

The Wendy Bear Patient Assistance Program is named in memory of the wife of hockey legend Darryl Sittler, a long-time supporter of CCC. Wendy was instrumental in assisting with raising awareness and funds for Colon Cancer Canada before her passing in 2002. She wanted to ensure that anyone diagnosed with colon cancer would have the necessary support to help them manage their life with this disease. It is in her memory that the Wendy Bear was created with 100% of the proceeds of the bear going directly to support palliative care patients in need of financial assistance.

PROGRAM GUIDELINES

Program Eligibility

All palliative (Stage 3 or 4) colorectal cancer patients residing in Canada who are experiencing financial hardship due to the disease are eligible to apply to this program. Financial assistance is provided on a calendar year basis to patients that are determined to be in financial need and meet our income qualification guidelines of less than a combined **\$60,000** per household annually.

1. A copy of their previous year tax return
2. A copy of spouse/partner's previous year tax return
3. A letter from the social worker or patient stating the financial situation of the patient and their notice of assessment.
4. All receipts from the calendar year of request.

Returning Applicants

Patients may submit multiple applications for the same calendar year provided they complete a new application for each submission. Patients may re-apply for support as often as it is needed but Colon Cancer Canada reserves the right to decline additional funding to a patient if:

The additional funding will bring the total over the calendar year maximum of **\$1,000** per patient.

Each application for assistance is reviewed by the board of directors taking into consideration income level and current out-of-pocket medical and day to day expenses.

Costs that are supported by CCC Funding:

- Medications not covered by Provincial/Private Healthcare (*i.e. pain medications etc.*)
- Homecare assistance (nursing, specialized bedding, etc.)
- Colostomy/Stoma Supplies (up to maximum of **\$500** per application)
- Pharmacy Bills (non prescription symptom relief/toiletries (vitamins, cough drops, Ensure, Dulcolax, etc.)
- Groceries (up to a **\$250** maximum per application)
- Rent/Utilities/Mortgage Payments (phone coverage up to **\$100**, utilities up to **\$500**)
- Petrol/Parking/Transportation (up to **\$250** maximum per application)
- Child Care Costs (care during parental absence due to treatment)

Costs that are not supported by CCC funding:

- Treatment Protocols not covered completely by Provincial/Private Healthcare (*i.e. Infusion Therapies, Chemotherapies etc.*)
- Credit Card Payments (without substantiating the origin of the costs i.e. if credit card was used to cover costs for any of the above supported by CCC funding criteria then these expenses can qualify)
- Alternative Medical Therapies

Costs that are supported by CCC funding on a case-by-case basis:

(Each must be accompanied by a letter from medical professional detailing requirement for care)

- Dental Care
- Eyeglasses/Eye Care



ALL FIELDS MUST BE FILLED BEFORE SUBMITTING APPLICATION

All applications should be completed by a physician or social worker. Fax or mail the form to Colon Cancer Canada. Once the form has been reviewed, we will contact the appropriate person.

Patient Information

NAME OF PATIENT		DATE OF APPLICATION:
DATE OF BIRTH	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	
MAILING ADDRESS		
PHONE	EMAIL	
Will you allow Colon Cancer Canada to contact you with resources, support, and updates? Yes <input type="checkbox"/> No <input type="checkbox"/>		
MARITAL STATUS	NAME OF SPOUSE/PARTNER	
DEPENDENTS Yes <input type="checkbox"/> No <input type="checkbox"/>	IF YES, PLEASE LIST DEPENDENTS LIVING AT HOME	

Administration Information

CONTACT NAME (Social Worker or Physician)	PROFESSIONAL TITLE
ORGANIZATION	
MAILING ADDRESS	
PHONE	EMAIL

Medical Information

TO BE FILLED IN BY PHYSICIAN

DIAGNOSIS		STAGE	DIAGNOSIS DATE
TREATMENTS REQUIRED <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Surgery Occurrence of Treatments: _____ / per year		MATERIALS REQUIRED <input type="checkbox"/> Stoma Bags <input type="checkbox"/> Other: _____	
NAME OF PHYSICIAN		PROFESSIONAL TITLE	
MAILING ADDRESS		PHONE	
SIGNATURE OF PHYSICIAN			

Financial Information

Please fill out the following financial information to assist in the decision making process. A copy of the previous year's tax return and a letter from the social worker or patient stating the financial situation of the patient must also be submitted.

EMPLOYMENT STATUS <input type="checkbox"/> Employed Full Time <input type="checkbox"/> On Disability or Sick Leave <input type="checkbox"/> Health Coverage <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Unemployed		
FINANCIAL ASSISTANCE <input type="checkbox"/> Government Funding Program: \$ _____ <input type="checkbox"/> Charitable Funding Program: \$ _____ <input type="checkbox"/> Other: \$ _____		AMOUNT RECEIVED ANNUALLY
NAME OF FINANCIAL ASSISTANCE PROGRAM		

Funding Request Information

Receipts, invoices or statements must be submitted for all funding requests. All receipts provided must be dated with the same calendar year as application. Requests without these documents will NOT be funded.

Medications not covered by provincial/private health care	\$
Home Care Assistance (Nursing, specialized bedding, etc.)	\$
Colostomy/Stoma Supplies (up to a maximum of \$500 per application)	\$
Pharmacy bills – non-prescription symptom relief/toiletries (Visine, vitamins, Ensure, cough drops, Immodium, Dulcolax)	\$
Groceries (up to a maximum of \$250 per application)	\$
Dental Care/Eye Care (Letter from Doctor detailing need for care is required, up to a maximum of \$250 per application)	\$
Rent/Utilities/Mortgage (phone coverage up to \$100, utilities up to \$500)	\$
Petrol/Parking/Transportation – costs related to appointments/treatment (up to a maximum of \$250 per application)	\$
Child Care Costs (Care during parental absence due to treatment)	\$
Other (please describe below)	\$
TOTAL AMOUNT REQUESTED – Up to \$1,000 per year	\$

Please submit this application and all required documents (copies of all receipts, the previous year tax returns and a letter stating the financial situation of the patient) to the below coordinates via fax or mail.

Colon Cancer Canada
RE: Wendy Bear Patient Assistance Program
5915 Leslie St, Suite 204
Toronto, ON, M2H 1J8
Tel: 416-785-0449 | Fax: 416-785-0450
Email: info@coloncancerCanada.ca | Website: coloncancerCanada.ca