UNI-AIDE FOUNDATION & LOWER NORTH SHORE HEALTH FUND

FINANCIAL ASSISTANCE APPLICATION
2016 - 2017

Introduction:

The Coasters Association established the *Lower North Shore Cancer Fund (LNSCF)* in 2010 as one of measures needed to support Cancer Patients on the Lower North Shore. The Lower North Shore Cancer Fund was a regional fund managed by the Coasters Association through a volunteer committee called the Cancer Fund Administrative Committee whose mission was to support cancer patients financially burdened by cancer and to enhance the quality of life for people living with cancer. The mission was achieved by: Supporting people living with cancer and advocating for healthy public policy**.**

The Fondation Uni-Aide was created in 1992 by a group of concerned citizens with the help of administrators of the Caisse populaire Desjardins de Blanc-Sablon, to help residents from Old Fort Bay to Blanc-Sablon who had medical expenses and could not afford to get them. The Foundation progressed through the years, it still gives donations for medical related expenses and also gives temporary loans for the same purpose for those who travel and will get the 150$ reimbursement from the Health Center. Fondation Uni-Aide is managed by a Board of Administrators and a separate committee evaluates the requests.

In 2012 the Coasters Association met with Fondation Uni-Aide to discuss how the Cancer Fund & Uni-Aid could work together and better serve the population of the Lower North Shore. Thus the **Lower North Shore Health Fund (LNSHF)** was born – to support the population of the Lower North Shore financially burdened by illness and to enhance the quality of life for those living with health issues.

The Lower North Shore Health Fund is one of the support services offered by the Coasters Association and Fondation Uni-Aide. The program gives support to people in financial need for transportation, medication and living allowances when traveling to and from treatment facilities. Some financial assistance is also available for caregivers.

100% of all funds donated go directly to support patients on the Lower North Shore.

Support includes:

1. Medication

- Prescribed by a Doctor but not covered under Medicare or by insurance (experimental treatment will require detailed analysis)
- Receipts must be provided
- Determined on a case by case basis

2. Travel

- Escort to accompany patient – maximum of $1,800.00
- Lower North Shore residents temporarily off the coast due to work or travel, contribution to aid in return to Quebec (maximum of $1,800.00)

3. Living allowance

- Available to patient and escort—a maximum total of $250.00 per week (amount allocated depends on subsidies already being received from other sources)

Guidelines for Requests for Financial Assistance

Health issues can be a tremendous financial burden, on a patient as well as a family.

The Lower North Shore Health Fund Administration Committee is a volunteer committee, consisting of concerned and compassionate individuals who responsibly administer financial aid to persons dealing with health issues.

When completing the application, please ensure:

⇒ All submissions are accompanied by a formal estimate of cost and/or receipt (s)
⇒ That the form is completed and signed by the applicant and professional in charge

Moreover, please note:

⇒ Requests for financial assistance will be granted based on admissibility and availability of funds
⇒ Failure to comply with conditions will result in automatic refusal of subsequent request

Additionally:

⇒ Upon approval of your request, the conditions of acceptance will be stated

Should there be any questions or concerns regarding the request for financial assistance application or its guidelines, please forward them to the Lower North Shore Health Fund Administration Committee or the Uni-Aide Board of Directors a:

313 Boul. Bonne Esperance
P.O.Box 10
St. Paul's River, QC
G0G 2P0
Tel: 418-379-2006
Fax : 418-379-2621

Uni-Aide Foundation Lower North Shore Health Fund

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CONFIDENTIALITY: We respect your privacy. Collection of your personal information is to assess your eligibility and process your file for assistance. Only authorized staff will access this information.

Type of Assistance you are seeking:

[ ] **Travel Assistance** *(Please complete this form)*
[ ] **Medical** *(Please complete this form)*
[ ] **Living allowance** *(Please complete this form)*

Patient's Name ______________________________

Medicare # (required) ______________________ Date of Birth _____ / _____ / _____
D M Y

Address (Street or R.R. #) ______________________________

Town, City, etc. ______________________ Postal Code ______________

Telephone (Res.) ______________________ (Work) ______________________

E-mail(optional) ______________________ bank account : transit _________ folio_________

Married ______ Common - Law ______ Single ______ Separated ______ Widowed ______

Next of kin ______________________ Tel. # ______________

Address: Same as above _________ or ______________________

____

Number of children at home_________ Ages __________ # of people in household: ____________

Family Physician ______________________ Tel. ______________

Specialist ______________________ Tel. ______________

Type of illness ______________________________

Date you were diagnosed ______________________
Is this a recurrence? Yes ______________ No ______________

Treatment required and dates: (Please check)

Surgery [yes] [no] Date: __________

IV Chemotherapy [yes] [no] Dates: _________

Other (specify)_______________Date: __________

Radiation Therapy [yes] [no]
Dates: __________

Oral Chemotherapy [yes] [no] Dates: __________

Signature of Specialist and or Physician: ______________________________

Foundation Uni-Aide & Lower North Shore Health Fund

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Requesting Assistance for:

Travel Allowance	
Amount	$: ________________

Treatment Expenses	
Food, drink and/or supplements	$:_________
Medicine	$: __________
Equipment	$: _________
Other	$: _________

Transportation means	
Personal Vehicle (.25/km)	$: _________
Private transportation (.25/km)	$: _________
Taxi	$: _________
Bus	$: _________
Parking	$: _________
Other	$: _________

Additional Information

Family income $:______________

Savings and Investments, please give details and attach statements:

- Chequing account balance $: _________
- Non registered savings accounts balance $: _________
- Registered (RRSP TSFAs etc..) balance $: _________
- Other investments or savings (Please give details) ___________________________ balance $: _________

Amount received from CSSSBCN $:_________

Please note that all original receipts and/or invoices must be attached

Has your income decreased? No ☐ Yes ☐ if yes, give details:

____

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____

____

Are you currently working, or receiving Employment Insurance, Disability, OAS, QPP or income from any other source? No ☐ Yes ☐ if yes, give details:

____

____

____

____

Have you requested or received financial assistance from:

Insurance company No ☐ Yes ☐ if yes, give details:

____
____
____
____

Other sources No ☐ Yes ☐ if yes, give details:

____
____
____
____

Where will you be residing and what is the cost of lodging?

Address: ______________________
____
____
____

Cost: $: __________ per day☐ week☐ month ☐

Have you resources available to you in the location where your treatment will take place?

No:☐ Yes:☐ Family/friends ☐ Other (specify) _________________________

How will they assist you:

____
____
____
____

I consent to the collection of financial information with my financial institution(s). This information will only be used for this analysis of financial aid with the Lower North Shore Health Fund and will remain confidential. No ☐ Yes ☐

I understand that all financial information is required in order to thoroughly access my application and that if, at any date, my financial information deems that my application is ineligible then I am required to reimburse the Uni-Aide Foundation for the appropriate amount.

____ ___________________________
I declare that the information provided is true: Signature *Date*

Please mail completed form to: 313 Bonne Esperance Boul., P.O. Box 10, St. Paul's River, Qc, G0G 2P0

Please fax completed form to: 418-379-2621

Please email completed form to: hssnpi@globetrotter.net