Title: Criteria for funds administration
Revisions: July 1, 2018

Purpose: This criteria guides the association in assessing requests from applicants who submit a formal application to the charity requesting financial assistance in relation with their breast cancer treatment/diagnosis. The mission is to provide assistance to women/men in order to make their fight with breast cancer a little less challenging.

NOTE: We are NOT funded by any government agencies. We are a charity run by volunteers relying solely on the generous support of donations from the general public and business communities. Criteria is reviewed and updated annually.

Criteria Statements:

1. Application must be complete in full, and must include the mandatory supporting documents outlining their need for financial assistance. Applications missing the mandatory documents are considered incomplete and cannot be processed until required documentation is received. (Please refer to #7 this criteria for a complete list of required documents)

2. The applicant must be diagnosed with breast cancer (priority given to those on active treatment)

3. The applicant must be a Canadian citizen, approved landed immigrant or permanent resident.

4. Each application can be submitted for a maximum of $1000.00 (funds permitting).

5. The applicant can apply 3 times to the Trust per calendar year, funds permitting. A new application may not be sent to the Charity before the current application has been submitted, reviewed and a response sent to the applicant. Only one application will be accepted monthly.

6. Each application MUST include at least one expense directly related to applicant’s diagnosis/treatment.

7. In order to establish financial need:
   ✓ Applicants must provide current income tax notice of assessment and your current full income tax return.
   ✓ Applicants must provide the current notice of assessment for their spouse/partner/significant other/Adults age 18 and older living in the household.
   ✓ Applicants must disclose ALL sources of income (including but not limited to child support, spousal support, etc.)
   ✓ Receipts must be provided for amounts claimed through the fund (note receipts dated prior to diagnosis will not be considered). Receipts must be legible, organized and not have a date more than 1 calendar year from date of application.
   ✓ Proof of citizenship/approved landed immigrant status must be provided.
✓ Applicants applying for financial assistance for rent or mortgage must supply supporting documentation verifying the amount they are requesting.
✓ Applicants that were working (self employed or employed by other means) that are now currently not working must submit their ROE (record of employment)
✓ ORIGINAL receipts must accompany your application. Receipts must be organized and please do not any type of highlighter on receipts.
✓ Proof of any and all funding/income received by other organizations, agencies or family support
✓ Applicant must include medical report supporting diagnosis

(Please note that applications cannot be considered complete and put before the committee unless ALL pertinent documentation is included, documentation requested is mandatory – if documentation is not included it will only delay any financial assistance that could be provided. Please note that occasionally the Charity may request further supporting documents for financials such as bank statements).

8. Criteria is reviewed annually and amended accordingly.

9. All personal information is protected under the Canadian Privacy Act.

10. If applicant has any type of Long Term Disability (LTD) coverage, a copy of your coverage is required to be submitted with your application.

11. The Approval Committee, under their discretion, retains the right to deny any application.

Some examples that fit the funding criteria (but not limited to):

- Transportation to/from the centre for appointments or treatment
- Accommodation
- Medications that are not covered by any other plans (or non-covered % portions) related to your cancer.
- Parking at the cancer centre/hospital
- Food costs while on active treatment
- Child-care services while at the centre/hospital for an appointment or treatment or in hospital
- Home health aides
- Prosthetics/specialized lingerie/Wigs (less available provincial funding) **
- Supportive care: counseling services for patient, partner and/or children; attendance to a cancer support program/course
- Rehabilitation supportive care: e.g., lymphedema management, weight management/nutrition consultation special needs due to chemo treatment (e.g. prescription glasses due to change of vision. Will need approval from a licensed medical practitioner)
- Other expenses related to treatment, living costs during treatment & recovery
- Rent payment/mortgage payment
- Expenses not listed above can be submitted and considered after review by Directors and Approval Committee
- NOTE: some items carry a cap on amount(s) that can be approved

** Did you know that each province provides partial funding for prosthesis? Refer to our resource page for more details or contact your provincial government**
Application Process:

1. Submit a **completed** Kelly Shires Breast Cancer Foundation application by **MAIL**. Applications can be downloaded on-line at www.kellyshiresfoundation.org or requested by calling 1-877-436-6467. The applicant must disclose if they are receiving any financial assistance from other sources (e.g., programs in centre, child support, government assistance health insurance programs, and group insurance programs (LTD benefits), etc)

2. Priority will be given to:
   - to low income applicants (size of family will be taken into consideration, low income determined by Stats Canada)
   - To applications where costs are medically related to breast cancer diagnosis and treatment
   - All Canadian residents diagnosed with breast cancer can apply for assistance to this fund.

