Financial Assistance Application Form
Physical, psychological and/or learning sequelae arising from pediatric cancer

This form and the other required documents must be sent by mail or email using the following addresses:

Leucan Information Centre
CHU Sainte-Justine
3175 Côte-Sainte-Catherine, Room B1246
Montréal, Québec, H3T 1C5

Or at patrick.cossette2@leucan.qc.ca or par fax at 514-345-7774

IMPORTANT: Before completing this form, please refer to the Reference Guide for assistance to know all the terms and conditions, as well as all required documents.

IDENTIFICATION		
Applicant's name and surname		Date of birth: _____/_____/____ MONTH/DAY/YEAR
Name and surname of parent or legal guardian (if applicant is a minor)		Check if child's legal guardian ☐

Applicant's contact information (parent/legal guardian's contact information if applicant is a minor)		
Address (number and street):	Apt.:	City:
Postal code:	Email:	
Phone number at home:	At work:	Cellphone:

Supplementary information on diagnosis	
Date of diagnosis:	Diagnosis:
Hospital:	Date of last treatment:
Date of last follow-up visit:	Attending physician during treatments:

SECTION 1

TO BE COMPLETED AND SIGNED BY THE ONCOLOGIST OR THE FAMILY PHYSICIAN.
THIS SECTION DOES NOT HAVE TO BE COMPLETED IF YOU HAVE SUBMITTED AN APPLICATION FOR THIS PROGRAM WITHIN THE LAST TWO YEARS.

1. **Describe the sequela(e) for which financial assistance is required and the causal link between the cancer treatments and sequela(e):**

2. **Describe the impact of the sequela(e) on the patient's health and quality of life:**

Name:	**Signature:**	**Date:**	**Phone:** **Email:**

SECTION 2.1. : FIRST ESTIMATE

TO BE COMPLETED AND SIGNED BY THE HEALTH CARE PROFESSIONAL (OR OTHER QUALIFIED PROFESSIONAL) WHO WILL PROVIDE THE CARE/SERVICES.
ANOTHER DOCUMENT CAN BE USED AND SIGNED BY THE PROFESSIONAL.

1. Type of proposed treatment/service (including description and frequency):

2. Total cost of treatment/service (including taxes):

Estimate cost (if charged by the professional): _____$

3. Payment modes required (how many and amounts):

Name and occupation:	**Signature:**	**Date:**	**Phone:** **Email:**

SECTION 2.2. : SECOND ESTIMATE

TO BE COMPLETED AND SIGNED BY THE HEALTH CARE PROFESSIONAL (OR OTHER QUALIFIED PROFESSIONAL) WHO WILL PROVIDE THE CARE/SERVICES. ANOTHER DOCUMENT CAN BE USED AND SIGNED BY THE PROFESSIONAL.

1. Type of proposed treatment/service (including description and frequency):

2. Total cost of treatment/service (including taxes):

Estimate cost (if charged by the professional): _____$

3. Payment modes required (how many and amounts):

Name and occupation:	**Signature:**	**Date:**	**Phone:** **Email:**

SECTION 3. : TRAVEL EXPENSES (you must first check if you are eligible under the conditions described in the program reference guide)

MUST BE ACCOMPANIED BY THE TREATMENT PLAN OF THE HEALTH CARE PROFESSIONAL WHO WILL PROVIDE CARE / SERVICES

1. **If this is not a service already described in your estimate, for which you are requesting a grant (previous sections 2.1. And 2.2.), please describe the care for which you must attend:**

2. **Name and/or address of the establishment where the treatment will take place:**

3. **Enter the dates fixed for the appointments:**

4. **Check the means of transport:**

Automobile ☐ **Taxi (only if it is not possible to use the automobile)** ☐

Parking fee: $ _____ **Estimated cost of a return taxi ride: $ _____**

- **Based on this information, Leucan will inform you of the price for a trip by car according to the mileage calculated by the Google Maps application.**
- **As soon as new appointment dates are confirmed, please notify us. Leucan reserves the right to communicate directly with the professional.**

More than one type of treatment/service can be covered by the grant. Please complete Sections 2.1 and 2.2 (estimates) or 3. for each one of them.

Note: Please attach any documentation supporting your financial assistance request (see reference guide below). Incomplete applications will not be processed.

FINAL AMOUNT

Voluntary contribution:

Leucan wishes to distribute the available budget dedicated to the Financial assistance program for post-treatment sequelae as equitably as possible and maximize its impact. If you are able to contribute financially to some of the costs of the service, please indicate how much your contribution could be in dollars or percentages: _____

Excluding the cost for automobile travel that will be communicated to me later, I request a total grant or scholarship (or a reimbursement) for total amount of _____ $

Please tick if your request is urgent ☐ and must be dealt with as soon as possible

Signature of the applicant, parent or legal guardian: _____

Date: _____

Please take note:

1. **Leucan reserves the prerogative to claim any other document needed for better analysis of this demand.**
2. **Leucan reserves the prerogative to reimburse the estimates, irrespective of whether or not a grant is granted.**
3. **Leucan reserves the right to allocate the requested amount(s) in whole or in part and is not required to explain its decisions.**
4. **Leucan reserves the prerogative to consult a medical advisory committee before making its decision.**

IMPORTANT

Make sure your application is complete before submitting this form

Required for all requests in this form:

- Applicant identification and diagnosis;
- Section 1: recommendation signed by a physician (unless an application has been made during the last two years);
- Sections 2: two signed estimates (description of care/services and costs)
- Signature, final amount requested and date

Other required documents: See the reference guide