Patient Comfort & Care

Caring for our Communities.

DISCOVERY HEALTH CARE FOUNDATION

PLEASE NOTE: The Patient Comfort & Care program is 100% funded through corporate and individual donations to the Discovery Health Care Foundation, and therefore, assistance that can be provided is limited and based on each individual's unique situation.

****Note: Applying to this program does not guarantee funding.****

PATIENT COMFORT & CARE PROGRAM GUIDELINES: ***(Please read the guidelines carefully)***

- The Patient Comfort & Care program is accessible to Cancer, Dialysis, Mental Health & Addictions, and Emergency Care patients who do not fully qualify for Government funding assistance through the Provincial and/or Federal Government.
- This financial assistance program is to help supplement medical expenses for residents of the Clarenville & Bonavista Areas who are currently on active Cancer Care, Dialysis, and Mental Health & Addictions treatment, or those in Emergency Care scenarios.
- Emergency Care is defined as in response to a critical situation. Routine medical travel and/or follow-up appointments are not covered under urgent care.
- Travel is defined as gas, parking, taxi or bus expenses. This travel can include travel both on the Clarenville and Bonavista Areas for regularly scheduled appointments at the Dr. G.B.Cross Memorial Hospital & BPHC, or to St. John's up to a maximum of $75 gas, or two taxi vouchers (to and from appointment) per application.
- Accommodations are defined as a registered accommodations provider that would be a hostel, hotel, motel and/or licensed apartment provider such as an apartment building up to a maximum of two nights at $55/night. Request for accommodation expenses to stay with family members will not be considered.
- Meals are defined as expenses for meals during your treatment up to a maximum of $25/application.
- Please allow up to a maximum of 10 business days for your application to be processed and any approved funding to be dispersed. Your social worker/nurse/healthcare worker that assisted with the completion of this application will notify you of the status of your application.
- Applications must be completed in full in order to be considered.
- Applications submitted posthumously will not be considered. Funding will not be issued posthumously to a family.
- Funding is not in cash. Based on availability and identified need, eligible patients will be issued gas or grocery gift cards, or transportation vouchers.
- Applications can be submitted twice per year, up to a maximum of $350 annually.

Applications can be submitted via mail, email or in person to the address below:

Mail: Discovery Health Care Foundation
67 Manitoba Drive
Clarenville, NL A5A 1K3

Email: dhc.foundation@nlhealthservices.ca

In Person: DHCF Office, located next to the Gift Shop at Dr. G.B. Cross Memorial Hospital

Patient Comfort & Care

Caring for our Communities.

Patient MCP #: _____ _____

Date Received

PATIENT COMFORT & CARE PROGRAM APPLICATION FORM

The Patient Comfort & Care program is 100% funding through donations to Discovery Health Care Foundation. Assistance that can be provided is limited and unique to each patient's situation.

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____

Next of Kin/Spouse/Partner Name: _____

Complete Mailing Address: _____

Home Phone #: _____ Cell Phone #: _____

Home Town: _____ Return distance from your home to hospital (km): _____

Where did you hear about this fund? _____

Are you receiving any other travel assistance from any other funding source? ☐ Yes ☐ No

If yes, please define funding source and amount: _____

TREATMENT INFORMATION:

Diagnosis: _____ Physician Name: _____

Are you receiving chemotherapy? ☐ Yes ☐ No If yes, how often? _____

Are you receiving radiation? ☐ Yes ☐ No If yes, how often? _____

Are you receicing dialysis? ☐ Yes ☐ No If yes, how often? _____

Is this an Emergency Care request? ☐ Yes ☐ No Details: _____

REQUEST DETAILS:

Reason for financial assistance request. **DATE REQUIRED** (Please include as much information as possible)

_____

_____

_____ Date: _____

Anticipated expenses (in dollars): Meals: $_____ Accommodations: $_____ Travel: $_____

Duration of treatment/stay: _____

STATEMENT OF UNDERSTANDING:

I understand the statements above and ask for assistance from the Discovery Health Care Foundation's Patient Comfort & Care program. The information I have provided in this application is true and complete, to the best of my knowledge. I understand that my personal information will only be used to assess my application, communicate with me about my application, process any approved funding and seek my feedback about the program.

_____ _____

Signature of Applicant Signature of Healthcare Worker

Date: _____ Date: _____