3. Applicants will be notified of application status by post (mail) or e-mail. Please note that our office is only staffed 3 days per week and we will process applications as quickly as possible.

Please note that in order to help as many breast cancer patients as possible assistance for funds relating to the following items (but not limited to the list) will be capped at the following amounts per application:

- Mortgage/rent will be capped at $700/request, please also note that if government or other assistance is already provided this amount will be deducted from any amount approved as part of this application
- Groceries will be capped at $400/request
- Utilities (i.e. Hydro, gas, electricity, water, heating/cooling (combined)) will be capped at $300/request
- Medical travel costs (gas, bus, taxi, (combined), etc) will be capped at $300/request
- Lifetime financial assistance will be capped at $12,000.00 (CANNOT be issued as a one-time lump sum)

Items that will **NOT** be considered for approval are as follows (but not limited to):

- Credit card payments
- Property taxes/condominium maintenance fee’s
- Car repairs
- Cable/internet (with exception)
- Cellular phone (with exception)
- House, life, car, critical illness insurance premiums, etc

A detailed list can be found on our website www.kellyshiresfoundation.org
APPLICATION FOR FINANCIAL ASSISTANCE

Please use this 2018 revised form, any previous version will not be accepted
This form MUST be completed in full (5 pages) and ALL pertaining documents included

TELL US ABOUT YOURSELF
Is this your first application for assistance? Yes ☐    No ☐

First Name: _______________________________ Last Name____________________________________

Address: _____________________________________________________________ Apt#:____________

City:__________________________________ Province:____________  Postal Code: ________________

E-mail Address:_________________________________________________________________________

Home Phone # _____________________________  Bus/Cell Phone # ______________________________

Canadian Citizen:     YES □ NO □  Landed Immigrant: YES □ NO □ If YES, since when __________
Permanent Resident: YES □ NO □  If YES, have you been sponsored YES □ NO □

Marital Status____________________ # of Dependents and ages:_____________________________

Number of people living at this address (including non dependants & dependants): __________________

Relation to you: ________________________________________________________________________

HELP US UNDERSTAND YOUR DIAGNOSIS

Date diagnosed with breast cancer on_______________________ Type: ☐ Ductal ☐ Infiltrating

Stage: [ ] 1 [ ] 2 [ ] 3 [ ] 4 (metastasis to __________________________________)

<table>
<thead>
<tr>
<th>Treatment(s) received, current, or required</th>
<th>Date (from-to)</th>
<th>Name of Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

If you need more room please use a blank sheet of paper and attach with your application. Please label the additional sheet accordingly.

Are you still receiving chemotherapy and/or radiation?    YES □    NO □
Are you receiving treatment related to any side effects of treatment (lymphedema, neuropathy, etc)?
YES □    NO □ (if requesting assistance for above, medical proof is required)
YOUR MEDICAL TEAM

Family Doctor: ___________________ Phone Number ___________________ Ext.

Oncologist’s name: ____________________________ Phone Number ___________________ Ext.

Social Worker: ____________________________ Phone Number ___________________ Ext.

The confirmation of your diagnosis and the information related to the treatments received or currently received or to follow must be provided by your medical team on a letterhead from the health center. This document must be sent along the present form.

