LAO COMPASSION FUND APPLICATION

DATE: _____

REFERRED BY: _____

CRITERIA: Eligible lymphedema patients must apply in writing to the LAO outlining their need for financial assistance in the form of a letter and this completed form and any attached documents required as requested below

SUBMITTED BY:

Patient Signature: _____

Date Signed _____

YOUR INFORMATION:

ARE YOU A CANADIAN CITIZEN OR PERMANENT RESIDENT ONTARIO (Yes or No):
_____

HOW LONG: _____

OHIP#: _____

NAME: _____

HOME ADDRESS: _____

HOME PHONE: _____

CELL PHONE: _____

Lymphedema Association of Ontario
262-2869 Bloor St. W.
Toronto, ON M8X 1B3
Canada
www.lymphontario.ca
1.877.723.0033
416.410.2250

EMAIL ADDRESS:_____

ALTERNATE CONTACT: _____

PHONE NUMBER: _____

RELATIONSHIP TO CONTACT: _____

CLINICIAN INFORMATION:

PHYSICIAN (FAMILY DOCTOR) OR ONCOLOGIST:_____

PHONE NUMBER: _____

CLINIC ADDRESS: _____

REFERRING LYMPHEDEMA TRAINED THERAPIST:

NAME: _____

PHONE NUMBER: _____

• ATTACH REFERRAL LETTER FROM FAMILY DOCTOR AND LYMPHEDEMA TRAINED THERAPIST

• PROVIDE NAME OF THE COMPANY AND THE POLICY NUMBER OF ANY HEALTH INSURANCE PROGRAMS, PRIVATE OR GROUP INSURANCE BENEFITS, INCLUDING LETTER OF CLAIM REFUSAL

• MUST PROVIDE PROOF OF INCOME STATUS, PROVIDING EVIDENCE OF COMBINED HOUSEHOLD INCOME (I.E. NOTICE OF ASSESSMENT, T1 OR ODSP STATEMENT)

LAO COMPASSION FUND CONSENT FORM

SUBMITTED BY:

Patient Signature: _____

Date Signed _____

Welcome to the Lymphedema Association of Ontario.

This consent form will be maintained confidentially in your file. This form covers the application for your present condition, as well as any documents attached. Please take the time to read and check if fully understood.

CONSENT TO THE COLLECTION OF INFORMATION:

All personal information, assessment information and records will be safeguarded and remain confidential. Any personal health information collected will remain confidential as per the Personal Health Information Protection Act, 2004.

I _____ give my consent for the collection of personal information.

I _____ agree that the information I have provided is true to the best of my knowledge.

I _____ understand the information I have provided on this form is confidential and will not be released without my written permission.

I _____ give my permission to share information if necessary, to

_____ Doctor _____ other health care professionals

I _____ do not give my permission