HOWARD D. TROTMAN NET PATIENT ASSISTANCE PROGRAM APPLICATION FORM

The Howard D. Trotman NET Patient Assistance Program was created to address the financial impact of a cancer diagnosis on Canadian persons with neuroendocrine cancer. The program offers a grant of up to $3,000 per family to provide some relief from economic hardship during a very challenging time in their life. The program was founded to assist those experiencing acute financial hardship resulting directly from the diagnosis and ongoing monitoring, treatment and management of your neuroendocrine cancer.

The program is run by volunteers and funded solely on the generous support of Sue Folinsbee, CNETS and general donations to the program via CNETS. Launched in 2025, this is a pilot program.

The criteria outlined in this application are reviewed and updated annually.

Please complete the application in full and provide all required documentation listed below. Before submitting your application, please use the enclosed checklist.

Eligibility Criteria

- The applicant must be diagnosed and living with neuroendocrine cancer.
- The applicant must be a Canadian citizen, approved landed immigrant or permanent resident.
- The applicant must have exhausted other available sources of support before applying. (Please refer to the Summary of Financial Assistance Programs)
- Each application can be submitted for a maximum of $3,000 per family (funds permitting). Receipts are required for reimbursement.
- Caregiver expenses will also be considered (for example, airfare when accompanying a patient).
- The application can be completed and signed by the patient or authorized desigate.
- The application must also be signed by the patient`s social worker, nurse or oncologist.
- Pre-approval of an anticipated expense is permitted however payment will not be made until receipts are submitted with the application.

Required Supporting Documents

- A copy of the previous year's Notice of Assessment(s) from the Canada Revenue Agency for yourself and anyone in your family who is 18 or older and lives in your household or appropriate equivalent proof of income.
- Applicants must disclose ALL sources of income (including but not limited to child support, spousal support, investment revenue, etc.)
- If the applicant has any long-term disability (LTD) coverage, a copy of your coverage must be submitted with your application.

Examples of eligible expenses (but not limited to):

- Transportation to/from the center for appointments or treatment.
- Accommodations ($185-$250 per night)
- Meals at a per diem rate of $50 per day
- Medications that are not covered by any other plans (or non-covered % portions) related to your cancer.
- Cost of diagnostics not available to you under the public health system (example: Ga68 PET/CT)
- Parking at the cancer center/hospital.
- Childcare costs
- Expenses not listed above can be submitted for consideration by the review committee.

CNETS | 333 Pitt Street Suite 102 - Cornwall, Ontario K6J 3R1
www.cnets.ca | 416-628-3189 | (toll free): 1-844-628-6788 |85623 3986 RR0001

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CNETS CANADIAN NEUROENDOCRINE TUMOUR SOCIETY

Financial Assistance Application Form

PERSONAL INFORMATION					
First Name		Last Name			
Date of Birth (DD/MM/YY)		Email			
Phone(Home)		Phone (Cell)			
Address		Apartment			
City		Province		Postal code	
Permission to leave voicemail on home phone number? ◯Yes ◯No Permission to leave voicemail on cell phone number? ◯Yes ◯No					
Is this your first application for assistance? ◯Yes ◯No					
Have you applied for reimbursement to additional reimbursement programs? ◯Yes ◯No If yes, please advise which programs:					
Why is this fund important to you?					
Are you willing to provide a testimonial for our website? ◯Yes ◯No					

MEDICAL INFORMATION This section must by signed by your health care professional (e.g. doctor, nurse, social worker)					
Date of Diagnosis (MM/YY):		Type of Neuroendocrine Cancer:			
Tumour Grade: (eg, 1, 2, 3 NET or NEC)		Disease Stage: (eg. 0, 1, 2, 3, metastatic)			
Last day of work due to diagnosis (DD/MM/YY): (if applicable)		Expected return to work date (DD/MM/YY): (Mandatory if applicable)			
Name and Title of Health Care Professional					
Hospital Centre		Phone		Email	
Health Care Professional's Signature: (attesting the accuracy of the information indicated above)					
Date (DD/MM/YY)					

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FINANCIAL INFORMATION					
YOUR HOUSEHOLD INCOME					
Household Gross Annual Income	**Source**	**Yourself**	**Spouse/Partner**	**Child(ren)**	**Other Person**
Employment Income		$	$	$	$
Employment Insurance		$	$	$	$
Disability Insurance		$	$	$	$
CPP Disability		$	$	$	$
Retirement Income		$	$	$	$
CPP Pension		$	$	$	$
Government Assistance		$	$	$	$
Child Support		$	$	$	$
Rental Income		$	$	$	$
Spousal Support		$	$	Not Applicable	Not Applicable
Investment Revenue		$	$	$	$
Other		$	$	$	$
Total Per Person		**$**	**$**	**$**	**$**
TOTAL HOUSEHOLD ANNUAL INCOME			**$**		

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FOR ELECTRONIC REIMBURSEMENT

If you would like to be reimbursed electronically please complete the following section.

