



## ABOUT THE RUBY SLIPPER & Black Boot FUND

The Ruby Slipper & Black Boot Fund provides financial assistance to people living on the Sunshine Coast who have received a cancer diagnosis. **After all other means of support have been exhausted** the Ruby Slipper & Black Boot Fund aids with the costs of treatment-related transportation, some prescriptions not otherwise covered under medical plans.

Please note that all financial assistance provided to our applicants is made possible through local fundraising events and donations from the Coast community. Amounts provided for assistance are determined based on available funds and the number of monthly applicants. Because of this, some requests are not always filled. We wish to help relieve as much of the financial stress as possible and strive to do the best we can.

Applicants must be Sunshine Coast residents (Langdale to Earls Cove) in order to receive assistance. All information shared will be kept strictly confidential. If you have any questions about completing this application, send an email to: [rubyslipperfund@gmail.com](mailto:rubyslipperfund@gmail.com)

## HOW TO APPLY

The following steps are to be completed in order to apply for assistance from the Ruby Slipper Fund:

- Complete page 1 and 2 of this application form (a PDF of this form can be found on our website)
- Please include a brief letter summarizing your current situation in order for your request to be processed in a timely manner
- Please mail or scan and email completed applications to:

**Ruby Slipper & Black Boot Fund**  
P.O. Box 457  
Sechelt, BC, V0N 3A0  
or Email: [rubyslipperfund@gmail.com](mailto:rubyslipperfund@gmail.com)

- Please allow up to 4 weeks of processing time once you have submitted your application.

## RUBY SLIPPER FUND – ASSISTANCE APPLICATION

### PATIENT INFORMATION (please print clearly)

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Last name: \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_

Address: \_\_\_\_\_ City/postal code: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (M/D/Y)

Marital status: \_\_\_\_\_ # of Dependents: \_\_\_\_\_

### CONTACT PERSON INFORMATION

Contact Person: \_\_\_\_\_ (relationship to you) \_\_\_\_\_

Contact Person Home Phone #: \_\_\_\_\_ Cell: \_\_\_\_\_

# RUBY SLIPPER FUND – ASSISTANCE APPLICATION

## MEDICAL INFORMATION (please print clearly)

Date of Diagnosis: \_\_\_\_\_

Type of Cancer: \_\_\_\_\_ Stage: \_\_\_\_\_

Is this a new primary diagnosis? \_\_\_\_ Yes \_\_\_\_ No

Is this a recurrence? \_\_\_\_ Yes \_\_\_\_ No

Is the patient in active treatment? (chemotherapy, radiation, surgery) \_\_\_\_ Yes \_\_\_\_ No

If not in active treatment, indicate the follow up: \_\_\_\_ Yearly \_\_\_\_ 6 months \_\_\_\_ Other: \_\_\_\_\_

Please indicate the type of treatment(s) received in past 12 months (check all that apply)

\_\_\_\_ Chemotherapy \_\_\_\_ Radiation \_\_\_\_ Surgery \_\_\_\_ Hormonal \_\_\_\_ Palliative care \_\_\_\_ Other: \_\_\_\_\_

## HEALTH CARE PROFESSIONAL INFORMATION:

Doctors name: \_\_\_\_\_ Clinic: \_\_\_\_\_

## INCOME INFORMATION (please print clearly)

Please indicate your **monthly** income for the following:

Employment income: \$ \_\_\_\_\_

Disability income: \$ \_\_\_\_\_

Medical EI: \$ \_\_\_\_\_

Social Assistance: \$ \_\_\_\_\_

Spousal income: \$ \_\_\_\_\_

Other income: \$ \_\_\_\_\_

**TOTAL:** \$ \_\_\_\_\_

## EXPENSES INFORMATION (please print clearly)

Please use this space to indicate your current expenses:

## ASSISTANCE REQUEST (please print clearly)

Check which of the following you are applying for and amount requested. (Attach copies of receipts or bills where applicable)

Volunteer Drivers \$ \_\_\_\_\_

Rent \$ \_\_\_\_\_

Counselling \$ \_\_\_\_\_

Prescriptions \$ \_\_\_\_\_

Essential Utilities \$ \_\_\_\_\_

Other: (please specify) \_\_\_\_\_

Food \$ \_\_\_\_\_

Gas \$ \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctors signature: \_\_\_\_\_