Reduced Rate Application for Patients of the CCNM Integrative Cancer Clinic

CCNM CLINICS | Integrative Cancer Clinic
Canadian College of Naturopathic Medicine

At the CCNM Integrative Cancer Clinic, we believe integrative cancer care should be accessible to everyone who needs it regardless of income. We offer a financial assistance program for people with cancer who have a clear financial need or who are on social assistance or ODSP.

To apply, you will need to complete this application form detailing your financial situation so we can obtain a clear picture of your specific financial need and determine the assistance level appropriate to you.

CCNM Privacy Statement: We understand the importance of privacy and protecting your personal information. We are committed to collecting, using, and disclosing your personal information responsibly. All information provided in this application will be retained by CCNM and shall not be released to any other party without expressed written consent of the applicant.

Applicant Information:

Name: _____ Date of Birth: _____

Address: _____

Phone number: _____ Email: _____

Income Information:

List gross monthly income (before deductions). Please include all household income including partner's income.

	Name	Source (i.e. employment, EI, pensions, income assistance, etc.)	Gross Monthly Income ($)
1			
2			
3			
4			
5			
6			
7			
8			

Application Checklist:

Before returning your Reduced Rate Application, have you:

- Completed your application in full
- Enclosed a copy of income verification
- Included most recent “Notices of Assessment” for self and partner
- Signed and dated the application in the space below

I declare:

- This is my application; and
- All the information in it is correct and complete to the best of my knowledge and belief.

I understand:

- That this application does not constitute any agreement on the part of the CCNM Integrative Cancer Clinic to provide me with reduced rates.
- That it is my responsibility to advise the CCNM Integrative Cancer Clinic of any changes to the information given in this application and to provide any supporting materials required for my application.
- That the reduced rates will only apply after the application is processed.
- That I will not be entitled to reimbursement of fees already paid to CCNM Integrative Cancer Clinic and the Schad Naturopathic Clinic.

Signature of Applicant*: _____ Date: _____
**By typing your name above, you are signing this application electronically*

Please complete this form and return it, along with proof of financial need to clinic reception.
You may also email or fax the application to:
ccnmclinics@ccnm.edu
Fax: 647-689-5794

THIS SPACE IS FOR OFFICE USE ONLY			
Income Verification Provided:	Application Approved:	Processed By:	Date:
Subsidization level provided:			
Notes:			