



# Patient Application and Consent Form

## WOMEN

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### PATIENT INFORMATION

Last name \_\_\_\_\_ First name \_\_\_\_\_ Middle \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone (     ) \_\_\_\_\_ Alt # (     ) \_\_\_\_\_

Email \_\_\_\_\_ Date of Birth (yyyy/mm/dd) \_\_\_\_\_

*\*required in order to receive reimbursement*

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

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### HEALTH INFORMATION

Health Card Number \_\_\_\_\_ Version Code \_\_\_\_\_

Cancer Type \_\_\_\_\_

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### FINANCIAL ARRANGEMENTS

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.



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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

Last name \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_

Phone (     ) \_\_\_\_\_ Email \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date (yyyy/mm/dd) \_\_\_\_\_

**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 visit the following link to view details on how to obtain this document:  
<http://www.cra-arc.gc.ca/esrvc-srvce/tx/ndvdl/prffncmsttmnt-eng.html>
  - Original receipt for fertility preservation treatment showing a balance of \$0 (*Administering Fertility Centre must be a member of the Power of Hope Program.*)
  - If applicable, completed expense reimbursement form (Appendix A) along with original receipts of expenses incurred due to your fertility preservation procedure (example: fuel, hotel, meals).
  - No more than one year has elapsed since fertility preservation was performed.
- *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.*