PLEASE HELP US UNDERSTAND YOUR FINANCIAL SITUATION

Are you receiving financial aid from the government or other institutions? YES □ NO □
If YES, please indicate the origin: ___________________ and amount: $___________________

Are you presently working? YES □ Current position: ________________________________
Full time □ Part time □
NO □ If NO, state the last day of work: _______________________
Position: __________________________________________

<table>
<thead>
<tr>
<th>Household Gross Monthly Income</th>
<th>Origin</th>
<th>Yourself</th>
<th>Spouse/Partner</th>
<th>Child(ren)</th>
<th>Other Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Insurance Income</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td></td>
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<tr>
<td>Social Aid</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td></td>
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<tr>
<td>Pension Disability</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td></td>
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<tr>
<td>Child Tax Benefits</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Child Support</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>CPP/Pension</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Rental Income</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>HST Credit</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
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</tr>
<tr>
<td>Other (specify)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Total per person</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

Your monthly expenses:

<table>
<thead>
<tr>
<th>Monthly Mortgage/Rental Payment</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groceries/Food</td>
<td>$</td>
</tr>
<tr>
<td>Cable/phone/internet</td>
<td>$</td>
</tr>
<tr>
<td>Utilities (hydro/water/gas)</td>
<td>$</td>
</tr>
<tr>
<td>Car payment/loan</td>
<td>$</td>
</tr>
<tr>
<td>Insurance</td>
<td>$</td>
</tr>
<tr>
<td>Money sent to support family in another country</td>
<td>$</td>
</tr>
<tr>
<td>Other (please indicate)</td>
<td>$</td>
</tr>
</tbody>
</table>

Total gross revenues $__________ Total expenses $__________ Difference $__________
PLEASE TELL US HOW THE "KELLY SHIRES FOUNDATION" CAN HELP?
Our goal is to financially assist you so that you can focus on your convalescence

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Note: Your request MUST include at least one expense related to your medical treatment.
(Alcohol, pop, magazines, lottery tickets, pet food and products, and plastic bags are not eligible. Please make sure that you deduct their cost from the requested amount.)

Your breast cancer treatment related expenses

<table>
<thead>
<tr>
<th>Type of expense (please indicate)</th>
<th>Amount</th>
<th>Receipts to include</th>
<th>Include d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication (for applicant only)</td>
<td>$</td>
<td>Original pharmacy receipts (patient’s name)</td>
<td></td>
</tr>
<tr>
<td>Other medical expense(s) (please indicate) (for applicant only)</td>
<td>$</td>
<td>Original receipts</td>
<td></td>
</tr>
<tr>
<td>Prosthetics, bras, wigs, sleeve</td>
<td>$</td>
<td>Original receipts</td>
<td></td>
</tr>
<tr>
<td>Medical travel expenses (gas, bus, taxi, etc) (maximum allowance is $300)</td>
<td>$</td>
<td>Original receipts and copy of the appointment-visit schedule</td>
<td></td>
</tr>
<tr>
<td>Parking, accommodation and meal expenses during the treatment (please indicate)</td>
<td>$</td>
<td>Original receipts and copy of the appointment-visit schedule</td>
<td></td>
</tr>
</tbody>
</table>

Your other expenses

<table>
<thead>
<tr>
<th>Type of expense</th>
<th>Amount</th>
<th>Receipts to include</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortgage or lease (maximum allowance is $700)</td>
<td>$</td>
<td>Copy of current lease or mortgage statement of account</td>
</tr>
<tr>
<td>Do you have mortgage insurance?</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Groceries (maximum allowance is $400)</td>
<td>$</td>
<td>Original cashier receipts</td>
</tr>
<tr>
<td>Hydro, gas, expenses related to the housing (maximum allowance is $300)</td>
<td>$</td>
<td>Copy of the invoice(s)</td>
</tr>
<tr>
<td>Telephone (maximum allowance is $50)</td>
<td>$</td>
<td>Copy of the invoice(s)</td>
</tr>
<tr>
<td>Other (please indicate)</td>
<td>$</td>
<td>Original receipts or copy of the invoice</td>
</tr>
<tr>
<td>Other (please indicate)</td>
<td>$</td>
<td>Original receipts or copy of the invoice</td>
</tr>
<tr>
<td>Other (please indicate)</td>
<td>$</td>
<td>Original receipts or copy of the invoice</td>
</tr>
</tbody>
</table>

Total amount requested: $ ____________

Note: The maximum amount payable per request is $1,000. Excess amounts WILL NOT BE
carried over for a future request (some exceptions however can be made). **ORIGINAL RECEIPTS MUST BE INCLUDED** and must be dated within 12 months of your application date. If you do not submit a treatment related expense, this request could be denied. Your application date is the date that WE receive your file at our office.

