KELLY SHIRES BREAST CANCER FOUNDATION

Criteria for Financial Assistance

Title: Criteria for Funds Administration

Revisions: April 9, 2024

Purpose: This criterion guides the association in assessing requests from applicants who submit a formal application to the charity requesting financial assistance in relation to their breast cancer treatment/diagnosis. The mission is to provide assistance to women/men 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 a need for financial assistance. Applications missing the mandatory documents are considered incomplete and cannot be processed until the required documentation is received. Please refer to #7 of the criteria document 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 **$1,300.00** (funds permitting).

5. Applicants can apply 3 times to the Trust per calendar year, funds permitting. A new application may not be submitted to the Charity before the current application has been submitted, reviewed and responded to. Only one application will be accepted monthly. Sending multiple or post-dated applications will result in the complete file being returned without approval consideration. Only complete applications will be accepted, please do not send your application incomplete or without supporting documents, this will only delay or result in the return of the application.

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

7. In order to establish financial need:
   - ✓ Applicants **must** provide current income tax Notice of Assessment (NOA) **and** their current full income tax return (T1 General).
   - ✓ Applicants **must also** provide NOA and T1 General 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, investment revenue, etc.)

- ✓ **ORIGINAL** receipts **must** accompany your application 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. Receipts must also directly apply to the request. Please do not use any type of highlighter on receipts.
- ✓ 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).
- ✓ Proof and disclosure of any and all funding/income received by government, other organizations, agencies or family support.
- ✓ Copies of 4 consecutive weeks of paystubs from all employed members living in the household.
- ✓ Applicant must include medical report supporting diagnosis.

Please note that applications cannot be considered complete and presented to the approval committee unless **ALL** pertinent documentation is included, documentation requested is mandatory – if documentation is not included it will 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 the applicant has any type of Long-term disability (LTD) coverage, a copy of your coverage is required to be submitted with your application.

11. If you have a monthly surplus your application can possibly be denied.

12. The Approval Committee, under discretion, retains the right to deny any application. Abuse of the application process, Charity Staff /Volunteers WILL result in automatic disqualification indefinitely.

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

- Transportation to/from the center 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 center/hospital.
- Food costs during **active** treatment.
- Child-care services while at the center/hospital for an appointment or treatment or in hospital.
- Home health aides.
- Prosthetics/specialized lingerie/wigs (less available provincial funding) **
- Supportive care: counselling 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, prescription glasses due to change of vision (will need approval from a licensed medical practitioner).

- Other expenses related to treatment; living costs during treatment and recovery.
- Rent/mortgage payment.
- Expenses not listed above can be submitted and considered after review by the 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 prostheses? Refer to our resource page for more details or contact your provincial government****

Application Process:

1. Submit a **COMPLETED** application to the Kelly Shires Breast Cancer Foundation by **MAIL** with **ALL** supporting documents**.** Partial or emailed applications will NOT be accepted. Applications can be downloaded online at www.kellyshiresfoundation.org or requested by email at info@kellyshiresfoundation.org. Applicants must disclose if they are receiving any financial assistance from other sources (e.g., programs in center, child support, any government assistance, health insurance programs, group insurance programs (LTD benefits), etc.

2. Priority will be given to:
    - low-income applicants (size of family will be taken into consideration, low income determined by Stats Canada).
    - 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 mail or e-mail. Please note that applications are processed as quickly as possible.

In order to help as many breast cancer patients as possible, assistance for funding 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 $800/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 $500/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 $500/request.
- Wig cap of $500.
- Lifetime financial assistance cap of $15,000.00 (**CANNOT** be issued as a one-time lump sum).

Updated: April 9, 2024

Kelly Shires Breast Cancer Foundation

APPLICATION FOR FINANCIAL ASSISTANCE

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-dependents & dependents): _____
Relation to you: _____

HELP US UNDERSTAND YOUR DIAGNOSIS

Date diagnosed with breast cancer on_____ Type: ☐ Ductal ☐ Infiltrating
Stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4 (metastasis to_____)

Treatment(s) received, current, or required	Date (from-to)	Name of Facility

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)

OTHER HEALTH ISSUES & MEDICATION

Please let us know any other health conditions and medications prior to your breast cancer diagnosis:

Other Health Conditions	Date Diagnosed	Medication(s)

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, 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 with this application.

