Lilly's Fund Program Application Form

Mandatory fields are marked with *

Section 1 Patient Information

Family name/Last name: *	Middle Name:	First Name: *
Date of Birth (YYYY-MM-DD): *	Beneficiary number: *	Social Insurance Number (999-999-999): *
Residence: * Home: Facility:	Address (Number / Street Name / PO Box): *	
LHC Community: *	Phone number (999) 999-9999:	Postal Code:
email:		

Section 2 If Patient is under 18 - Information about the Parent/Guardian

Family name/Last name: *	Middle Name:	First Name: *
Date of Birth (YYYY-MM-DD): *	Beneficiary number: *	
LHC Community: *	Address (Number / Street Name / PO Box): *	
Link with the patient: *	Phone number (999) 999-9999:	Postal Code:
email:		

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Section 3 Request I want to receive/receive on behalf of my under 18 child Lilly's fund financial support *

I am eligible (or my child is) for the Canada Disability tax credit : *

Yes No

Family name/Last name: *	Middle Name:	First Name: *

Date (YYYY-MM-DD): *

Signature: *

I understand that Lillys fund financial support is renewable every 12 months:

Section 4 For Health Professional *(optional if the patient receives the Canada Disability Tax Credit)*

I have assessed the beneficiary's limitations and this person meet the conditions of the program *

Yes No Section 1: Score Section 2: Score

Family name/Last name: *	First Name: *

Institution: *	Title / Profession: *	License or Registration # (Optional)

Date (YYYY-MM-DD): *	Signature: *

Section 5 Supporting documents: Reminder

Proof of Medical Assessment:

Yes No

if you have been assessed by a health professional, you don't need to add any additional supporting document.
if you are eligible to the Canada Disability tax credit, please add a proof of eligibility (letter, etc.)

Proof of Disability Tax Credit (DTC):

Yes No

For further information, please contact: Lillysfund@makivvik.ca and visit: https://www.makivvik.ca/lillys-fund-support-program/