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.

Patient Assistance Program personnel may access relevant information in your health record to verify eligibility for the program.

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).	
☐ Parking.	
☐ 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 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

☐ 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