**AUTOGRAPH**

(Applicant must sign and authorize release to confidential information)

☐ I have read and understood the guidelines listed in the document “criteria”. I certify that the above information is accurate. I also understand that this information and the documents included are to be used by the Kelly Shires Breast Cancer Foundation for the sole purpose of assisting me financially.

☐ I understand and agree that my personal and medical information for purpose of this application will be shared with the members of the approval committee and/or Directors/staff of the charity.

___________________________________________              _______________________
Signature of Applicant                                      Date of Application

**Note:** Any false, fraudulent or misrepresented information will result in the denial of the application. If an application is denied due to the fore mentioned no further applications will be considered for the remainder for the calendar year.

**PLEASE HELP US TO HELP OTHERS**

PLEASE TELL US HOW YOU FOUND THE “KELLY SHIRES FOUNDATION” FINANCIAL ASSISTANCE PROGRAM (ie. Hospital, doctor, etc):

________________________________________________________________________________________
________________________________________________________________________________________

OTHER COMMENTS OR SUGGESTIONS?

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Kelly Shires Breast Cancer Foundation
523 Elizabeth Street, Suite #203
Midland, Ontario  L4R 2A2

Telephone: 705-528-1053  Toll free: 1-877-436-6467
E-mail: info@breastcancersnowrun.org

www.kellyshiresfoundation.org  www.breastcancersnowrun.org
“OFFERING FINANCIAL ASSISTANCE TO BREAST CANCER PATIENTS”
PLEASE NOTE THAT ALL FIVE (5) PAGES OF THIS APPLICATION MUST BE FILLED OUT AND SENT BY MAIL ONLY (NO FAXED APPLICATION PLEASE) TO BE ADMISSIBLE BEFORE THE COMMITTEE

Please Read Carefully and Fully

Document Checklist for Application

We understand that life is difficult and would like to make this application process as easy as possible for applicants. Therefore, it is important to note that the documentation requested below is MANDATORY in order for a request to be considered. It is important to note that an application is considered to be incomplete and will not be submitted to the Approval Committee if ALL pertinent documentation is not included. An incomplete application will be returned to applicant for re-submittal when complete

In order to establish financial need, applicants **MUST:**

Provide current income tax notice of assessment (approval committee reserves the right to request previous years complete income tax return upon request). If lost, a copy can be obtained by calling CRA at 1-800-959-7383

- Receipts **MUST** be provided for amounts claimed through the fund (originals are required, must be organized and NOT high lighted).
- Proof of citizenship/approved landed immigrant status **MUST** be provided.
- Applications requesting assistance for rent or mortgage **MUST** include documentation supporting the amount they are requesting.
- Each application must include an item directly related to breast cancer diagnosis and/or treatment

All personal information is protected under the Canadian Privacy Act. (kindly note that if the requested documentation is not included, it will only delay any financial assistance that could possibly be provided).

THE FOLLOWING MUST BE INCLUDED WITH YOUR APPLICATION:

<table>
<thead>
<tr>
<th>Documents to include</th>
<th>For 1st request</th>
<th>For additional request the same calendar year</th>
<th>For additional request the next calendar year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Official document from your health center confirming the diagnosis, treatments received, current and to follow</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copy of your current taxes filing Federal and Provincial, your spouse/partner one if applicable</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copy of your current or last Tax Assessment Federal and Provincial, and your spouse/partner's, and any adult other household member (adult children, parents, in-laws, etc)</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proof of Citizenship or landed immigrant status or Birth Certificate or copy of Passport</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Proof of other funding received / copy of income statement</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Original receipts (medication, groceries, transportation, parking, accommodation, meals)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document Required</td>
<td>Status</td>
<td></td>
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<tr>
<td>-------------------------------------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Copy of the utilities invoices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copy of your current lease or mortgage statement (document showing the paid amount)</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copy of your LTD (long term disability coverage) summary, if applicable</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Application form signed by the applicant</td>
<td></td>
<td></td>
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</tbody>
</table>