF BIRTH: (day)__________(month)__________(year)_____________

I understand that the Haying in the 30's Cancer Support Society provides financial assistance to patients being treated for **CANCER**. Assistance can only be distributed based on the amount of donations the society has received at any given time. I hereby give this society permission to verify the information provided. ALL INFORMATION PROVIDED WILL BE KEPT CONFIDENTIAL. No emails are accepted as original signatures are required.

PLEASE NOTE: THIS IS A ONE TIME PAYMENT ONLY

If your application is accepted, you can expect to receive assistance within 3 months.

Inquiries on the status of an application will only be provided to the individual seeking assistance. In signing this form, I am declaring that to the best of my knowledge, the information contained in this application is true and is an accurate description of my medical status.

APPLICANT'S SIGNATURE ____

DATE ____

*If applicant is less than 18 years of age, provide parent's/guardian's signature:

NAME (print) ____

RELATIONSHIP ____

SIGNATURE _______________________________ DATE _________________

No emails are accepted, as original signatures are required. **Mail** all pages to:
Haying in the 30's Cancer Support Society **Box 35, Mallaig, AB T0A2K0**

PAGE D	**FOR OFFICE USE ONLY**				