BCANS CARES Breast Cancer Support Fund

The BCANS Care Fund Guidelines

In order to be considered for funding through the BCANS Care Fund, please read below and follow the below instructions:

Please note: Applying for the BCANS Care Fund does not guarantee funding

1. The BCANS Care Fund is a program for anyone that has been diagnosed with breast cancer in the Atlantic Provinces. (Nova Scotia, New Brunswick, Newfoundland and Labrador and Prince Edward Island)

2. Only requests submitted on this form will be considered for funding.

3. A maximum of $200.00 may be approved per person, per calendar year. If an application is denied, the patient is welcome to apply the following month with new updated circumstances.

4. All sections of the application must be completed. Failure to complete the entire application will result in ineligibility of funding.

5. Please input recipient's full address clearly as we will not be responsible for lost or stolen gift cards.

6. Only utility bills 30 days overdue, and rent payments 60 days overdue will be considered. A utility request is defined as heating, electrical, or water bill as well as home phone. Cell phone bills are not eligible for funding unless it is the only phone being used at home. This information needs to be included in the narrative provided by hospital personnel. Cable and/or internet payments, mortgage payments, car payments, insurance, and tax bills are not eligible for funding.

7. A brief narrative describing the patient's situation and the family's need must be included and written by the social worker, doctor, or nurse. Be sure to include any additional, compelling and relevant information, as this narrative plays a vital role in the application selection process.

8. If the application is approved, cheque (s) will be cut and distributed on or before the last day of the month.

9. Social workers, doctors, or nurses will receive notification for approved and declined applications via email within two weeks after receipt. They will be responsible for notifying the patient of their application status. We do not contact the patients directly.

10. Cheque(s) will be made payable to the utility company and/or landlord and mailed to the patient.

11. If the cheque(s) is not cashed within 60 days of the printing date, Breast Cancer Action Nova Scotia has the right to cancel the check.

12. Applications must be emailed or faxed by the social worker, doctor or nurse to the following: a. bcans@bcans.ca

BCANS CARES Breast Cancer Support Fund Application

Please write legibly for clarity of Review.
Date:_____

Section 1: Family Information
Patient's Name:_____
Birth Date:_____
Address:_____
City:_____Province_____Postal Code_____ Telephone:
(___)_____
Email address:_____
Sources of Monthly Income: Employment_____ Employment Insurance _____
Child Support_____ Disability_____
Social Assistance_____ Other_____
Total Yearly Family Income (Including Costs listed above)_____

For office use only:

Approved by:_____ Date:_____
Amount :_____ Payable to_____
Amount:_____ Payable to_____
Amount:_____ Payable to_____
Amount Available:_____ Amount remaining for this year_____
Notified SW/N_____By email:_____By Phone:_____

Section 2: Health Information

Diagnosis:_____ Date of Diagnosis_____

Name of Physician/Oncologist:_____

Name of your Medical Facility:_____
Address:_____

Social Worker/Nurse:_____

Telephone: (___)_____ Fax: (___)_____

Email address:_____

Section 3 Request for Funding

Please check the appropriate box (es) for the type of funding being requested. Additional, list the company, the cost associated with the bill and its due date

___Rent ___Utility ___Phone ___Grocery Cards ___Wig
___Prosthesis ____Other (please explain)_____

Company:_____Cost:_____Due:_____

Payment Address:_____

Company:_____Cost:_____Due:_____

Payment Address:_____

Company:_____Cost:_____Due:_____

Payment Address:_____

*A utility requested is defined as a heating, electrical, or water bill.

*Cell phone bills are not eligible for funding unless it is the only phone being used in the home.

* Please specify in the narrative provided by your social worker or nurse

Do you have any Shut off or Eviction Notices? ____Yes___No___Shut off___Eviction

Section 4: Copies of Utility Bills or a letter from the Landlord

Attach copies of all utility bills and/or a letter from the Landlord stating the amount of arrears

Section 5: Narrative from Social Worker or Nurse

Attach a brief narrative describing the patient's situation and the family's need. This information should be written by the social worker, doctor or nurse. Be sure to include any additional, compelling and relevant information

Section 6: Review and Sign

I have reviewed this application and, to the best of my knowledge, this information is true and correct

Please note: It is the social worker's, doctors, or nurse's responsibility for notifying the patient of their application status. We do not contact the patient directly. You will be notified by phone or the email address that you provided two weeks after the application period closes on the status of the patient's application (approved or declined)

Patients Name: (Print)_____
Signature:_____Date_____

Social Worker/Case Manager Signature: (Print)_____
Signature:_____Date:_____