London Health Sciences Centre

Date of Application: _____

PATIENT ASSISTANCE PROGRAM – Application

The Patient Assistance Program is intended to help people who experience a financial hardship as a result of their cancer diagnosis and treatment. The Program helps people at all points in their journey including diagnosis, treatment, palliative care and survivorship.

Funding is available for emergency, short-term situations when funding from other sources and services is not available. Expenses incurred within 6 months of the date of the application will be considered.

Incomplete information will result in delays processing your application.

FAMILY INFORMATION

Patient Name: (include middle initial)	Date of Birth:
Address:	
City:	Province:
Postal Code:	Daytime Telephone:
Patient's Email:	
If follow-up is required can we contact you by email? ☐ Yes ☐ No	
Referred By: ☐ Healthcare Provider ☐ Self ☐ Other (Please Specify):	

HEALTH INFORMATION

Diagnosis:	Date of Diagnosis:
Current Treatment:	
Oncologist/Surgeon:	Hospital/Facility:
LHSC Verspeeten Social Worker (if applicable):	

REQUEST FOR FUNDING (Explanation of need and anticipated costs.)

All original receipts must be attached and less than 6 months old.	ACTUAL / ANTICIPATED COST
☐ Childcare during treatment	
☐ Drugs/Prescriptions (NOTE: Trillium Drug Program assists Ontario residents with high prescription drug costs relative to their household income.) For information, contact the Trillium Drug Program at 1-800-575-5386 or visit their Website: http://www.health.gov.on.ca	
☐ Equipment rentals (e.g, wheelchair)	
☐ Lymphedema supplies (e.g., compression sleeves) - portion not covered by Assistive Devices Program (ADP)	
☐ Mastectomy bras (maximum of four)	
☐ 1 Mastectomy swimsuit and breast form	
☐ Nutrition beverages (e.g., Ensure©, Boost©, etc.) – Dietitian referral required	
☐ Prostheses (portion not covered by ADP)	
☐ Respite care	
☐ Transportation (when volunteer drivers are not available through the Canadian Cancer Society or other organizations). **Pre-approval required.**	
☐ Parking. **Pre-approval required.**	
☐ 1 Wig (up to a maximum of $800)	
☐ Other head coverings (up to a maximum of $200)	
☐ Other:	

Do you have extended health benefits to cover some of these expenses related to your treatment? ☐ YES ☐ NO
(e.g., wigs, Personal Support Worker etc.)

Do you have a private drug plan? ☐ YES ☐ NO

Are you receiving services from the South West LHIN? (formerly Community Care Access Centre) ☐ YES ☐ NO

Are you seeking: ☐ Reimbursement (attach original receipts) or ☐ Direct payment to vendor

Financially, how has the diagnosis and/or treatment of your cancer impacted your ability to pay for these expenses?
Please explain:

OTHER SOURCES OF FUNDING RECEIVING OR APPLIED (If YES, for what expenses)

Trillium Drug Program ☐ YES ☐ NO

Assistive Devices Program (ADP) ☐ YES ☐ NO

Kelly Shires Fund (Breast Cancer) ☐ YES ☐ NO

☐ Other:

HOUSEHOLD INCOME (A household is a single person, or two or more people dependent on each other financially.)

Do you have dependents living in your home? (e.g., spouse, children) ☐ YES ☐ NO

If YES, please list the ages of the dependents: _____

Financial Benefits you are receiving or made application to: (please ☑ all that apply)

	APPLICANT (PATIENT)		SPOUSE (PARTNER)	
	RECEIVING	APPLIED	RECEIVING	APPLIED
☐ Employed	☐	☐	☐	☐
☐ Ontario Works	☐	☐	☐	☐
☐ Employment Insurance - Sick Benefits	☐	☐	☐	☐
☐ Ontario Disability Support Program	☐	☐	☐	☐
☐ Canada Pension Plan Disability	☐	☐	☐	☐
☐ Short Term Disability Benefits from Employer	☐	☐	☐	☐
☐ Long Term Disability from Employer	☐	☐	☐	☐
☐ Other _____ (e.g., critical illness insurance, retirement benefits)	☐	☐	☐	☐

The information provided in this application accurately reflects my current financial situation. I have experienced financial hardship as a result of being diagnosed with cancer and undergoing treatment.

APPLICANT'S NAME (PLEASE PRINT): DATE:

APPLICANT'S SIGNATURE:

OFFICE USE ONLY

APPROVED BY: DATE:

AMOUNT APPROVED:

COMMENTS:

Contact Information:
Website Link- https://www.lhsc.on.ca/verspeeten-family-cancer-centre/verspeeten-family-cancer-centre-patient-assistance-program
Phone: 519-685-8600 ext. 53627
Email-verspeetenpatientassistancefund@lhsc.on.ca

Completed forms can be dropped off at the Patient and Family Resource Centre, located on Level 1 in Atrium;
or mailed to: Patient Assistance Fund, LHSC Verspeeten Family Cancer Centre, London Health Sciences Centre,
800 Commissioners Road East, London, ON N6A 5W9