Shine Through the Rain Foundation

Supporting families through life threatening illnesses.

The Rainy Day Fund

Please note: Submission of an application does NOT guarantee funding. We kindly ask that you read the following guidelines carefully before completing and submitting an application form.

General Guidelines:

- The patient, a Canadian Citizen, must currently be in treatment for a life-threatening illness to be eligible for financial assistance, regardless of when the expense was incurred.
- Transportation is defined as parking, taxi, bus, and train expenses. Please provide proof of original receipts and record of appointments which must correspond to the date on the original receipts (please see Section 3A).
- STTRF will consider reimbursement for transportation expenses incurred during the current year and up to January of the following year.
- Only rent, utilities (heating, hydro and electricity), and home phone expenses 30 days overdue will be considered (please see Section 3B).
- Cell phone expenses will not be considered unless it is the only phone in use (please note in supporting narrative), and data plans will not be considered for financial support. For rent expenses, please attach a statement from the landlord detailing the overdue balance and the number of months overdue. For all utilities, please attach a copy of the most recent bill detailing the date and (overdue) amount.
- A maximum funding award of $1000.00 may be considered per family, per calendar year. Please note we also apply a minimum financial support request of $15.00.
- The deadline for all applications is the 15th of every month, unless the 15th falls on a weekend, in which case the deadline will be the Friday.
- **All** applications must include supporting narrative documentation from the social worker, doctor, nurse, or case manager involved in your care. Please include any compelling information which you believe may help the application.

Additional Information to Note:

- All patient information will be kept strictly confidential. However, should the patient specifically agree to share their experience with STTRF to aid promotion of the organization's services and activities, this agreement will be considered informed consent to use their story to advocate for STTRF.
- STTRF does not contact patients directly. All inquiries must be directed to your social worker or case manager.
- We do not assist with cable or internet payments, mortgage, credit card payments, auto or home insurance, hotel, gas, or medically-related expenses.
- Cheques are made payable to the landlord or company and sent directly to the patient.
- Approved patients must cash received cheques within a reasonable timeframe. STTRF reserves the rights to cancel outstanding uncashed cheques. Please inform your social worker/nurse of any issues regarding approved cheques.
- Address must be written clearly as we are not responsible for any lost or stolen grocery cards.
- Applications must be completed in full to be considered.
- Please allow up to two weeks for STTRF to notify the social workers, nurse or case manager. It is the responsibility of the social workers to contact the patients and advise of the application status whether approved or declined.
- Please submit only ONE copy of the application by email program.services@shinethroughtherain.ca or by fax 905-477-4251.

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APPLICATION FORM

FOR OFFICE USE ONLY: Date Received ___/___/___

PLEASE WRITE LEGIBLY FOR CLARITY OF REVIEW

Please note: Submission of an application does NOT guarantee funding

Section 1: Family Information

Patient's Name: _____

Age: _____ Male: ☐ Female: ☐

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: (_____) _____ Are you a CA Citizen? _____

Email Address: _____

Sources of **Monthly** Income: (Please write the dollar amount per month)

Employment: _____ Unemployment: _____ Child Support: _____

Disability: _____ Welfare: _____ CPP: _____

OAS: _____ Other: _____

Total Yearly Household Income (Including costs listed above): _____

Number of dependents aged 18 and under _____

Do you identify as First Nations, Metis or Inuit? ☐ No ☐ Yes If Yes: ☐ Status ☐ Non-Status

If yes, please include a copy of your Native Status Card. We may occasionally have additional funding available and are required to ask for proof of status. Please note, funders will not be provided with your name and contact information.

FOR OFFICE USE ONLY:

Approved by: _____ Date: _____

Amount: _____ Payable to: _____

Amount: _____ Payable to: _____

Amount: _____ Payable to: _____

Amount Available: _____ Amount remaining for this year _____

Notified SW/N on: By Email: By Phone:

Is copy of Native Status Card included, if Native Status indicated? ☐ No ☐ Yes

Phone: 905-477-7743 **Toll Free:** 1-866-753-0303 **Fax:** 905-477-4251 **Email:** program.services@shinethroughtherain.ca

Office: 1211 Gorham Street, Unit 12, Newmarket, ON L3Y 8Y3

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Section 2: Diagnosis

Diagnosis:_____ Date of Diagnosis: _____

Are You Currently in Active Treatment? Yes ☐ No ☐ Date of last treatment:_____

Name of Physician/Oncologist: _____

Patient's Primary Medical Facility: _____

Address: _____

Social Worker/Nurse:_____ Title: _____

Telephone: ( )_____ Fax: ( ) _____

Email Address: _____

Section 3: Request for Funding

Please complete Section 3A and/or Section 3B:

Section 3A: Transportation Expenses

For any funding application towards transportation expenses, please provide **all original applicable receipts** and record of appointments which correspond to the original receipts. Please note: we do not reimburse for gas.

