Please fill out the following application and provide a financial statement and a signed treatment letter from your doctor. Once completed, please mail it to the following mailing address:

Canadian Chiari Association
30 Paardeburg Place
Kingston, ON K7K 5J2

I am applying for (please make a selection)

- **Financial Support Program Only** (Travel and accommodations)
- **Financial Support Drug Program Only** (Symptom Control Drugs)
- **Financial Support Program** and **Financial Support Drug Program**
- **Housekeeping**

Have you **previously** received assistance from the:

- Financial support Program ☐Yes ☐No
- Financial Support Drug Program ☐Yes ☐No

Section 1 – Personal Information

Name of person receiving treatment	**Date of application**
Name of Parent/Guardian (if person receiving treatment is under 18 years of age)	**Language spoken at home**
Date of birth (of person receiving treatment)	**Gender** (of person receiving treatment) ☐Female ☐Male
Mailing address	

City	**Province**	**Postal Code**
Phone (Daytime)	**Phone** (Evening)	
Email Address	**Marital Status**	
Name of spouse/common-law partner	**Number of dependents**	
Name of hospital/clinic providing treatment	**City where treatment takes place**	
Date of next appointment	**Anticipated number of appointments**	
Do you have any **extended health benefits or disability insurance that covers treatment or medications?** ☐Yes ☐No o If yes, please contact your plan to assist with coverage		