Believe IN THE GOLD

FAMILY INFORMATION		
Patient Name:		Date of Birth:
Parent Name:		
Email Address:		
City:	Province:	Postal Code:
Telephone:	Referred By:	

HEALTH INFORMATION	
Diagnosis:	Date of Diagnosis:
Estimated Treatment Time – Plan:	
Oncologist:	Hospital/Facility:
Primary Nurse or Social Worker (if applicable):	

REQUEST FOR FUNDING	
Prescription Drugs:	
Equipment Rentals - Purchase:	
Transportation & Meals (Separate Travel Application Required):	
Wig:	Other:
Do you have extended health benefits to cover some of these expenses related to your treatment? YES ■ NO ☐	
Are you receiving services from the Community? YES ☐ NO ■	
How has the diagnosis and/or treatment of your cancer impacted your ability to pay for these expenses?	

VERIFICATION: *By signing you are consenting to release information to Believe in the Gold*

I (Parent/Guardian) verify this information to be true: _____ _____

Signature *Date*

Believe in the Gold use: _____ _____

Signature *Date*

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