Please check box(es) that apply: Parking ☐ Taxi ☐ Bus ☐ Train ☐

Amount you are applying for: $_____

Section 3B: Rent, Utility, Phone & Grocery Expenses

For rent, please attach copy of a letter from the landlord stating overdue balance and how many months in arrears in order to be considered for funding. For utilities such as hydro and electricity, please provide a copy of the bill showing the date and overdue balance. Please note, financial aid towards phone *data plans* will not be considered.

Please check box(es) that apply: Rent ☐ Utilities ☐ Phone ☐ $100 Grocery Card ☐

Please Select Preferred Grocery Card:

☐Sobeys Gift Card can be used at: IGA, Foodland, Freshco., Lawtons Drugs, Thrift Foods & Needs President's

☐Choice Gift Card can be used at: Loblaws, Loblaw Great Food, Dominion, No Frills, Real Canadian Superstore, Maxi, Provigo, Extra Foods, Your Independent Grocer, Atlantic Superstore, Zehrs Markets, Valumart, Fortinos, and Shopper's Drugmart

Do you have any Shut-Off or Eviction Notices? No ☐ Yes ☐ (If yes, please provide copy of documentation)

Please list the name of the payee, the total amount that is overdue, and the due date.

Payee:_____ Cost:_____ Due: _____

Payee:_____ Cost:_____ Due: _____

Payee:_____ Cost:_____ Due: _____

Payee:_____ Cost:_____ Due: _____

Amount you are applying for $_____

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Section 4: Further Expenses

If you have concerns about additional expenses that fall outside the general remit of this fund (detailed in application guidelines), please indicate details and amount below (if possible). Supporting documentation such as an invoice should be provided. Consideration for further financial assistance may be given, however please note that funding is not guaranteed.

Nature of Expense: _____

Amount: $_____

Section 5: Supporting Documentation from Social worker or Case Manager

Please provide a brief supporting narrative written by a social worker, doctor, or nurse. This supporting report is essential to assist us in considering the needs of the patient and their family. Please use a separate sheet and include details such as:

- patient's current medical situation
- perceived impact to family and financial circumstances
- difficulties associated with existing professional and/or personal responsibilities
- brief outline of treatment plan
- access or attempts to access other support resources
- any other compelling and relevant information

Section 6: Review and Sign

By signing this document, I confirm that the information detailed is, to the best of my knowledge, true and correct.

Patient Name (Print): _____

Signature:_____Date: _____

Social Worker/Case Manager Name (Print): _____

Signature:_____Date: _____

Please note it is the responsibility of the Social Worker/Doctor/Nurse to notify the patient of the status of their application - an application status update will be provided by STTRF within two weeks of the application deadline (whether approved or declined). STTRF does not make direct contact with the patient to communicate the outcome of an application.

Section 7: Photo Waiver and Release Information

To provide our services, Shine Through the Rain Foundation relies on donations and the kindness of others to help us raise awareness, deliver effective programs of support and develop our portfolio of services for those in need. To generate support our community must understand the difference they can make through donations and volunteering their time or services. We ask our applicants to please kindly consider allowing us to share their stories as an example of how our organization helps patients and their families when unexpectedly faced with life challenges as a result of a health crisis.

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This section must be completed for the application to be considered

Please check the appropriate box below.

☐ I authorize Shine Through the Rain Foundation to use my story for the promotion of its programs and support services, although would prefer to be contacted before initial publication of material featuring my story.

☐ I authorize Shine Through the Rain Foundation to photograph me (and/or use images I have provided of myself and my family). I acknowledge that STTRF will retain the right to use these images in marketing materials (both web based and printed) for the purposes of promoting the organization and associated services, events and activities.

☐ I DO NOT authorize Shine Through the Rain Foundation to use my story or image for any advocacy efforts, events or activities delivered by the organization or associated parties.

Please attach or email your photo to program.services@shinethroughtherain.ca

Patient Signature:_____ Date: _____

Phone: 905-477-7743 **Toll Free:** 1-866-753-0303 **Fax:** 905-477-4251 **Email:** program.services@shinethroughtherain.ca

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