PAYEE INFORMATION			
Name:		Phone Number:	
Mailing Address:			
Email Address:			

If the following section is not completed a cheque will be issued.

FINANCIAL INSTITUTION INFORMATION			
Bank Name:		Account Holder's Full Name:	
Transit Number: (5 digits)		Bank Number: (3 digits)	
Account Number: (up to 12 digits)			
Attach a cheque marked "VOID" or the direct deposit information provided by your bank verifying the account holder's name and bank details.			

MEDICAL EXPENSES

Please list itemized expenses below and provide copies of receipts as back-up.

Images of receipts are to be submitted with the application

NOTE: EXPENSES MUST RELATE TO YOUR MEDICAL TREATMENT, DIAGNOSIS OR ONGOING MANAGEMENT AND MUST BE INCURRED WITHIN THE SAME CALENDAR YEAR AS APPLICATION SUBMISSION

Expense	Date	Amount
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
TOTAL REIMBURSEMENT AMOUNT REQUESTED		$

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Expenses eligible for reimbursement:

- Transportation to/from the center for appointments or treatment
- Accommodations at mid-range pricing ($185-$250).
- Meals at a per diem rate of $50 per day
- Medications that are not covered by any other plans (or non-covered % portions) related to your cancer
- Parking at the cancer centre/hospital
- Childcare costs
- Expenses not listed above can be submitted for consideration by the review committee

AUTHORIZATION

If submitting form by Email:

☐ I understand that email is not a secure means of communication. I consent to sending and receiving communications including banking information by email.

☐ I agree that CNETS will not be liable for any breaches of privacy, whether caused by myself, or a third party.

☐ I understand that if I am not comfortable with email, all communication will be by mail instead.

☐ I authorize CNETS to execute electronic credit deposit to the above designated bank account identified on this form.

I certify that the above information is accurate and complete. The anonymized data will be used for statistics. For verification purposes, I authorize the CNETS to discuss my file with the members of my medical team. I understand that CNETS reserves the right to refuse my 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: (please type full name if filling out electronically)	**Date:**

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CANADIAN NEUROENDOCRINE TUMOUR SOCIETY

CHECKLIST

PLEASE READ CAREFULLY

This checklist is provided so that you can be sure that all of the mandatory documents are included with your application.

We understand that the Application is comprehensive and will take some time and effort on your part to complete - at a time when you may be feeling unwell. **However, we cannot review your application unless all of the relevant documents are included.**

Checklist for Applicant:

☑	
☐	All sections of applications completed in full
☐	Application signed by applicant or authorized designate
☐	Application signed by Social Worker, Medical Oncologist or Primary Care Nurse
☐	Copy of latest NOA for patient and all other members of household, as applicable, or equivalent
☐	Receipts for expenses
☐	Self-Employed must include a copy of T2125 and/or T5013 or an audited statement
☐	LTD coverge statement if applicable

Please send your application (with all required documentation) by email:

CNETS – The Howard D. Trotman NET Patient Assistance Program
Phone (toll free): 1-844-628-6788
Email: HDTAssistance@cnets.ca

PLEASE SHARE A TESTIMONIAL

Finally, YOU CAN HELP US help other patients! When we send a THANK YOU to donors of this Fund, we would like include a TESTIMONIAL and/or information about the persons with cancer we have supported. You can help by writing a brief testimonial about your experience and how the support you received helped you and your family. Please forward by email HDTAssistance@cnets.ca, with this application, by separate cover or by mail to CNETS, The Howard D. Trotman NET Patient Assistance Program, 333 Pitt Street, Suite 102, Cornwall, ON, K6J 3R1.

OUR PRIVACY POLICY

CNETS is committed to protecting the privacy of the personal information of its constituents. (applicants, donors, health care professionals and other stakeholders). We have taken the necessary actions to ensure that our Policy on the rules for collection, use, disclosure, and retention of your personal health information, in any format (paper or electronic), is based on internationally recognized privacy principles.