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**FINANCIAL AID FOR COLD CAPPING IN COLLABORATION WITH COLD CROWNS  
APPLICATION FORM**

CURE Foundation’s partnership with Cold Crowns was created to break down financial barriers, making cold capping more accessible, so that financially disadvantaged breast cancer patients have the option to retain their hair – and with it, a sense of confidence and normalcy – throughout treatment.

In collaboration with Cold Crowns, low-income breast cancer patients can now apply for a **one-time grant of up to $2000** to assist with covering cold capping expenses through Cold Crowns.

***Kindly note that those applying for this grant are not eligible to apply to CURE’s Financial Assistance Program.***

**Eligibility Criteria**

• The applicant must be **recently** diagnosed with breast cancer.

• Must be **starting active chemotherapy**.

• The applicant must be a Canadian citizen, approved landed immigrant or permanent resident.

• The application must be signed by either the patient`s social worker, nurse or oncologist.

**Required Documents**

• Completed application ;   
• A copy of Notice of Assessment for the last fiscal year (all 4 pages)

• A copy of spouse’s Notice of Assessment (if applicable) for the last fiscal year (all 4 pages)

• Only 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.

• Letter of intent written by the applicant explaining his or her situation in detail and desire for cold capping.

|  |  |  |  |
| --- | --- | --- | --- |
| **Personal Information** | | | |
| First Name | | Last Name | |
| Date of Birth (DD/MM/YY) | | Email | |
| Phone (Home) | | Phone (Cell) | |
| Address | | Apartment | |
| City | Province | | Postal code |
| Marital status   * Married * Common law * Widow * Single * Divorced/separated | | | |
| Number of dependents under the age of 18  Please submit Proof of Birth if applicable | | | |
| What are your current sources of income?   * Employment income * Salary insurance/employment insurance/disability insurance * Retirement income * Welfare * Other (please specify) | | | |
| The CURE Foundation relies on testimonials to continue its work. Would you be willing to share your story with us to help make a difference for other patients?   * **YES** * **NO** | | | |

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**Financial Assistance Program Application Form**

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|  |  |  |  |
| --- | --- | --- | --- |
| **Medical Information**  **This section must be completed by your health care professional (e.g. doctor, nurse, social worker)** | | | |
| Date of Breast Cancer Diagnosis (MM/YY) | | If this is a recurrence, please indicate date of recurrence (MM/YY) | |
| * Stage 0 * Stage 1 * Stage 2 * Stage 3 * Metastatic * Unknown | | Has Cold Capping been recommended by your Health Care Professional?  (Y/N) | |
| Expected Start Date of Chemotherapy (DD/MM/YY) | | Expected End Date of Chemotherapy (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 | |
| By signing, I authorize the CURE Foundation to contact me directly by phone or email to confirm the applicant’s medical information. Confirmation of the applicant’s medical status can also be sent directly to [infocure@curefoundation.com](mailto:infocure@curefoundation.com). | | | |
| Name of Health Care Professional | | Title | |
| Hospital Centre | Phone | | Email |
| Health Care Professional’s Signature  (attesting the accuracy of the information indicated above) | | Date (DD/MM/YY) | |

I certify that the above information is accurate and complete. The anonymized data will be used for statistics. For verification purposes, I authorize the CURE Foundation to discuss my file with the members of my medical team. I understand that the CURE Foundation reserves the right to refuse any 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.

Signature

Date

**Please send your application (with all required documents) by mail or email:   
CURE Foundation Financial Assistance Program: 1320 Graham Blvd, Suite 110, Montreal, QC H3P 3C8   
Toll-Free Telephone 1-888-592-CURE |** [**infocure@curefoundation.com**](mailto:infocure@curefoundation.com)