BELIEVE IN THE GOLD TREATMENT ASSISTANCE PROGRAM (TAP)

FAMILY INFORMATION		
Patient Name:		Date of Birth:
Parent Name:		
Email Address:		
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
Reason for request:
Do you have extended health benefits to cover some of these expenses related to your treatment? YES / NO
Are you receiving support/services from the Government or Community? YES / NO

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*

Nurse/Social Worker/Oncologist:

_____ _____
Signature *Date*

NOTE: To be approved all fields must be filled out.

APPROVAL

Believe in the Gold:

_____ _____
Signature *Date*

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