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: $_____

Do you receive housing subsidiary YES ☐ NO ☐ If yes, amount received monthly $_____

Are you presently working? YES ☐ Current position: _____ Full time ☐ Part time ☐

NO ☐ If NO, state the last day of work: _____Position: _____

Is your Spouse/Partner presently working? YES ☐ NO ☐ If NO, state the last day of work:_____

Household Gross Monthly Income	Origin	Yourself	Spouse/Partner	Child(ren)	Other Person
Salary		$	$	$	$
Insurance Income		$	$	$	$
Social Aid/Gov. Assistance		$	$	$	$
Pension Disability		$	$	$	$
Child Tax Benefits		$	$	$	$
Child Support		$	$	$	$
CPP/Pension		$	$	$	$
Rental Income		$	$	$	$
HST Credit		$	$	$	$
Spousal Support		$	$	N/A	N/A

Investment revenue		$	$	$	$
Other (specify)		$	$	$	$
Total per person		$	$	$	$
Total Revenue		$	$	$	$

Your monthly expenses:	Monthly Mortgage/Rental Payment	$
	Groceries/Food	$
	Cable/phone/internet	$
	Utilities (hydro/water/gas)	$
	Car payment/loan	$
	Insurance	$
	Money sent to support family in another country	$
	Other (please indicate)	$

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 (for applicant only)

Type of Expense	Amount	Receipts to Include	Included
Medication	$	Original pharmacy receipts (patient's name)	
Other medical expense(s)	$	Original receipts	
Prosthetics, bras, wigs, sleeve	$	Original receipts	
Medical travel expenses (gas, bus, taxi, etc.) Maximum allowance is $500	$	Original receipts and copy of the appointment-visit schedule	
Parking, accommodation and meal expenses during the treatment	$	Original receipts and copy of the appointment-visit schedule	

Your other expenses

Mortgage or lease (maximum allowance is $800) Do you have mortgage insurance? _____	$	Copy of current lease or mortgage statement of account	
Groceries (maximum allowance is $500)	$	Original cashier receipts	
Hydro, gas, expenses related to the housing (maximum allowance is $300)	$	Copy of the invoice(s)	
Telephone (maximum allowance is $50)	$	Copy of the invoice(s)	
Other (please indicate)	$	Original receipts or copy of the invoice	
Other (please indicate)	$	Original receipts or copy of the invoice	
Other (please indicate)	$	Original receipts or copy of the invoice	

Total amount requested: **$ _____**

The maximum amount payable per request is $1,300. 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 (i.e. hospital, doctor, etc.):

_____

_____

_____

_____

_____

OTHER COMMENTS OR SUGGESTIONS?

_____

_____

_____

_____

WOULD YOU BE INTERESTED IN SPEAKING AT ONE OF OUR FUNDRAISING EVENTS, SHARING YOUR STORY AND HOW THE FOUNDATION HELPED YOU?

_____

_____

_____

_____

Kelly Shires Breast Cancer Foundation
P.O. Box 93366
RPO Yonge Mulock
Newmarket, Ontario
L3X 1A3

E-mail: info@kellyshiresfoundation.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 APPROVAL 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** for a request to be considered. It is important to note that an application is 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 the Canada Revenue Agency (CRA) at 1-800-959-7383.
- ✓ Receipts **MUST** be provided for amounts claimed through the fund (originals are required, must be organized and NOT highlighted).
- ✓ 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 delay any financial assistance that could possibly be provided.

THE FOLLOWING MUST BE INCLUDED WITH YOUR APPLICATION:

Documents to include (use this table as a checklist. Once the document is included, check off the appropriate box)	**1st request**	**additional request the same calendar year**	**additional request the next calendar year**
Official document from your health center confirming the diagnosis, treatments received, current and to follow.		**N/A**	
Copy of your current T1 General tax return filing Federal and Provincial **and** your spouse/partners T1 General.		**N/A**	
Copy of your current or last tax Notice of Assessment (NOA) Federal and Provincial, **and** your spouse/partner's, and any adult other household member (adult children, parents, in-laws, etc.)		**N/A**	
Proof of Citizenship/landed immigrant status or Birth Certificate or copy of Passport.		**N/A**	**N/A**
Proof of other funding received / copy of income statement.		**N/A**	
Original receipts (medication, groceries, transportation, parking, accommodation, meals).			
Copy of the Utility invoices.			
Copy of your current lease or mortgage statement (document showing the paid amount).		**N/A**	
Copy of LTD (long term disability coverage) summary, if applicable.		**N/A**	
If not working, copy of your ROE (Record of Employment)			
Application form signed by the applicant.			