power of hope
cost reduction program

Patient Application and Consent Form

Women

Patient Information

Last name: _____ First name: _____ Middle: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: ( ) _____ Alternative Number: ( ) _____

Email: _____ Date of Birth: ____/____/____ (dd/mm/yyyy)

Applicants must be 40 years of age or younger to qualify for the program.

Health Information

Health Card Number: _____ Version Code: _____ _____

Cancer Type: _____

Insurance Information

☐ I do not have any health insurance ☐ I do have health insurance

Plan Number: _____ Policy Number: _____

Please provide proof from your insurance company (if applicable) that procedures are not covered.

**You may contact your individual fertility clinic to discuss the possibility of compassionate medication if your insurance company does not cover medication.*

Financial Information

Please check the following statement that applies to you

☐ I am a single applicant with a gross annual income of $100,000.00 or less.

☐ I am a married (or common-law) applicant with a gross annual income of $125,000.00 or less.

250 City Centre Avenue, Unit 100, Ottawa, ON K1R 6K7 | 613.440.3302 | Toll free: 1.877.HOPE.066 | F: 613.440.3329 | www.fertilefuture.ca

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Privacy Information

☐ I have read and understand the Fertile Future Privacy Policy and am aware Fertile Future will use and retain my information as described within this policy.

☐ I give my physician(s) permission to disclose medical information to Fertile Future for the purpose of processing my application for the Power of Hope program.

☐ I agree to be contacted annually by Fertile Future in order to provide an update as to the outcome of my treatment.

Please provide an alternate contact

Name: _____ Relationship to applicant: _____

Phone: ( ) _____ Email: _____

Patient Signature: _____ Date: ____/____/____ (dd/mm/yyyy)

DISCLAIMER: *Fertile Future will review and process completed applications when received. To ensure prompt processing of your application, please make sure that all requested information and materials are provided. An application under this program does not guarantee funding. Fertile Future will review completed applications and make funding decisions based on program criteria, and availability of funds.*

Applicant Checklist

Please note: Only complete applications that include the following documentation will be processed.

☐ Complete Patient Application Consent Form

☐ Complete Physician Information and Consent Form

☐ Option C Documentation *(Please call the Canada Revenue Agency at 1-800-959-8281 to request your 'Option C' documentation.)*

- Single Applicants: Please provide most recent Option C document indicating a gross annual income of $100,000 or less.
- Married (or Common-Law) Applicants: Please provide most recent Option C document of applicant and applicant's significant other, indicating a combined gross annual income of $125,000 or less.
- Applicants under 18 years of age: Please provide parent(s) or guardian(s) most recent Option C document(s). Same rules apply as above.

☐ Original receipt for fertility preservation treatment showing a balance of $0.
(Administering Fertility Centre must be a member of the Power of Hope Program.)

☐ No more than one year has elapsed since fertility preservation was performed.

☐ Submit completed application by email (scanned originals accepted) at info@fertilefuture.ca, mail or fax

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Physician Information and Consent Form

Women

Patient Information

Last name: _____ First name: _____ Middle: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Date of Birth: ____/____/____ (dd/mm/yyyy)

Oncologist Information

Last name: _____ First name: _____

Title: _____

Name of Treatment Centre: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone/Extension: ( ) _____ Fax: ( ) _____

Email: _____

Treatment centre's Power of Hope administrator (if known): Name: _____

Phone/Extension: ( ) _____ Fax: ( ) _____

Email: _____

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Health Information of Patient

Cancer Type: _____

Past treatment and dates of treatment completed (if applicable): _____

_____

If the patient has had a history of cancer and treatment has already occurred:

- At least one year must have passed since completing that treatment, and;
- Additional cancer treatment is planned imminently that will further affect fertility.

Treatment Plan (please indicate location of surgery, type of chemotherapy, location(s) and dose of radiation, if applicable): _____

_____

Please note: Only complete applications that include the information as outlined on page 2 of this application will be processed.

☐ I believe that this patient's cancer treatment presents a risk to her fertility and support fertility preservation as a safe and appropriate option for this patient.

Oncologist Signature: _____ Date: ____/____/____ (dd/mm/yyyy)

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