FINANCIAL AID APPLICATION

Guérir en Communauté – More Than a Cure MTAC's (hereinafter "**MTAC**") Financial Assistance Program was created to address the financial impact of a breast cancer diagnosis on patients. When an individual is fighting for their life, MTAC believes that no person should ever have to ask themselves whether they can afford to survive. The program provides up to $2,000 per individual on a one-time basis via gift certificates directed towards basic needs (ex. food, pharmacy costs, hospital transport, etc.) to provide some relief of the economic hardship being faced.

Eligibility Requirements

- Diagnosis of breast cancer - Must be in active treatment (surgery, chemotherapy, radiation or immunotherapy) or within 12 months of having completed treatment
- Applicant is a Canadian citizen, permanent resident or asylum-seeker
- Application must be signed by patient's oncologist, oncological nurse or oncological social worker

Required Documents

- A copy of the Provincial and Federal Notice of Assessment the last fiscal year (all pages)
- A copy of the Provincial and Federal spouse's Notice of Assessment for the last fiscal year, if applicable[1].(all four pages)
- If applicable, a copy of the latest Financial Statement, for any Legal Person or business where you hold at least 25% control and receive or are expected to receive a benefit as dividend, bonus, or otherwise.
- If on sick leave-Proof of employment income in the year prior to breast cancer diagnosis; last pay stub, recent proof of salary, disability insurance or employment insurance.
- If you are currently receiving spousal support, please provide confirmation of the sums received and, if applicable, the expected end date for said payments along with supporting documents.[2] [3]
- Letter of intent - Written by the Applicant explaining their situation in detail and need for financial assistance. Applicant must explain the financial impact of the diagnosis and which basic needs the funds will be used for.

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[1] If you have been separated from your spouse for at least 90 days due to a breakdown in the relationship and with no foreseeable chances of reconciliation, you are exempted from providing said document. While the information is deemed to have been submitted in good faith, MTAC reserves its rights to take any reasonable measure, including but not limited to ceasing financial aid, should it be determined false information has been submitted in order to influence one's eligibility for financial aid.

[2] Supporting documents can be a copy of the safeguard, interim, or divorce judgment, consent, or T1 form indicating the spousal support payments.

[3] The following information is and will remain strictly confidential and is exclusively used by the MTAC Board of Director for the sole purpose of analysing and determining financial aid.

Additional Information

- Please send your application & all supporting documents to: morethanacure.financialprogram@gmail.com

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Disclaimer: By completing the following form, you agree to communicate the information contained within the form and the supporting documents with MTAC, and for the said information to be used internally for the purpose of determining financial aid and internal statistics. The information will remain strictly confidential and will not be shared with third parties, unless pre-approved by the Applicant, and solely for the purpose of providing adequate services. Should information be used for statistical purposes, it will be confidential and separated from the identity of the Applicant. For more details regarding our terms and conditions, and privacy policy, please visit www.morethanacure.com.

<table>
<tr><th colspan="3">PERSONAL INFORMATION</th></tr>
<tr><td colspan="2">First Name</td><td>Last Name</td></tr>
<tr><td colspan="2">Date of Birth (DD/MM/YY)</td><td>Email</td></tr>
<tr><td colspan="2">Phone (Home)</td><td>Phone (Cell)</td></tr>
<tr><td colspan="2">Address</td><td>Apartment/Unit#</td></tr>
<tr><td>City</td><td>Province</td><td>Postal code</td></tr>
<tr><td colspan="3">Immigration Status

Canadian citizen Permanent Resident Asylum seeker other: _____</td></tr>
<tr><td colspan="3">Marital status

Single Common law Married Widow Divorced Separated[4]</td></tr>
<tr><td colspan="2"># of dependents under age 18 _____
# of dependents over age 18 _____</td><td>Ethnicity
White Black Asian Indigenous Hispanic Arab
Multiracial/Other _____ Prefer not to say</td></tr>
</table>

[4] The general definition of separation is when there is a voluntary separation due to a breakdown in a relationship of 90 days or more with no foreseeable possibility of reconciliation.

What are your current sources of income? If more than one option applies, please circle all options.

Employment income Salary insurance Employment insurance Disability Insurance

Pension Welfare Other (please specify) _____

Where would financial aid be most helpful?

Food / groceries Childcare Transport Pharmacy Phone Bill Wigs/Cold Cap

Other (please specify) _____

Would you be interested in any of the following, if available? (Indicate Yes / No)

Age-appropriate workshops to help children cope with a parent's cancer diagnosis _____

Legal advice / help with regards to divorce, custody _____

Access to health and wellness programs _____

Products to aid with sensitive skin _____

Would you be interested in sharing your story (ie. in writing, in a video, social media)? _____

**Please note that financial aid is NOT dependent on sharing your story and this is NOT required **

MEDICAL INFORMATION

This section must be completed by your health care professional (e.g. oncologist, nurse, social worker)

Patient First Name	**Patient Last Name**
Date of Breast Cancer Diagnosis (MM/YY)	**If recurrence, indicate date of recurrence (MM/YY)**
Stage at time of diagnosis Stage 0 Stage 1 Stage 2 Stage 3 Metastatic Unknown	**Last treatment received** Mastectomy Chemotherapy Immunotherapy Radiation therapy Is treatment ongoing Other _____

more than a cure

Treatment Start Date (DD/MM/YY)		**Treatment End date (if applicable) (DD/MM/YY)**
Last day of work due to diagnosis (DD/MM/YY) (if applicable)		**Expected return to work date (DD/MM/YY):** Mandatory if applicable
Name of Health Care Professional		**Title**
Hospital Centre	**Phone**	**Email**
Health Care Professional's Signature (attesting the accuracy of above information)		**Date (DD/MM/YY)**

- ☐ I, the undersigned, _____, consent to this information being shared with members of MTAC's Board of Directors with the sole purpose of being able to provide financial support and aid to me. I also consent to members of the MTAC team to discuss my file with members of my medical team if need be. Finally, I understand that MTAC Foundation reserves the right to refuse any financial aid request for any reason that it deems reasonable, that the amount paid must respect the limits of the budget allocated annually for this program and that the amounts granted, and eligibility criteria are subject to change without notice.
- ☐ I consent for MTAC to use the following information for internal statistics to better understand and adjust the goal of their mission. I understand that MTAC undertakes to maintain all information confidential and ensures that any statistic is not traceable to specific individuals.
- ☐ I confirm that all the information that has been submitted is true and complete and understand that, while MTAC relies on the good faith of Applicants, should MTAC find any discrepancies caused by, but not limited to, false information being submitted, MTAC reserves its rights to take all reasonable and necessary measures which might include a refusal to provide additional services or legal procedures.

_____ _____ _____

Applicant Name Applicant Signature Date (DD/MM/YY)