Kelly Shires Breast Cancer Foundation

Updated: September 10, 2025

Financial Assistance Program

The Kelly Shires Breast Cancer Foundation understands that a breast cancer diagnosis brings many unexpected expenses. Our goal is to ease some of the financial burden so you can focus on your health and recovery. We rely on the generosity of donors and are not government-funded. We are a volunteer-based Foundation.

Who Can Apply?

- Anyone diagnosed with breast cancer (priority is given to those currently in treatment).
- Applicants must be Canadian citizens, permanent residents, or approved landed immigrants.
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How Much Can I Apply For?

- Up to $1,300 per application (funds permitting).
- Up to 3 times per calendar year (maximum once per month). Post-dated applications not accepted.
- Lifetime cap: $15,000 (not issued as a lump sum).

What We Can Help With (examples but not limited to)

- Transportation, parking, or accommodation for treatments.
- Breast cancer-related medications that are not covered by insurance.
- Groceries (up to $500).
- Rent or mortgage (up to $800).
- Utilities (up to $300).
- Prosthetics (also check with your provincial government for prosthetic funding)
- Wigs (up to $500).
- Eyewear due to treatment side effects (up to $500/year).
- Childcare, counselling, and home support during treatment.
- Supportive care (i.e. counselling for the patient or family members)

What You Need to Include

- Completed 5-page application form (signed) with supporting documents.
- Proof of breast cancer diagnosis (medical report and/or letter from your medical team).
- Original receipts for expenses (dated within the last 12 months). Photocopies will not be accepted.
- Schedule of appointments if requesting funds for transportation, parking, or accommodation for treatments.
- T1 General tax return and Notice of Assessment (NOA) for you, spouse/partner, and any adult 18+ household members.
- Proof of ALL income sources (pay stubs, social aid, child tax benefits, rental income, ROE, benefits, pensions, child support, spousal support etc.).
- Paystub copies for spouse/partner or other earning adults in household (4 consecutive weeks).
- Proof of citizenship/residency (passport, birth certificate, PR card, etc.).
- Proof of rent/mortgage.
- LTD coverage details (if applicable).
- ROE (Record of Employment, if applicable)
- Void cheque if requesting direct deposit.
- Bank statements may be requested in order to help validate your gross monthly income.

You must include at least ONE expense directly related to your diagnosis/treatment.

How to Apply

Mail your completed application form and supporting documents with original receipts to:

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

Applications that are emailed will **not** be accepted.

Application forms can be downloaded at www.kellyshiresfoundation.org or requested by email at info@kellyshiresfoundation.org.

💡 Tip: Keep copies of all receipts and documents before mailing your application.

We are here to help. Assistance is reviewed as quickly as possible, and applicants will be notified of their status by mail or email.

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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 <u>monthly</u> 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 <u>and</u> copy of the appointment-visit schedule	
Parking, accommodation and meal expenses during the treatment	$	Original receipts <u>and</u> 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.

Please indicate if you would prefer Direct Deposit or cheque (if approved)

☐ **Direct Deposit (Please attached void cheque)** ☐**Cheque**

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)			
Copy of Void Cheque (if you chose Direct Deposit option)		Only if banking	Details changed
Application form signed by the applicant.			